

Winthrop-University Hospital
EMPLOYEE HEALTH DEPARTMENT REQUIREMENTS FOR AFFILIATES*
222 Station Plaza North Room 515
Mineola, NY 11501
Tel: (516) 663-2534
Fax; (516) 663-8472

Name: _____

Address: _____

(Town)

(Street)

(Zip)

Winthrop University Hospital's health and immunization standards are based on Nassau County and New York State Department of Health requirements and recommendation. If you do not provide necessary documentation, you may not begin as scheduled.

ALL AFFILIATES MUST PROVIDE THE FOLLOWING DOCUMENTS

I. Rubella Immune Status:

A copy of the laboratory report of the titer **OR** acceptable documentation of vaccination.

II. Rubeola (Measles) Immune Status:

1. All individuals born in or after 1957 must show acceptable documentation of having received two doses of MMR or the Measles vaccine after their first birthday **OR** physician documented history of clinical measles **OR** serologic (laboratory blood test) confirmation of measles immunity.
2. All individuals born before 1957 will show serological (laboratory) immunity to measles. In the event of a negative titer, the individual will require vaccination.

III. Chicken Pox status:

History of Disease _____ or
Titer _____ (attach) or
Vaccines _____ (date)

THE FOLLOWING DOCUMENT IS REQUIRED AT INITIAL CLEARANCE AND ANNUALLY THERAFTER:

PPD skin test (Date given) _____ If PPD Positive
Reaction _____ mm induration _____ or date of last CXR _____
Date Evaluated _____ Results _____
Evaluated by _____

FOR CLINICAL STAFF ONLY:

Practitioner Certificate:

I have performed a physical examination of sufficient scope to ensure that the above mentioned person is free from 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 [per N.Y.S. Code 405 3 (b)]

Practitioner signature _____ Date _____ License # _____

Practitioner name (Print) _____ Telephone _____

Address: _____

THE EMPLOYEE HEALTH DEPARTMENT WILL ISSUE A CLEARANCE FORM WHEN ALL REQUIREMENTS ARE MET.

***Affiliate = contracted worker, student, rotating resident, intern/clerk or any other personnel not on Winthrop University Hospital payroll.**

EHS expiration: _____

Rotation ends: _____

Ehd imm cert.