

**WESTCHESTER MEDICAL CENTER (WMC) - HEALTH CLEARANCE FORM  
(TO BE COMPLETED BY THE INDIVIDUAL'S HEALTH CARE PROVIDER)**

The following health and immunization requirements are subject to change in accordance with applicable law and Hospital policy. The healthcare provider signing below certifies the following:

**NAME:** \_\_\_\_\_ **DATE OF EXAM:** \_\_\_\_\_  
**DEPARTMENT:** \_\_\_\_\_ **JOB TITLE:** \_\_\_\_\_  
**ESSENTIAL FUNCTIONS:** \_\_\_\_\_

In the case of outbreak, exposure or WMC inspection the contract agency must submit to the occupational health center (OHC) or its medical designee copies of laboratory results and pertinent medical information to support the following items within 24 hours.

The applicant is medically qualified for designated work and is free from any health impairment which is of potential risk to patients or which might interfere with the performance of the applicant's duties, including the habituation to drugs or alcohol, which may alter the applicant's behavior. YES: \_\_\_ NO: \_\_\_

**WMC ONLY RECOGNIZES SEROLOGY AS PROOF OF IMMUNITY**

RUBELLA (German Measles) IMMUNE: \_\_\_ NON IMMUNE: \_\_\_

RUBEOLA (Measles) IMMUNE: \_\_\_ NON IMMUNE: \_\_\_

VARICELLA (Chicken Pox) IMMUNE: \_\_\_ NON IMMUNE: \_\_\_

MUMPS IMMUNE: \_\_\_ NON IMMUNE: \_\_\_

HEPATITIS B: HBsAg \_\_\_\_\_ Positive \_\_\_\_\_ Negative \_\_\_\_\_

HBsAb \_\_\_\_\_ Positive \_\_\_\_\_ Negative \_\_\_\_\_

TUBERCULOSIS SCREENING : TEST RESULTS:

TUBERCULOSIS SCREENING (MANTOUX Purified Protein Derivative)  
TEST RESULT (all results in millimeters (mm) of induration including 0 mm).

(PPD) NEGATIVE \_\_\_ \*POSITIVE \_\_\_ Date Read: \_\_\_\_\_

\*If positive Chest X-Ray result: \_\_\_\_\_ Date: \_\_\_\_\_

**RESPIRATORY PROTECTION:**

Applicant is medically cleared to wear respiratory protection. YES \_\_\_ NO \_\_\_

Applicant has been fit tested for respirator use. YES \_\_\_ NO \_\_\_

If yes what type of respirator? \_\_\_\_\_

**INDIVIDUALS WORKING WITH LASERS:**

Applicants who will work directly with lasers shall have had a baseline eye examination, including:

- ocular history, including photosensitizing medications
- visual acuity for far and near vision
- macular function by use of Amsler grid
- color vision by use of Ishihara test

THIS CLEARANCE IS VALID FOR ONE YEAR FROM THE DATE OF EXAMINATION INDICATED ABOVE. THE CONTRACT AGENCY MUST RESUBMIT AN UPDATED CLEARANCE FORM AT THAT TIME.

**PROVIDER NAME:** \_\_\_\_\_

**PROVIDER SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**Revised: April 1, 2008, August 27, 2008**