Downtown Campus
Employee/Student Health Office
175 Elizabeth Blackwell St.
Syracuse, NY 13210
315-464-4260 (telephone)
315-464-5471 (fax)
eshealth@upstate.edu

UPSTATE MEDICAL UNIVERSITY

Non-Employee Medical Clearance

(NEMC)

Incomplete/Illegible forms will not be processed.

Community Campus
Employee Health Office
4900 Broad Road
Syracuse, NY 13215
315-492-5624 (telephone)
315-492-5117 (fax)
eshealth@upstate.edu

Today's Date: _____

Last Name: _____ First Name: _____ DOB: _____

Phone Number: _____ Email: _____

Your School/Agency: _____ Upstate Contact: _____

Upstate Job Title or Description: _____ Start Date: _____ End Date: _____

Job Location (circle): Downtown | Community | UHCC | Other: _____ Patient contact expected? (circle): Yes | No

Section I: In the PAST YEAR have you had or CURRENTLY have: *(explain all YES responses, add pages as needed)*

1. Any medical conditions? No / Yes (LIST)_____
2. Recent surgery (within 90 days)? No / Yes_____
3. Mental health condition? No / Yes_____
4. Frequent use of alcohol or any use of illicit drugs? No / Yes_____
5. Skin infection or open (non-healing) wounds? No / Yes_____
6. Recent weight loss, cough, fever, loss of appetite and/or night sweats? No / Yes_____
7. Medications? No / Yes (LIST)_____
8. Allergies? No / Yes (LIST)_____
9. Accommodations/Limitations? No / Yes_____
10. Lived or traveled outside of the U.S for more than 1 month? No / Yes_____
11. Close contact with someone who has had active tuberculosis (TB)? No / Yes_____

I certify that the above information is true and complete: _____(signature) Date:_____

Section II: ALL APPLICANTS MUST COMPLETE AND SUBMIT SUPPORTING VACCINES RECORDS AND/OR LAB REPORTS

1. Documentation of immunity to the below:
   - a. ☐ Rubeola (Measles): 2 doses of MMR vaccine or positive Rubeola antibody titer
   - b. ☐ Mumps: 2 doses of MMR vaccine or positive Mumps antibody titer
   - c. ☐ Rubella (German Measles): 1 dose of MMR vaccine or positive Rubella antibody titer
   - d. ☐ Varicella (Chicken Pox): 2 doses of Varicella vaccine or positive Varicella antibody titer
2. Documentation of the following vaccines:
   - a. ☐ Covid: 2 doses of Moderna or Pfizer or 1 dose of J&J (booster not currently required for clearance)
   - b. ☐ Flu Vaccination: Flu Season Aug-May: Vaccine required for clearance after Nov. 1.

Section III: TO BE COMPLETED BY HEALTH CARE PROVIDER OR NURSE (Applicant MUST provide any required documents)

Any Applicants who will be working inside a hospital and/or have direct patient care/contact need TB testing

3. Tuberculosis Testing (must be within 12 months of start date): (*If positive, Chest X-ray report is also required)

   Tuberculin Skin Test (TST) **[Must be read within 2-3 days from placement]**

   Date placed:_____ Date read:_____ Reaction (induration measured in mm):_____mm

   Readers Signature and Title:_____ Phone:_____

   or TB Blood test (such as QuantiFERON or T-spot): MUST INCLUDE LAB REPORT

Section IV: Physical Attestation Statement: TO BE COMPLETED BY HEATH CARE PROVIDER (exam must be within 1 year of start date)

The person listed above underwent a physical examination on_____(date) and was found to be free of communicable disease and is able to work without restrictions or limitations.

Provider Name (print):_____ Signature:_____ Date:_____

Provider medical license number/state:_____ Phone:_____

Provider Stamp/Address:

ESH Office Use Only: