North Shore-LIJ Health System

Visiting House Staff and Medical Student Medical Clearance Form Instructions

Health Assessment

*Visiting House Staff and Medical Student Clearance Form which must be completed and signed by your health care provider. Practitioner must put title and stamp on form*

Tuberculosis Screening

**Option 1:** Provide date and result of two (2) Tuberculin Skin Tests within 12 months of rotation on licensed practitioner’s or hospital Employee Health Service letterhead. **The 2nd TST must be within 3 months of the rotation start date**

-OR-

**Option 2:** Provide documentation from Blood based Tuberculosis Screen Tests within 3 months of rotation. Approved FDA test are: QuantiFERON-TB Gold; QuantiFERON-TB Gold In-Tube; TSpot.TB.

If TST or Blood Based Tuberculosis screening results is positive, then submit chest x-ray report performed within 12 months of rotation documenting no active disease.

Proof of Immunity via blood titers OR vaccination records

**Titers:**
- All titers must be official lab reports.
- The name and address of the lab must be on the lab results.

**Vaccination Records must include the following:**
- Name of Product (Vaccine)
- Date the vaccination was administered
- Contact information of the vaccinator or facility (i.e.; Office Stamp)

Requirements for Medical Clearance:
- Rubella lab report OR documentation of one (1) MMR immunization
- Rubeola lab report OR documentation of two (2) MMR immunizations
- Mumps lab report OR documentation of two (2) MMR immunizations
- Varicella lab report OR documentation of two (2) Varicella immunization OR documented dates of disease signed by the practitioner
- Hepatitis B Surface Antibody Titer lab report and documentation of Hepatitis B vaccination series
- Hepatitis B Surface Antigen Titer lab report

Other Requirements:

**Tdap – Tetanus, Diptheria and Pertussis Vaccination**

**Influenza** - (Flu) Vaccination during Influenza season which is determined by New York State Department of Health Commissioner (as of July 2013 forward).

Vaccine documentation must include the Name of the Vaccine, the date the vaccine was administered, Contact information of the vaccinator or facility.

Instructions for submission:

- Once you have uploaded the above requirements as a supplemental document in VSAS, **YOU MUST** send an email to qualityrn@nshs.edu with notification of the upload. No documents will be accepted via email or fax
- Please be sure to include: VSAS/ your name/ your rotation date in the subject area
- You must send the email **every time** you upload new documentation. **No documents will be accepted via email or fax**
Visiting House Staff & Medical Student Medical Clearance Form

Name (Please Print): ___________________________________________________________________________

Department: ___________________________________________ Contact Phone: __________________________ Email Address: _________________________________

Rotation Date(s): ______________________________

To be Read and Signed by Applicant:

- I certify that I do not use illegal drugs, nor do I misuse/abuse controlled or other substances which may alter or impair my behavior and/or ability to function including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other substances.

- I furthermore authorize North Shore-LIJ, its practitioners and my health care provider (if applicable) to release any and all information obtained in the medical examination to authorized representatives of clinical facilities when requested. I understand that giving false or misleading information or failure to disclose requested medical information will be grounds for denying my application or for dismissal. I certify that I have disclosed all known current health conditions which my pose a risk to others or which might interfere with the performance of my duties.

____________________________________     _____________________________________          ___________________
Signature of Student                                                 Print Name                                                     Date

You must provide the following information in order to start your clerkship. A health care practitioner must sign this form to indicate you have had a complete physical in the last 12 months prior to commencement of the clerkship. Failure to complete this form and submit it at least 10 working days prior to the date of the clerkship will result in the loss of the clerkship. There are no exceptions to this medical clearance requirement.

THE AREA BELOW IS TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER

Please Note: If vaccination dates are not available for any of the infectious diseases below, you must submit proof of immunity via blood titers on laboratory letterhead. All information must be provided in English

| I | MEASLES (Rubeola) | Two immunizations with live measles vaccine |
| II | MUMPS | Two immunizations with live mumps vaccine |
| | RUBELLA (German Measles) | One immunizations with rubella vaccine |
| | VARICELLA | Two immunizations with Varicella vaccine |
| | Tdap vaccination documentation |
| | Flu vaccination documentation (Proof of flu vaccination or declination during Flu season which is determined by NYSDOH Commissioner) |
| | HEPATITIS B HbsAG & HEPATITIS B Anti-HBS |
| | Laboratory Titers and documentation of all Hepatitis B Vaccines |
| | Both Titers are required |

Blood based Tuberculosis infection screening test (e.g. QuantiFERON TB Gold) |

| Date (within last three months):__/__/____ |
| □Negative □Positive □Indeterminate |
| Size of Induration |

If positive, you must provide proof of a chest x-ray with no active disease. Chest X-ray (within One year of the rotation start date):__/__/____ |

| Date:__/__/____ |
| Result: |
| Treatment given: Date(s): |
| Medication(s): |

To be Read and Signed by Examing Practitioner:

I have personally examined the above named applicant in the past 12 months and find him/her free from any physical/emotional impairment which is a potential risk to patients or which might interfere with the performance of service duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other substances.

I also certify that the above-named applicant has received the immunizations listed above on the dates indicated.

Health Care Provider: ___________________________ Phone ( ) -

(Please Print)  Health Care Provider Signature: ___________________________ Date: _____________/___________/___________

Health Care Provider Stamp/Office Stamp for Address and Telephone Number: Office Stamp

Revised 4/25/14