NYU Winthrop Hospital

222 Station Plaza North Room 515, Mineola NY 11501
Phone: 516-663-2534 Fax: 516-663-1197

Name: _____
Address: _____

NYU Winthrop Hospital's health and immunization standards are based on Nassau County and New York State Department of Health requirements and recommendations. ***If you do not provide necessary documentation, you may not begin as scheduled.*** EHD does not save any of your documentation. In the event that you need to renew your clearance, you must come back to our office with all necessary documentation.

I. Rubella Immune Status:

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

Lab Titer- MUST SHOW COPY OF REPORT
Vaccine #1 Date: _____

II. Rubeola (Measles) Immune Status:

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.

All individuals born before 1957 will show serological (laboratory blood test) immunity to measles. In the event of a negative titer, the individual will require a vaccination.

Lab Titer- **MUST SHOW COPY OF REPORT** Vaccine #1 Date:_____ Vaccine #2 Date:_____

III. PPD Documentation: (MUST BE DATED WITHIN 12 MONTHS)
PPD skin test (**Date given**) _____
PPD 5TU Mantoux Connaught Lot#_____
RFA or LFA, implanted by: _____
Reaction: _____ mm induration
Date Evaluated _____
Evaluated by: _____
IF POSITIVE-MUST SHOW X-RAY REPORT

IV. Influenza Vaccine: (Starting Starting Oct. 1st through end of NYS Flu Season) DATE: _____ (MUST SUPPLY COPY)

V. Practitioner Certificate: (MUST BE DATED WITHIN 12 MONTHS)

Have your practitioner fill out this section or provide documentation stating Good Health.

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) _____ Phone _____
Address: _____

THE EMPLOYEE HEALTH DEPARTMENT WILL ISSUE A CLEARANCE FORM WHEN ALL REQUIREMENTS ARE MET
*OBSERVATION/NON-EMPLOYEE= contracted worker, student, temp agency referral, vendor, rotating resident, intern, or any other personnel not on NYU Winthrop Hospital payroll.