UNIVERSITY OF ROCHESTER

PSYCHOLOGY DOCTORAL INTERNS and POSTDOCTORAL FELLOWS FOR 2007-2008
Strong Memorial Hospital

RETURN FORM TO:
University Health Service
250 Crittenden Blvd., Box 617 (OH)
Rochester, NY 14642-8617
Compliance Coordinator (585)275-4955
FAX #: (585) 276-0149

INSTRUCTIONS and INFORMATION FOR MANDATORY FORM COMPLETION:

The information obtained from this pre-placement health assessment will be used solely to determine whether you have a condition that would pose a risk to patients or interferes with your performance of job duties. The information obtained in this health assessment will be kept with your records at University Health Service, which is separate from employee records in Human Resources.

PLEASE PRINT ALL INFORMATION

Today's Date	Last Name First Name MI		
Social Security Number	Date of Birth	Sex: ❒ Male ❒ Female	Phone
Address (Street) (City) (State) (Zip)			

Person to notify in case of emergency

Name	Relationship
Address (Street) (City) (State) (Zip)	

Registration Data

❒ DOCTORAL INTERNS
POSTDOCTORAL FELLOWS Starting Date (mo/day/yr)____________________ Department::______________________

Previous Relationship with the University of Rochester:

❒ Previous full time student ❒ Patient at University Health Service ❒ Patient at Strong Memorial Hospital ❒ Previous/current employee

Compliance Requirements

New York State Title 10 Health Code 405.3 (b)(10)(11):

- The provision for a **physical examination and recorded medical history** for all personnel and members of the medical staff. The examination shall be of sufficient scope to ensure that no person shall assume his/her duties unless he/she 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.
- **Proof of immunity against rubella**
- **Proof of immunity against measles**
- **PPD (Mantoux) skin test** for tuberculosis prior to affiliation and no less than every year thereafter.

US Public Health Service; Centers for Disease Control and Prevention (CDC):

- **Proof immunity against mumps**
- **Recommend Tetanus/Diphtheria (Td) or Td with Acellular Pertussis vaccine (Tdap)**

Occupational Safety and Health Administration (OSHA):

- Standard for Occupational Exposure to Bloodborne Pathogens, 29 CFR 1910.1030-**Hepatitis B vaccine**
- Respiratory Protection, 29 CFR 1910.139- **N95 mask fitting and training**

Name:________________________________ **Date of Birth:** ____/____/____ **Date of Examination:** ____/____/______

Medical History - to be completed by applicant

Medical: ____

Surgical: ____

Family History: ____

Medications: ____

Allergies: ____

Latex ❒No ❒ Yes (describe)____

Habits:

- Do you currently smoke? ❒ No ❒ Yes If so, how much? ____
- Do you drink alcohol? ❒ No ❒ Yes If so, how much, and how often? ___________________________________
- Have you used any drugs such as marijuana, cocaine, heroin or crack within the last year? ❒ No ❒ Yes If so, describe ______________
- Have you had any treatment for drug or alcohol abuse? ❒ No ❒ Yes If so, year and describe____________________________
- Do you have any health impairments (including habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter behavior) that would pose a potential risk to patients or personnel, or which might interfere with the performance of responsibilities?
  ❒ No ❒ Yes If so, describe ____

TO THE BEST OF MY KNOWLEDGE THE ABOVE IS TRUE:

Intern/Resident/Fellow Signature: ____ Date:______________

Physical Examination – to be completed by examining health care provider **within the last 12 months**

Date of physical exam____________

Weight: ________Blood Pressure: ________/_______ Vision: Corrected ______________ Uncorrected __________

Lymph Glands: ____

Ears, Nose & Hearing: ____

Breasts: ____

Lungs: ____

Heart: ____

Abdomen: ____

Extremities: ____

Other: ____

Identified Health Problems: ____

I confirm, based on history and physical examination, that there are no health impairments (including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter behavior) that would be of potential risk to patients or personnel, or which might interfere with the performance of the above named practitioner's responsibilities. If you do not concur, explain:_______________________________

Examining health care provider signature: ______________________________ **Date of completion of form** _____/_____/______

Examining health care provider PRINTED name:___________________________________

Address: ____ **Telephone (   )**____________________

Name: ______________________________ **SSN:** ___-___-___ **DOB:** __/__/__

THE REQUIREMENTS BELOW NEED HEALTH CARE PROVIDER VERIFICATION:

REQUIRED IMMUNIZATIONS

FEDERAL, NEW YORK STATE & UNIVERSITY MANDATORY REQUIREMENTS

MMR	MEASLES (RUBEOLA)	MUMPS	RUBELLA
⇨ **See instructions**	▪ **2 doses of live vaccine** given on or after the first birthday: must be given at least 30 days apart with the second dose after age 15 months ▪ OR **physician documented** disease ▪ OR **serologic test** showing positive titer ▪ ***May substitute MMR.***	▪ **2 doses of live vaccine** given on or after the first birthday: must be given at least 30 days apart with the second dose after age 15 months ▪ OR **physician documented** disease ▪ OR **serologic test** showing positive titer ▪ ***May substitute MMR.***	▪ **1 dose of live vaccine** given on or after the first birthday ▪ OR **serologic test** showing positive titer ▪ ***May substitute MMR.***
1st Immunization:________ **mo/day/yr** **AND** **2nd Immunization:**________ **mo/day/yr**	**1st Immunization:** ________ **mo/day/yr** **AND** **2nd Immunization:** ________ mo/day/yr **OR** **Date of Disease:** ________ Year **OR** **Serologic Test:**________ **mo/day/yr** **Result:** positive / indeterminate / negative	**1st Immunization:** ________ **mo/day/yr** **AND** **2nd Immunization:** ________ mo/day/yr **OR** **Date of Disease :**________ Year **OR** **Serologic Test:**________ **mo/day/yr** **Result:** positive / indeterminate / negative	**Immunization:** ________ **mo/day/yr** **OR** **Serologic Test:**________ **mo/day/yr** **Result:** positive / indeterminate / negative

TUBERCULIN SKIN TEST (MANTOUX) REQUIREMENTS		PAST POSITIVE	CHEST XRAY
Two PPD (Mantoux intradermal skin test) tests and interpretations are **required, the first within one year of the second, the second within 3 months of starting residency program,** unless history of past positive PPD is reported. Tine tests are not acceptable. History of BCG **does not** meet the requirement-PPD is still required.			Obtained **after positive PPD,** report must be attached.
Manufacturer:________ **#1 Date Placed:**________ **mo/day/yr** **Date Read:**________ **mo/day/yr** **mm of induration:**________ **Interpretation:** negative / positive	**Manufacturer:**________ **#2 Date Placed:**________ **mo/day/yr** **Date Read:**________ **mo/day/yr** **mm of induration:**________ **Interpretation:** negative / positive	**Date:**________ **mm of induration:**________	**Date:**________ **Result:**______ Attach copy of **official radiology report** **DO NOT SEND X-RAY**

Name: ______________________________ **SSN:**_____-____-________ **DOB:** __/__/__

RECOMMENDED IMMUNIZATIONS AND TESTS: INFORMATION IS REQUIRED

Hepatitis B vaccine: The CDC **STRONGLY RECOMMENDS** hepatitis B vaccination (includes 3 vaccines and post-vaccine titer) for all health care professionals. A signed declination form **must be completed** if this applicant declines vaccine.

Varicella History: If no confirmed disease history, serological test is required. If negative, vaccination with 2 Varicella vaccines is strongly recommended. A signed declination form **must be completed** if the applicant declines vaccine.

Tetanus-Diphtheria (initial series and booster every 10 years**)**
OR
Tdap The CDC recommends that health providers who have direct patient contact should receive a single dose of Tdap as soon as feasible if they have not previously received it. Reference: 12/06 http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5517a2.htm

HEPATITIS B

Immunization #1______________________
mo/day/yr

Immunization #2______________________
mo/day/yr

Immunization #3______________________
mo/day/yr

Serologic Test:_____________ **Result:** ________
mo/yr

o **DECLINATION:** I **decline** the Hepatitis B Vaccination at this time. I understand that by declining this vaccine. I continue to be at risk for acquiring Hepatitis B. In the future, if I continue to have occupational exposure to blood or potentially infectious materials and would like the Hepatitis B vaccine. I understand the risks of being susceptible to infections and blood borne diseases and decline immunization at this time. I understand I may choose to receive the vaccine at any time in the future.

Declination Signature of Intern/Resident/Fellow:

____**Date**__________

VARICELLA (CHICKEN POX)

Disease history ______________________
YEAR

OR (if no disease history)

Serologic Test:_____________ **Result:** ________
mo/yr

OR (if titer negative)

Immunization #1______________________
mo/day/yr

Immunization #2______________________
mo/day/yr

o **DECLINATION**: I **decline** the Varicella Vaccine and understand I am susceptible to chicken pox. I understand the risks of being susceptible to infections and blood borne diseases and decline immunization at this time. I understand I may choose to receive the vaccine at any time in the future.

Declination Signature of Intern/Resident/Fellow:

____**Date**___________

TETANUS- DIPHTHERIA OR Tdap

Immunization________________ **Td** **Tdap**
mo/day/yr

I certify the above information vaccination information.

Examining health care provider signature: ____

Examining health care provider PRINTED name:____

Address: ____

Telephone ( )____________________________ **Date of completion of form** _______/_______/_______