Maimonides
Medical Center

REQUIREMENTS FOR MEDICAL CLEARANCE FOR VOLUNTEERS AND STUDENTS

Forms to be completed by Private Physician

Annual Physical Examination Form – Completed, stamped, and signed by a Licensed Provider including his/her license number.

TST Form – Tuberculin Skin Test must be implanted and read within six (6) months.

- If positive TST, must have a chest X-ray completed within six (6) months and submit a copy of the **RADIOLOGIST report**.
- We accept the **Quantiferon TB Gold test**. Official lab report must be provided.

During flu season, **Vaccination Administration Record for Influenza** must be provided.

Note to Physicians regarding Lab Reports

Maimonides Medical Center policy requires **official lab reports** showing titer levels that prove immunity to **Measles, Mumps, Rubella, and Varicella**. All lab results submitted must bear the actual titer value, along with the laboratory's reference range used to determine immunity. All lab reports must have date of collection printed on forms.

If lab results show negative or equivocal titers, an immunization record must be provided indicating two vaccinations.

Forms to be completed by Volunteers and Students

Volunteers and Students must fill out a Pre-Employment Questionnaire and Hepatitis B History and Attestation forms provided in the medical packet.

Physician Assistant Students

Must have proof of fit testing for type of respiratory mask

Note: Once fully completed medical forms and labs are submitted, clearance may take up to two weeks. Please call the Volunteer office at 718-283-3980 if you have any questions.

Revised 9/11/2019

Maimonides

MEDICAL CENTER

PERSONNEL HEALTH SERVICES

PRE-EMPLOYMENT QUESTIONNAIRE

COMPLETE THIS FORM YOURSELF (FRONT & BACK)
SIGN AND DATE ON THE BACK

NAME	DATE OF BIRTH
ADDRESS	
TELEPHONE NO:	

OTHER EMPLOYMENT	POSITION	DEPARTMENT

DO YOU HAVE ANY OF THE FOLLOWING:	NO	YES	EXPLAIN
REACTIONS TO MEDICINES			
REACTIONS TO CHEMICALS			
SKIN RASHES OR ECZEMA			
FREQUENT DIARRHEA			
HERNIA			
HAVE YOU EVER HAD	**NO**	**YES**	
ASTHMA			
HAY FEVER			
BRONCHITIS			
SHORTNESS OF BREATH WHILE WALKING			
TIGHTNESS OF CHEST			
EMPHYSEMA			
PPD PLANTED			WHEN ____ WHAT WAS THE RESULT
HIGH BLOOD PRESSURE			
HEART TROUBLE			
HEART ATTACK			
SWELLING OF THE ANKLES			
FAINTING SPELLS			
VARICOSE VEINS			
EPILEPSY			
DOUBLE VISION			
NUMBNESS OF HANDS, FEET			
SEVERE HEADACHES			
DIZZY SPELLS			
NERVOUS BREAKDOWN			
BLOOD IN URINE OR STOOL			
KIDNEY TROUBLE			
DIABETES OR SUGAR IN URINE			
THYROID TROUBLE OR GOITER			
HEPATITIS OR JAUNDICE			
SYPHILIS OR GONORRHEA			
ANEMIA			
RHEUMATISM OR ARTHRITIS			
BACK PAIN			
BACK INJURY			
SWOLLEN JOINTS			
DISLOCATED SHOULDER			
ABDOMINAL PAINS			
SURGERY			WHEN ____ WHAT KIND

NAME ALL MEDICATIONS YOU TAKE REGULARLY
WRITE "NONE" IF YOU DON'T TAKE ANY

ARE YOU ALLERGIC TO ANY MEDICATIONS	NO	YES	NAME OF MEDICATION

HAVE YOU EVER HAD	DISEASE		VACCINE		DATE
	NO	YES	NO	YES	
CHICKEN POX (VARICELLA)					
MEASLES (RUBEOLA)					
MUMPS					
RUBELLA (GERMAN MEASLES)					

DO YOU RECEIVE ANNUAL	NO	YES	DATE OF LAST VACCINE
INFLUENZA VACCINE			

IF NO, WHY

- ☐ Perceived ineffectiveness of vaccine
- ☐ Medical contraindication (incl. Pregnancy)
- ☐ Insufficient time or inconvenient
- ☐ Perceived low likelihood of contracting influenza
- ☐ Avoidance of medications
- ☐ Fear of needles
- ☐ Reliance on treatment with homeopathic medications
- ☐ Egg Allergy
- ☐ Other: (please specify) _______________

	NO	YES	
DO YOU SMOKE			HOW MANY PACKS/DAY
			HOW LONG/YEARS
DO YOU DRINK ALCOHOL			IF YES, HOW OFTEN

FEMALES ONLY
HOW MANY MISCARRIAGES HAVE YOU HAD?
ARE YOU PREGNANT NOW?

I certify that all of the statements on both sides of this questionnaire are true and may be investigated and if found to be false will constitute sufficient reason for my dismissal. I understand that employment is contingent upon taking and passing a physical examination which includes drug testing.

_______________________ Signature

_______________ Date

COMPLETE & SIGN THIS FORM YOURSELF

Maimonides Medical Center

Employee Health Services

Hepatitis B History and Attestation

NYS DOH recommends health care workers receive HEPATITIS B (HBV) vaccination.

Have you had HBV or been vaccinated against HBV? [ ] Yes [ ] No

Would you like to receive the HBV vaccination? [ ] Yes [ ] No

Signature: ______________________ Print Name: ______________________

Date: ______________________ DOB: ______________________

Maimonides Medical Center

Employee Health Services

PRE-EMPLOYMENT PHYSICAL EXAMINATION

Must be completed and signed by a licensed provider

Name: ______________________________ DOB: ________________

BP	**Pulse**	**Respirations**
Height	**Weight**	
EYES		
ENT		
NECK		
LUNGS		
HEART		
ABDOMEN		
NEUROLOGICAL		
EXTREMITIES		
OTHER		

I have determined that the Individual identified on this document is free from any health impairment that may be of potential risk to patients or may interfere with the performance of his or 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 Signature	**Date**
Print Name	**License #**
Examining Provider Address & Phone #	

Maimonides Medical Center

Employee Health Services

Tuberculin Skin Test Form

Re: ____

(Print First and Last Name)

Check one: ☐ Volunteer ☐ Student

TST (PPD) was planted on ____________________ on **RIGHT** (forearm) **LEFT** (forearm)

(Date) ***(Circle)***

Please read the TST (PPD) in 48-72 hours

Reading Results: (*Please do not leave any blanks*)

Erythema ________________mm's (if zero write 0x0)

Induration ________________ mm's (if zero write 0x0)

Please circle reading: **NEGATIVE** **POSITIVE**

TST (PPD) Read on: __________________________

(Date)

Please **PRINT Name**: ____________________________________

Please **SIGN** here: ____ MD, RN or PA

(***Circle***)

Please write your **license #** or MMC Life #: ____

Official Stamp with Address & Phone # ____

OR

QuantiFERON-TB GOLD Test Administered on: ____________ (***Lab Report must be attached***)

(Date)

REMINDER

An official lab report must be attached
showing evidence of **antibody titers**
that indicate immunity to
Measles, Mumps, Rubella, and Varicella.

All labs must have **quantitative** values.

If the lab report shows negative
or equivocal titers, proof of two vaccinations
(e.g. immunization record) must be submitted.

<u>Please note that we do not accept
vaccination records as proof of immunity</u>.

Maimonides
Medical Center

2019 - 2020

Consent / Declination Form - Seasonal Influenza Vaccine
EMPLOYEE HEALTH SERVICES
5008 Fort Hamilton Parkway - Broklyn, NY 11219
Tel: 718.283.8978 Fax: 718.635.8949

Vaccine Recipient Information:
LAST NAME: (PLEASE PRINT)

FIRST NAME: (PLEASE PRINT)

Life Number: __________ D.O.B.: ___/___/___ Department:__________________ Contact Number: __________________

Personnel Status:
☐ Employee ☐ Voluntary Medical Staff ☐ Volunteer ☐ Vendor ☐ Student ☐ Other:____________________

Influenza (flu) is an acute viral illness that in most cases is limited to fever, cough, headache, malaise and fatigue lasting from a few days to a week. Flu generally occurs in epidemics, most cases occurring between November and March, but occasionally at other times. It is transmitted easily from person to person, by droplets through the air or by contact of unwashed contaminated hands with mouth or eyes. Rarely in healthy individuals, more frequently in small children, senior citizens, and chronically ill persons, dangerous complications may occur, such as pneumonia.

Flu vaccine is generally well tolerated. A vaccine, like any medicine, could possibly cause serious problems, such as severe allergic reactions. The risk of a vaccine causing serious harm is extremely small. Serious problems from influenza vaccine are very rare. The viruses in inactived influenza vaccine have been killed, so you cannot get influenza from the vaccine. Mild problems may occur from receiving the flu vaccine such as: soreness, redness or swelling at the injection site where the shot was given: fever, muscle aches.

The flu virus changes from season to season, and last years' vaccine will NOT protect against this year's epidemic.

THE FOLLOWING PERSONS SHOULD NOT RECEIVE FLU VACCINE without discussion with their primary care physician:

- Persons allergic to egg, when reaction is severe enough to require medical attention (the vaccine virus is grown in eggs and small amounts of egg protein may be present in the purified vaccine).
- Persons with severe allergies to any vaccination components.
- Persons who have had a severe reaction after a previous dose of influenza vaccine.
- A rare disease called Gullian-Barre syndrome has been associated with the 1976 swine flu vaccine. If you have Guillian-Barre syndrome, you should not receive the flu vaccine.
- People who are moderately or severely ill should usually wait until they recover before getting flu vaccine. People with a mild illness can usually get the vaccine.

"I have read, or have had explained to me, the information on this form and on the Vaccine Information Sheet with which I have been provided. A nurse/doctor has explained to me the reasonably foreseeable risks, possible complications and consequences involved both in receiving the vaccination and in not proceeding with the influenza vaccination. I have been given the opportunity to ask questions and all my questions have been answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and consent to the administration of the influenza vaccination".

EMPLOYEE SIGNATURE: ______________________________ DATE: ___/___/___

EMPLOYEE NAME PRINTED:______________________________

Vaccine Manufacturer:____________________ Lot #: __________ Dose:______ 0.5ML

Vaccine Expiration Date: ___/___/___ Location: ☐ Right ☐ Left ☐ Deltoid

Signature of Vaccine Administrator:____________________ Vaccinator Life #:__________

☐ VIS Given on ____/____/201___ (publication date August 15, 2019)

DECLINATION

I knowingly decline being vaccinated for the seasonal influenza vaccine for the following reasons:

__ Medical contraindication ___ Egg allergy ___ I believe the cons outweigh the pros

__ I received it elsewhere (**Must submit proof to the Volunteer office**) ___Other: __________________

SIGNATURE: ____________________ DATE: ____________________

PARENT SIGNATURE: (If under the age of 18 years old) ____________________ **DATE:** __________