NewYork-Presbyterian
Brooklyn Methodist Hospital

Volunteer Medical Clearance Form 18+
Fall/Winter

This form must be returned in-person to:
Employee Health Services
Wesley House
501 6th Street, room 8B
(718) 246-8570
Walk-In Hours: Monday-Friday 8am-3pm
Please remember to bring government issued photo identification

Date: _____

Volunteer Name: _____ Gender: _____

Date of Birth: _____SSN: _____

Address:_____

Home Phone: _____Other Phone: _____

I understand the medical tests on the following page are required by the New York State Health Code as a prerequisite to my beginning volunteer service at the hospital. I agree to undergo the following tests to obtain medical clearance.

Volunteer Signature: _____

NYPBMH Employee Health Office Use Only

☐ Urine toxicology_____ (Administered at Employee Health when volunteer returns the completed form)

Cleared _____ Not Cleared _____

Practitioner's Signature: _____Date: _____

Please check if volunteer had:

☐ CXR

☐ Seasonal flu vaccine

Medical Clearance Form 18+ **Name:** _____

Please have the following information completed and signed by your health care practitioner

1. TUBERCULOSIS SCREENING: Choose one option

Option 1: One-step tuberculosis blood test

QuantiFERON—TB Gold Blood test **(attach copy of lab results)**

Date Administered: _____ Results: +/- _____

Option 2: Two-step tuberculosis skin test (TST).

1st TST: Date planted:_____ Lot:_____ Location:_____ Administered by:_____

Date read:_____ Results: + / - _____mm induration Read By:_____

Wait at least 7 days between 1st TST & 2nd TST

2nd TST*: Date planted:_____ Lot:_____ Location:_____Administered by:_____

Date read:_____ Results: + / - _____mm induration Read By:_____

*Volunteer may receive second TST at NYPBMH Employee Health Services any weekday except Thursday.

If TST results are positive, perform CXR and attach the report.

Date of Chest x-ray:_____ Results: _____

2. VACCINATION SCREENING: Blood work for MMRV. You must attach copy of lab results

Measles titer _____ + / - **Rubella titer**_____ + / -

Mumps titer_____ + / - **Varicella titer**_____ + / -

****MMRV blood titer lab results completed within the past 5 years are acceptable****

3. FLU VACCINE: Volunteer may receive the flu shot from their medical provider OR choose to receive it at Employee Health Services.

Date Administered _____ **Vaccine Lot Number**_____

Practitioner's Signature_____

OR

☐ Volunteer will receive flu shot at NYPBMH Employee Health Services

4. DISABILITIES: To the best of your knowledge, does this applicant have any disabilities that will require special accommodations prior to placement? _____Yes _____No

If yes, please explain_____

_____

_____

5. MEDICAL PROFESSIONAL SIGNATURE: In compliance with the New York State Health Code, I have examined the applicant and have found him/her to be free of any health impairments that would pose a potential risk to patients and hospital personnel or which might interfere with his/her duties.

_____ _____ _____

Practitioner's Name and License Number **Date** **Signature**