

## MEDICAL-DENTAL PROVIDER ~ ANNUAL HEALTH ASSESSMENT

In accordance with NYS Title 10 Health Code 405.3 (b)(10)(11), all employees (which includes **members of the medical-dental staff**, contract staff and volunteers) must have their health status reassessed annually to ensure they are free from physical and mental health impairments which could pose risk to patients, personnel or which may interfere with the performance of job duties. Additionally, OSHA Standard 1910.134 requires a Respirator Protection Program be in place that maintains the annual preparedness of employees to safely use N-95 respirators.

Print Provider Name	Date of Birth:	Department:
<p>I understand that this form is a confidential document and is provided for the purpose of compliance with Department of Health regulations pertaining to providers and will be placed in my medical staff credential file. Furthermore, it is understood that this document may not be photocopied or released without my expressed written consent.</p> <p>I certify that I am free from physical or mental impairments including habituation or addiction to depressants, stimulants, narcotics, alcohol or other behavior altering substance which might interfere with the performance of my duties or would impose risk to patients or personnel. If in the future I experience a severe illness, undergo major surgery, or require an extended leave of absence (lasting longer than 30 days) I shall notify the Medical Staff Office and obtain a release to return to practice by my attending provider.</p>		
Signature:		Date:

**THIS ASSESSMENT IS NOT TO BE CONSIDERED AS A SUBSTITUTE FOR A COMPLETE PHYSICAL OR REGULAR MEDICAL CARE BY YOUR PERSONAL PCP**

Please check YES or NO if you have or have had any of the below. If Yes, Please Explain In The Section Below.	YES	NO
Have there been any major changes in your physical health within the past year?		
Have there been any changes in your mental health within the past year? (Anxiety, depression, etc.)		
Have you been hospitalized within the past year?		
Have you had surgery within the past year?		
Have you had any changes to your vision or hearing within the past year? (Blurry vision, glaucoma, hearing loss, etc.)		
Are you currently under any limitations or are modifications needed in terms of work load?		
<b>USE THIS SECTION TO LIST OR EXPLAIN ANY OF THE ABOVE OR BELOW QUESTIONS THAT YOU ANSWERED YES:</b>		
Respirator Fit Test Screening - Please check YES or NO	YES	NO
Exempt from Fit Testing based on Medical Staff category COURTESY or AFFILIATE or TELEMEDICINE		
Exempt from Fit Testing based on practicing specialty PATHOLOGY or DIAGNOSTIC RADIOLOGY or Tele-NEUROLOGY or Tele-RADIOLOGY		
If you answered <b>NO</b> to all of the above questions, you are <b>REQUIRED</b> to complete annual Respirator Fit Testing. <ul style="list-style-type: none"> <li>If you have been Fit Tested outside of Employee Health within the last year or plan to be, please provide documentation.</li> <li>If you have not been Fit Tested within the last year and would like this done by Employee Health, please call that office for an appointment</li> <li>This Annual Health Assessment is not considered complete without current Fit Test documentation <i>if not exempt</i></li> </ul>		
Tuberculosis Screening - Please check YES or NO if you have or have had any of the below in the past <u>YEAR</u> .	YES	NO
Are you aware of being exposed to anyone with active TB? (family, friends, co-workers, patients)		
Have you had TB exposure, disease or diagnostic testing for an active infection?		
Have you received treatment for active TB or Latent TB infection? <ul style="list-style-type: none"> <li>If so, when/where/treatment received?</li> </ul>		
Have you held temporary or permanent residence of greater than or equal to (1) month in a country with a high TB rate other than the United States, Canada, New Zealand and those in Northern Europe or Western Europe since your last annual health assessment? <ul style="list-style-type: none"> <li>If so, where/when/how long?</li> </ul>		
Are you currently on medications that suppress your immune system? (please list in box above)		
Do you have any of the following signs and/or symptoms of active Tuberculosis disease?		
<ul style="list-style-type: none"> <li>Cough more than 3 weeks?</li> <li>Night Sweats?</li> <li>Loss of appetite?</li> <li>Unplanned weight loss of more than 10 pounds?</li> <li>Blood streaked sputum?</li> <li>Persistent low – grade fever?</li> <li>Unexplained Fatigue?</li> </ul>		

Reviewer Recommendation and/or Comments
I have reviewed this health assessment and tuberculosis screening tool with the provider, and based on the results of this review: <ul style="list-style-type: none"> <li><input type="checkbox"/> The provider is deemed to be at <b>low risk</b>: REPEAT TB SCREENING ANNUALLY</li> <li><input type="checkbox"/> Tuberculin testing is recommended.</li> </ul>
COMMENTS:
Examining Medical Professional Signature:
Date: