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

Exaining 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.

Exaining Provider’s Signature ____________________________ Date __________
Exaining Provider’s Printed Name
Exaining Provider’s Medical License #
Address
Telephone (_____)______________ Fax (_____)______________ E-mail: ___________________
Annual Respirator Mask Form

N95-TB Protection Mask: Brand  TecnoL  3M 8512  PAPR
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: ____________________
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: Date 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: ________________________