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

Examing 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 02/02/15
Annual Respirator Mask Form

N95-TB Protection Mask: Brand
Tecnol
Size
Other mask + size:
OSHA mandates a yearly fit test.

Examiner's Signature ___________________________ Date __________
Examiner's Printed Name ____________________________
Examiner'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 __________________________

Examing Provider’s Signature __________________________ Date __________
Examing Provider’s Printed Name __________________________
Examing Provider’s Medical License # __________________________
Address __________________________
Telephone (____)_____________  Fax (____)_____________  E-mail: __________________________