Employee Health Services

Dear Volunteer,

On behalf of Northwell Health we welcome you to our organization. For the health and well-being of our patients as well as staff members, New York State Department of health and/or the Northwell Health policy requires a medical evaluation and clearance for all individuals prior to the commencement of work, service privileges or observations. See instructions below.

Instructions:

- ☐ Please have your healthcare provider review and complete the attached Employee Health Services ***Medical Clearance form***
- ☐ Please submit your completed form(s) to your local Employee Health Services office. This should be done 30 days prior to your start date or as soon as possible to avoid any delays.

If you or your healthcare provider has any questions regarding the completion of this form, please contact your local Northwell Health Employee Health Services office listed below.

Costs associated with services performed outside of Northwell Health Employee Health Services are the responsibility of the individual.

Sincerely,

Employee Health Services

LOCATION	CONTACT	LOCATION	CONTACT
Corporate/LIJ/CCMC/Manha	(718) 470-7644	**Northern Westchester Hospital**	(914) 666-1244
	Fax: (516) 977-1714		Fax: (914) 666-1096
Forest Hills Hospital	(718) 925-6620 / 6621	**Phelps Memorial Hospital**	(914) 366-3160
	Fax: 718-925-6626		Fax: (914) 366-1250
Franklin Medical Center	(516) 256-6803	**Plainview Hospital**	(516) 719-2436
	Fax: (516) 256-6349		Fax: (516) 719-2717
Glen Cove Hospital	(516) 674-7629	**Southside Hospital**	(631) 968-3224
	Fax: (516) 674-7627		Fax: (631) 968-3225
Huntington Hospital	(631) 351-2484	**Staten Island University Hospital North**	(718) 226-8555
	Fax: (631) 351-4197		Fax: (718) 226-8201
Lenox Hill Hospital	(212) 434-2675	**Staten Island University Hospital South**	(718) 226-2099
	Fax: (212) 434-4532		Fax: (718) 226-2450
Long Island Home	(631) 608-5313	**Syosset Hospital**	(516) 496-6565
	Fax: 631-390-9508		Fax: (516) 496-2787

Employee Health Services Medical Clearance for Volunteers

Your medical clearance will be delayed if this form is not complete. Please contact your local EHS Office for questions.

Name: _____ Current Hospital/School: _____
(First Name, Last Name)

DOB: ____ /____ /____ Telephone: ( ) _____ Email: _____

TO BE COMPLETED AND SIGNED BY YOUR HEALTHCARE PROVIDER OR FACILITY

Tuberculosis (TB) Screening: 2-Step Tuberculin Skin Testing (TST) or Blood Assay

Instructions: The 1st TST needs to be within 1 year of start of service. The 2nd TST needs to be within 3 months of the start of service. The 2nd TST needs to be completed no less than 7 days after the 1st TST.

2-Step TB Skin Tests

#1 ___ / ___ / ___ Date 1st placed (within last 12 months) ___ / ___ / ___ Date Read _____ Result

#2 ___ / ___ / ___ Date 2nd placed (no less than 7 days after the 1st) ___ / ___ / ___ Date Read _____ Result

OR Blood Assay (within 3 months) Attach Lab Report: Date of Review: ___ / ___ / ___ Results: ☐ Negative ☐ Positive

Positive TST History: If you have a history of a positive TST, complete the chest x-ray and signs and symptoms section below.

You **must have had a chest x-ray** with no active disease

Chest X-Ray Date: ___ / ___ / ___ Results: ☐ No Active Disease TB Treatment given: Date(s): _____
☐ Other _____

Tuberculosis Signs and Symptoms Evaluation
Date of Review: ___ / ___ / ___ Results: ☐ Negative ☐ Positive

Vaccination History	Vaccine #1 Date	Vaccine #2 Date		Lab reports Attached
MMR Vaccine Two doses of MMR	___ / ___ / ___	___ / ___ / ___		☐
OR				
Measles *(Rubeola):* Two immunizations	___ / ___ / ___	___ / ___ / ___	**OR**	☐
Mumps: Two immunizations	___ / ___ / ___	___ / ___ / ___		☐
Rubella: *(German Measles)* One immunization	___ / ___ / ___	*Intentionally left blank*		☐
Varicella: Two immunizations or Disease History Date: ___ /___ /___	___ / ___ / ___	___ / ___ / ___		☐
Tdap/DTaP: Pertussis containing vaccine within last 10 years	___ / ___ / ___	*Intentionally left blank*		
Influenza: Vaccinated within the current flu season.	___ / ___ / ___	☐ Declined Vaccination		*Intentionally left blank*

Health Assessment: The above individual has been evaluated in the past 12 months. The results of our evaluation is of sufficient scope to ensure the above named 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, other drugs or substances which may alter the individuals behavior. ***The office that is completing this form will be responsible for maintaining updated records for the duration of participant's and/or faculty's interactions within the Northwell Health facilities and provide appropriate supporting documentation upon request.***

Health Care Provider or Facility: _____ Phone: _____
(Please Print) (School designee if applicable)

Health Care Provider or Facility Signature: _____ Date: _____

Provider/Facility Stamp with Address and Telephone Number: OFFICE STAMP

For Office Use Only: Department: _____

Program Name: _____

Northwell Health Program Contact Name: _____Program Contact Number:_____

Medical Clearance to be sent to (Email address): _____

Northwell Health EHS Reviewer Signature: _____ Date:_____