_____ _____ DOB: _____

Last Name, First Initial **Degree**

OFFICE USE ONLY
Date Received:

Annual Health Assessment Form

Each member must have an annual health review within 30 days of the previous year's exam. Health care providers must be in good physical and mental health, free from impairment of potential risk to patients or which might interfere with the performance of the practitioner's duties, exercise of clinical privileges and the provision of quality patient care.

This Uniform Annual Health Review Form, which conforms to New York State Title 10 Health Code 405.3(b)(10)(11), has been developed by the Monroe County Medical Society, in conjunction with hospitals and other health care facilities in the Finger Lakes region. **Use of this form will enable the applicant's examining practitioner to complete an Annual Uniform Health Review Form, only once, and then have the staff member submit photocopies to relevant facilities/organizations.**

Completed by the staff member:

Permission by Medical/Dental Staff Member: I give permission to_____to complete this annual health review form in accordance with New York State regulations.

Have there been any changes in your health status – physical or mental – in the past year or since your last physical examination? __ Yes __ No If yes, please record the details on a separate sheet.

_____ _____

Staff Member's Signature **Date**

Examining Provider's Statement: I the undersigned and designated primary care giver have completed this health assessment form with full knowledge and documentation in the medical record that this practitioner is free from a 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.

Examining Provider's Signature_____**Date**_____

Examining Provider's Printed Name _____

Examining Provider's Medical License # _____

Address _____

Telephone (_____)_____ **Fax (_____)**_____ **E-mail:** _____

Revised 05/08/15

Last Name, First Initial _____ **Degree** ____

DOB: _____

OFFICE USE ONLY
Date Received:

Annual Respirator Mask Form

N95-TB Protection Mask: **Brand** Tecnol 3M 8512 PAPR

Size____

Other mask + size: _____

OSHA mandates a yearly fit test.

Examining Provider's Signature_____ **Date**_____

Examining Provider's Printed Name _____

Examining Provider's Medical License # _____

Address _____

Telephone (_____)_____ **Fax (_____)**_____ **E-mail:** _____

Revised 05/08/15

_____ _____ DOB: _____

Last Name, First Initial **Degree**

OFFICE USE ONLY
Date Received

Annual TST/PPD Form

TB Status: Annual requirement

Tuberculin Skin Test (TST) ***unless there is a history of a past positive TST. Please note, a BCG vaccine is not a contraindication for TST. Repeat CXR is NOT required unless suggestive symptoms.***

Date of TST: _____ Time of TST: _____

Date of Result: _____ Time of Result: _____ ___Negative __Positive Result:_____mm (size of duration) interpretation

History of past positive TST: Date of last chest X-ray Results of X-ray: _____

Preventive treatment for positive TST No Yes If yes, specify _____
Any symptoms of active tuberculosis No Yes If yes, specify_____(evaluation required)

Interpreting practitioner: _____ Date:_____

QuantiFERON Date: _____ Result _____

Examining Provider's Signature_____**Date**_____

Examining Provider's Printed Name _____

Examining Provider's Medical License # _____

Address _____

Telephone (_____)_____ **Fax (_____)**_____ **E-mail:** _____

Revised 05/08/15