Winthrop-University Hospital

EMPLOYEE HEALTH DEPARTMENT REQUIREMENTS FOR OBSERVERS/AFFILIATES*

222 Station Plaza North Room 515
Mineola, NY 11501
Tel: (516) 663-2534
Fax; (516) 663-8472

Name: _____

Address: _____

_____

(Town) (Street) (Zip)

Winthrop University Hospital's health and immunization standards are based on Nassau County and New York State Department of Health requirements and recommendation. If you do not provide necessary documentation, you may not begin as scheduled.

ALL OBSERVERS/AFFILIATES* MUST PROVIDE THE FOLLOWING DOCUMENTS TO EHD UPON INITIAL CHECK-IN, AND EACH TIME THEY ARE RENEWING THEIR CLEARANCE.

I. Rubella Immune Status:

A copy of the laboratory report of the titer **OR** acceptable documentation of vaccination.
Lab titer _____ Vaccine #1 _____

II. Rubeola (Measles) Immune Status: (Show Lab Report)

1. All individuals born in or after 1957 must show acceptable documentation of having received two doses of MMR or the Measles vaccine after their first birthday **OR** physician documented history of clinical measles **OR** serologic (laboratory blood test) confirmation of measles immunity.
2. All individuals born before 1957 will show serological (laboratory) immunity to measles. In the event of a negative titer, the individual will require vaccination.

Lab Titer _____ Vaccine #1 _____ Vaccine #2 _____

III. PPD Documentation (Must be dated within 12 months)

*PPD skin test (Date given) _____
Reaction _____ mm induration
Date Evaluated _____
Evaluated by _____

or

If PPD Positive
date of last CXR _____
Results _____ Please attach report.

IV. Practitioner Certificate: (Must be dated within 12 months)

Have your practitioner fill out this section or provide documentation stating Good Health.

I have performed a physical examination of sufficient scope to ensure that the above mentioned person is free from health impairment which is of potential risk to the patient or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior [per N.Y.S. Code 405 3 (b)]

Practitioner signature _____ Date _____ License # _____

Practitioner name (Print) _____ Telephone _____

Address: _____

THE EMPLOYEE HEALTH DEPARTMENT WILL ISSUE A CLEARANCE FORM WHEN ALL REQUIREMENTS ARE MET.

***Observer/Affiliate = contracted worker, student, temp., vendor, rotating resident, intern/clerk or any other personnel not on Winthrop University Hospital payroll.**

Ehd imm cert.
Jan. 2012