UNIVERSITY EYE CENTER *
SUNY State College of Optometry
Credentialing Department
33 West 42nd Street, R1029, New York, NY 10036
Tel. (212) 938-5946 / 5898 | Fax (212) 938-5831

HEALTH ASSESSMENT

Last: _____ First: _____ Middle: _____

Immunization / Vaccines

RUBELLA (***Must be documented by positive titer or date of vaccination***)

☐ Titer Date: _____ **OR** ☐ Vaccine Date: _____ Results: _____

RUBEOLA (Measles) – (*Proof of immunization is required only for individuals born after 1/1/57*)

☐ Born before (1/1/57) **OR** ☐ Titer Date: _____ Results: _____

OR

( ) **Measles Vaccine**: (*Two doses of live measles vaccine administered on or after the age of 12 months given at least one month apart*)

Date of **1st** Dose: _____ Date of **2nd** Dose: _____

TUBERCULOSIS – Please complete one of the following three options:

1) FOR APPLICANT WITH PAST NEGATIVE PPD (Mantoux) skin test results for Tuberculosis: *(To be completed and read by: MD/DO/RN/LPN/NP/PA within 48-72 hours of date of injection)*

Date PPD Applied: _____ Administered By: _____

Date PPD Read: _____ Result: _____ Read By: _____

2) FOR APPLICANT WITH A HISTORY OF POSITIVE PPD (Mantoux) skin test for Tuberculosis: At this examination does the individual have any of the following (If yes to any question, a Chest X-Ray is required)

Chronic Cough (> three weeks)	☐ Yes	☐ No
Night Sweats	☐ Yes	☐ No
Chronic Fatigue	☐ Yes	☐ No
Bloody Sputum	☐ Yes	☐ No
Involuntary Weight Loss	☐ Yes	☐ No

By: _____ *(MD/DO/RN/LPN/NP/PA)* Interpretation Date: _____

If YES to any of the above, please provide the following information:

Date of Chest X-Ray: _____ Result of X-Ray: _____ (Attached X-Ray Results)

3) QuantiFERON-TB Gold Test (For individuals with either a history of a positive PPD or those who cannot have a PPD for any reason)

Test Date: _____ Result: _____

Interpretation By: _____ *(MD/DO/RN/LPN/NP/PA)* Interpretation Date: _____

Certifying Physician's Statements: I have assessed the above named individual. In my judgment, the applicant is free from any physical or mental health impairment which is of potential risk to patients or might interfere with the performance of his/her duties.

Date of Physical Exam: _____

Provider Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____ Fax: _____

Physician's Signature: _____ Date: _____

**** For new employees and new students, all physicals and tests must be within the past 4 months ****