NewYork-Presbyterian
The University Hospital of Columbia and Cornell

Non-physician Visitor Attestation of Medical Fitness (for 90 days or less)

Part 1. Applicant: please print legibly.

Name: _____ Date of Birth: ___/___/____
Email: _____ Phone:_____
Visit start date: ___/___/____& end date: ___/___/____ (**for 90 days or less**)
Visit arranged via: **Circle one** (New York-Presbyterian Hospital / Weill Cornell Medicine)
Direct Supervisor's Name for the visit: _____
Supervisor's Department: _____Email:_____ Phone:_____

In support of my application, I attest that:

1. During this visit I will be (check one):
   - □ providing patient care directly (visitors hosted by NYP only)
   - □ observing patient care
   - □ no patient care
2. I have been offered Hepatitis B vaccination and (check one):
   - □ have accepted and completed the series of Hepatitis B vaccinations
   - □ declined Hepatitis B vaccination and signed the OSHA declination form.
3. I am fully able to adhere to standard precautions, when applicable: personal protective equipment, respiratory hygiene/cough etiquette and safe infection practices.
4. I do not take prescribed or unprescribed drugs that may impair my cognition, judgment, or physical dexterity in such a way that could pose a hazard to patients
5. I have not traveled to a CDC designated Ebola Virus affected country in the past 21 days. For a list of affected countries please see the CDC website: http://wwwnc.cdc.gov/travel/notices
6. For this flu season I have (check one):
   - □ Received the influenza vaccination. And I will obtain NYP Flu Sticker from WH&S.
   - □ Declined the influenza vaccination, and if I declined vaccination, I agree to wear a surgical mask in designated areas during the "mask on" period designated by the New York State Commissioner of Health

I understand that to be a NYP/Weill Cornell Medicine non-physician visitor, I must be free of any health impairment, including habituation or addiction to alcohol or drugs or other behavior altering substances, that could pose a potential risk to patients or impede my ability to perform my duties. I hereby attest that I am free of any such impairment.

Applicant's Signature _____ **Date***: ___/___/_____
***Date cannot be earlier than 3 months prior to your start date.**

Part 2. The following must be filled out by your primary heath care provider. Any attachments cannot be used as a substitution for filling out this form. If any part of the form is incomplete or pending, you will not be allowed to start regardless of your start date.

- Medical & occupational history and physical examination were performed, and the examination was of sufficient scope to ensure that the visitor can perform his or her duties without restriction.
  Confirmation Date: __/__/__ Comments: _____
- Documentation of immunity to Measles, Mumps, Rubella, and Varicella either with positive titers or vaccination record. Note: Immunity to Measles, Rubella & Varicella are mandatory. Vaccination is required if not immune. Titer/Vaccine: Measles result & date:___& __/__/__; Rubella result & date: ___&__/__/__; Varicella result & date: ___&__/__/__
  - Tetanus, diphtheria, pertussis (Tdap) and Mumps vaccinations are not mandatory but strongly encouraged as is seasonal influenza vaccine. (Recommended) Tdap date: __/__/__; Mumps titer/vaccine result & date: ___&__/__/__

- Two-step TB (TST) skin testing, which requires having 2 skin tests done at least 9 days apart before starting work. If positive, must have documentation of positive TST in millimeters of induration. First TST should be done within the last 12 months and second TST should be done within the last 1 month. IGRA testing may be substituted for the two-step TST and should be performed within 1 month.
  1st TST (mm & date): ___&__/__/__; 2nd TST (mm & date): ___&__/__/__
  If applicable, IGRA result & date: ___&__/__/__ (indeterminate result will not be accepted)
- Chest x-ray for documented TST or IGRA positive should be performed after the date of the positive test but within the last 12 months. Please write "NA" if not applicable.
  Results & Test Dates:_____& __/__/__
- Hepatitis B surface antibody (HBsAb) and Hepatitis C antibody (HVC Ab) baselines are needed for those with potential exposure to human blood and body fluids. Hepatitis B surface antigen (HBsAg) should be done if HBsAb is negative. HBsAb result & date: ___& __/__/__; If HBsAb negative, then HBsAg result & date: ___&__/__/__; HCV Ab result & date: ___&__/__/__
- An offer for vaccination against Hepatitis B is an OSHA requirement for all healthcare personnel. Those with a negative titer who decline vaccination must sign a declination form at Workforce Health & Safety Office at Harkness Pavilion 1st Fl. New York, NY.
- S/he does not take prescribed or unprescribed drugs that may impair my cognition, judgment, or physical dexterity in such a way that could pose a hazard to patients.
- S/he is fully able to adhere to standard precautions, when applicable: personal protective equipment, respiratory hygiene/cough etiquette and safe infection practices.
- S/he confirmed that s/he has not traveled to a CDC designated Ebola Virus affected country in the past 21 days. For a list of affected countries please see the CDC website: http://wwwnc.cdc.gov/travel/notices
- For this flu season s/he has (check one):
  □ Received the influenza vaccination: date of last flu vaccination: __/__/__. And s/he will obtain NYP Flu Sticker from WH&S.
  □ Declined the influenza vaccination, and if s/he declined vaccination, s/he agrees to wear a surgical mask in designated areas during the "mask on" period designated by the New York State Commissioner of Health
- Please provide additional comments/documentation if there are any medical conditions that may affect the applicant's ability to perform his/her duty. Please write "NA" if not applicable.

Comments: _____ Date: __/__/__

I attest that based on physical examination and medical history, the applicant named is free of any health impairment, including habituation or addiction to alcohol or drugs or other behavior altering substances, that could pose a potential risk to patients or impede the applicant's ability to perform his/her duties.

Provider's Signature:_____ Date*:___/___/___
***Date cannot be earlier than 3 months prior to the applicant's start date**

Print Name & Title:_____

Provider License #:_____ Phone:_____

Provider's Office Address:_____

Part 3. Applicant: please submit this form to Workforce Health & Safety.

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WHS Reviewer Name: _____Signature: _____ Date reviewed: ___/___/_____