WINTHROP
University Hospital
Your Health Means Everything®
222 Station Plaza North Room 515 Mineola, NY 11501
**Tel:** (516) 663-2534 **Fax:** (516) 663-1197

**HOURS:**
Mon 7AM – 3PM
Wed, Thurs 7AM – 4PM
Tues, Fri 6AM – 3PM

Name: _____

Address: _____

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.*** EHD does not save any of your documentation. In event that you need to renew your clearance, you must come back to our office and re-clear with all your 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_____

## 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.

Lab Titer_____ **(MUST SHOW COPY OF REPORT)** Vaccine #1_____ Vaccine #2_____

## 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 PPD Positive **(MUST SHOW COPY OF REPORT)**
Date of last CXR: _____
Results: _____

## IV. Influenza Vaccine (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) _____ Telephone _____

Address: _____

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

***OBSERVER/NON-EMPLOYEE = contracted worker, student, temp., vendor, rotating resident, intern/clerk or any other personnel not on Winthrop University Hospital payroll.**