Employee Health Service
Immunization Requirements / New Non-Employee Healthcare Personnel

This completed record is to be returned to Employee Health via fax. Return as a completed document to prevent delays in clearance.

Check to which facility where you are applying:

- ☐ **Mount Sinai Beth Israel** – (P): 212-420-2885 #4 (F): 212-844-1762; bi_ehs@chpnet.org
- ☐ **Mount Sinai Brooklyn** – (P): 718-951-2903 (F): 718-951-3085
- ☐ **Mount Sinai Hospital** - (P): 212-824-7690 (F): 212-426-7704; employee.health@mountsinai.org
- ☐ **Mount Sinai Queens** - (P): 718-808-7725 (F): 718-808-7714
- ☐ **Mount Sinai West** – (P): 212-523-8530; (F): 212-523-8531; email: EHSphysicalsSLR@chpnet.org
- ☐ **Mount Sinai St. Luke's** – (P): 212-523-2342 (F): 212-523-2346; email: EHSphysicalsSLR@chpnet.org
- ☐ **New York Eye & Ear Infirmary of Mount Sinai** - (P): 212-979-4433 (F): 212-353-5958

Name _____ Date of Birth ____/____/____
(PRINT)

Address_____

Department _____ Title/Role _____
(examples: volunteer, student, extern, observer, vendor)

PHYSICAL EXAM Date ____/____/____ Must be within the past year.

TUBERCULOSIS

All new volunteers/students/observers, regardless of the current risk classification, should receive baseline TB screening using two-step Tuberculin Skin Test (TST) or a single Quantiferon gold (QFT) to test for infection with *M. tuberculosis*.

If using PPD, the first TST is to be administered and read within 48-72 hours. If the first-step TST result is negative, the second-step TST should be administered 1-3 weeks after the first TST result was read. Two consecutive PPDs are required.

Individuals with a documented positive Tuberculin Skin Test (TST) or documented positive QFT will be exempt from Tuberculin Skin Testing or an additional QFT. A current chest x-ray (within 12 months) will be required to confirm no active disease.

TST #1 ___/___/___ Date Read ___/___/___ Result _____mm (prior 12 months)

TST #2___/___/___ Date Read ___/___/___ Result _____mm (within 3 months of start date)

Quantiferon Gold Date ___/___/___ Result _____ Attach laboratory results and must be within 3 months of start.

Date of CXR ____/____/____ (within a year of the start date) Please attach report.

MEASLES, MUMPS, RUBELLA

Documented administration of two doses of MMR vaccine ***or*** laboratory evidence of immunity will be required. Include laboratory report.

MMR # 1 ____/____/____ MMR # 2 ____/____/____

Rubeola/Measles IGG Titer Date ____/____/____ Result _____

Mumps IGG Titer Date ____/____/____ Result _____

Rubella/German measles IGG Titer date ____/____/____ Result _____

Name _____ Title/Role _____
(examples: volunteer, student, extern, observer, vendor)

Dept_____

VARICELLA (CHICKEN POX):

Documented administration of two doses of varicella vaccine ***or*** laboratory evidence will be required (include laboratory report).

Vaccine # 1 ____/____/____ Vaccine # 2 ____/____/____

Varicella IGG Titer Date ____/____/____ Result _____

HEPATITIS B

Documentation of a completed Hepatitis B vaccine series ***or*** a positive titer ***or*** a signed declination will be required for any volunteer whose assignment may bring them into contact with blood or other potentially infectious body fluids (include laboratory report).

Vaccine # 1 ____/____/____ Vaccine # 2 ____/____/____ Vaccine # 3 ____/____/____

Hepatitis B Surface Antibody Titer Date ____/____/____ Result _____

Date declination signed ____/____/____ If declining, include declination in packet.

INFLUENZA

Documentation of annual influenza (flu) vaccination is **required** for the current season.

Date of Influenza (flu) vaccine ____/____/____

Manufacturer _____ Lot #_____ Route _____

TETANUS, DIPHTHERIA, PERTUSSIS

Documentation of Tdap vaccine will be required (within the past 10 years).

Date of Tdap vaccine ____/____/____

Does the applicant have any condition, illness or taking medication which might pose a potential risk to patients or which may interfere with his/her ability to do any of the volunteer/observer/student activities being accepted for?
Yes No
If yes, please explain:_____

_____

In compliance with the New York Health Code, I examined the above applicant. He/she is free from any health or behavioral issues. ***If PPD positive/QFT positive, I have examined the applicant and attest he/she is free of symptoms of tuberculosis.***

I attest that the above information is true.

Medical Provider Name: _____ **Signature:** _____

Address/phone/email:

_____

Office Stamp (required):

Date: month/day/year _____