



MOUNT SINAI
SCHOOL OF
MEDICINE

One Gustave L. Levy Place
Box 1043
New York, NY 10029-6574

Tel: (212) 824-7292
Fax: (212) 824-2327

Effective Academic Year 2009-2010.

All non-matriculating students must complete a Medical Status Form prior to the dates noted below:

Deadlines for Submission:

Autumn 2009 Term	Friday, September 18, 2009
Winter 2010 Term	Friday, January 15, 2010
Spring 2010 Term	Friday, April 16, 2010

Please return the form to Student Health Center (SHC) at the address below:

BY PERSON:

Center for Advance Medicine (CAM) Building
17 East 102nd Street, East Tower, 5th floor - room 241, New York, NY 10029

The SHC is open	Monday through Wednesday from 8:30 A.M. to 4:30 P.M.
Thursday	8:30 A.M. to 3:30 P.M. (SUMMER HOURS)
Thursday	10:00 A.M. to 5:45 P.M. (ACADEMIC YEAR)
Friday	8:30 A.M. to 3:30 P.M.

If you have any questions, please feel free to contact Ms. Jeanine Burrell, R.N.C. at
Tel: (212) 241-6023 or you may e-mail her at: jeanine.burrell@mssm.edu

BY FAX:

Fax:(212) 241-8008

BY MAIL:

Student Health Service
One Gustave L. Levy Place - Box 1260
New York, NY 10029



MOUNT SINAI
SCHOOL OF
MEDICINE

MOUNT SINAI SCHOOL OF MEDICINE MEDICAL STATUS FORM Non-Matriculated (Non-Degree) Students

Program (please check): Clinical Research Education Program Master of Public Health

First Name: _____ Last Name: _____

Address: _____

Telephone: _____ E-mail: _____

Please have your health care provider fill out the form and return to:

Fax: (212) 241-8008
Tel.: (212) 241-6023

Student Health Service
One Gustave L. Levy Place - Box 1260
New York, NY 10029

1. Measles (Rubeola) or MMR Dose #1 _____ Dose #2 _____
OR (date) (date)

Confirmed Immunity by blood titer Date of test: _____ Results: _____

2. German Measles (Rubella) Dose #1 _____
OR

Confirmed Immunity by blood titer Date of test _____ Results: _____

3. Mumps Dose #1 _____
OR

Confirmed Immunity by blood titer Date of test: _____

4. Varicella (Chicken-pox) Dose #1 _____ Dose#2 _____
History of disease Yes _____ No _____

5. PPD (Mantoux Skin Test/Tuberculosis Testing) Date Planted: _____ Date Read: _____
PPD must be within one year

Result: Negative _____ mm Positive _____ mm

OR

If history of Positive PPD- Dates of INH treatment: _____ and or date of CXR _____
(Must be in last year)

Health Care Provider Signature: _____ Date: _____

Health Care Provider Name: _____ Telephone# _____

Health Care Provider Address: _____

Student Health use only:

Cleared _____ Not cleared _____

Explanation: _____

Date: _____ Signature: _____