NewYork-Presbyterian	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: _____/_____/_____ Visit end date: _____/_____/_____ (**for 90 days or less**)

Direct Supervisor's Name: _____ Email: _____ Phone: _____
Supervisor's Department: _____

1. In support of my application, I attest that:
   During this visit I will (check one):
   i. □ be observing patient care
   ii. □ will **not** be providing patient care
   iii. □ working with animals only (ICM)

2. I have been offered Hepatitis B vaccination and (check one):
   i. □ have accepted and completed the series of Hepatitis B vaccinations
   ii. □ declined Hepatitis B vaccination and signed the OSHA declination form. https://www.osha.gov/SLTC/etools/hospital/hazards/bbp/declination.html

3. Regarding the COVID-19 vaccine, are you fully vaccinated? (Fully vaccinated is defined as two or more weeks after receiving the 2nd dose of Pfizer or Moderna vaccine or two or more weeks after receiving one dose of Johnson and Johnson vaccine.) □ YES □ NO □ N/A (minors 15 and younger)

4. If NO or N/A to the above question regarding COVID-19 vaccine, AND you have travelled internationally recently, have you quarantined for 7 days after arrival in the US with a negative SARS-CO-V-2 test on day 3-5 after your return? □ YES OR □ NO, but I agree to quarantine for 7 days after arrival in the US and show proof of a negative SARS-Co-V-2 test on day 3-5 after my return **OR** □ I have not travelled internationally.

5. For this flu season, I have □ received the flu vaccine on ____/____/20_____OR □ I have declined the flu vaccine for the 2021-2022 Influenza Season.

Part 2. The following must be filled out by your primary health care provider. Any attachments that will assist in the completion of this form should be sent. Attachments will only be accepted in english. 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.

Measles Mumps Rubella Vaccine (MMR) (1st Vaccine after 1st birthday)	OR	Measles/Rubeola Antibody Mumps Antibody Rubella Antibody
Date 1: ___/___/___ Date 2: ___/___/___		Measles Date: ___/___/___ Result: □ Positive □ Negative Mumps Date: ___/___/___ *(Not mandatory, but strongly encouraged)* Result: □ Positive □ Negative Rubella Date: ___/___/___ Result: □ Positive □ Negative

Hepatitis B Antibody Date: ___/___/___ Result: □ Positive □ Negative (If neg., then HBsAg needs to be performed) Not needed for ICM visitors	Hepatitis B Antigen (within 6 months of scheduled visit start date) Date: ___/___/___ Result: □ Positive □ Negative (Perform only if HBsAb is negative) Not needed for ICM visitors	Hepatitis C Antibody (within 6 months of scheduled visit start date) Date: ___/___/___ Result: □ Positive □ Negative Not needed for ICM visitors

Varicella Vaccination (2 Vaccines) OR Varicella Titer Not needed for ICM visitors	
Date 1: ___/___/___ Date 2: ___/___/___	Date: ___/___/___ Result: □ Positive □ Negative

Tuberculosis Screening
May provide either IGRA testing results OR 2 Mantoux TB skin tests

IGRA or Quantiferon blood test (within 60 days of scheduled visit start date)
Date: ___/___/___
Result: □ Positive □ Negative

OR

2 Mantoux TB Skin Tests (PPD)

(The 1st test within prior 12 months and the 2nd test within 60 days prior to the scheduled visit start date) OR present physician documentation of completed latent Tb treatment.

PPD #1 (within prior 12 months of scheduled visit start date) Plant Date: ___/___/___ Read Date (48-72 hours after plant): ___/___/___ Result: _____ mm (must be documented as a numerical value)	**PPD #2** (within 60 days scheduled visit start date) Plant Date: ___/___/___ Read Date (48-72 hours after plant): ___/___/___ Result: _____ mm (must be documented as a numerical value)

If positive, chest x-ray date (must be done after positive test and within prior 12 months** of scheduled visit start date)*
*Date:___/___/___ Results:*_____

Tdap (within the past 10 years)
Tdap Date: ___/___/___ (*Not mandatory, but strongly encouraged*)

*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: _____

*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

Confirmation Date: __/__/__ Comments: _____

Physician's Acknowledgement

- 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 his/her 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.

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:_____

Applicant's Acknowledgement

1. I am fully able to adhere to standard precautions, when applicable: personal protective equipment, respiratory hygiene/cough etiquette and safe infection practices.
2. 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

I understand that to be a NewYork-Presbyterian Hospital/Columbia/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.

Comments: _____Date: ___/___/_____

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

==========

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