Stony Brook Medicine

# Employee Self-Health Assessment

*Per New York State Title 10 Health code 405.3, employees are required to undergo an annual health assessment. Completed assessments must contain an actual physical signature or be signed with Adobe e-sign and sent to employeeannuals@stonybrookmedicine.edu between the first and last day of the employee's birth month.*

| | | | | | |
|---|---|---|---|---|---|
| Name | | Employee ID# | | DOB | |
| Job Title | | Department | | Supervisor | |
| Preferred Contact # | | May we leave a voice mail with medical info? | | | |

List pertinent health problems within the past 12 months. Examples include changes to mental or emotional wellbeing, injuries, hospitalizations, seizures, diabetes, allergies, increased blood pressure, heart, lung or breathing problems, etc.)

List current medications including over-the-counter medications:

Do you have a latex allergy and/or any other allergies? Yes ☐ No ☐

**If yes,** list allergies and describe reactions:

List any work-related health concerns below that you would like to discuss with a provider.

Check any of the following that you are exposed to in your current job:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Chemotherapy | | Ethylene Oxide | | Radiation | | Formaldehyde | |

List any other Hazardous drugs (refer to NIOSH Hazardous Drug List) you are exposed to in your current job.

If you checked any of the above and if you would you like to fill out the ***voluntary*** Medical Surveillance Questionnaire, please provide an email address you would like it sent to:

**Tuberculosis (TB) Control -** Please check all applicable boxes below:

| Questions: | Yes | No | If yes, provide details below: |
|---|---|---|---|
| Are you experiencing fever, sweats, cough, unexplained weight loss, or hemoptysis? | | | |
| Do you have a history of positive PPD? | | | |
| Do you have a history of INH Therapy? | | | |
| Have you traveled outside of the US within the past 12 months? | | | |
| If you have traveled outside of the US within the past 12 months, was it due to a medical mission and/or missionary work? | | | |

***Additional Information and Employee Attestation***

- I understand that if I work in an identified high-risk group for TB exposure, I will need to provide evidence of TB clearance and that EH&W will contact me if this is the case. (e.g. Respiratory Therapy, ED, Micro Lab, etc).
- I certify that the information I provided is complete and accurate to the best of my knowledge. I also attest that I am free from all known current health impairments that are of potential risk to patients or personnel or might interfere with the performance of my duties including but not limited to habit or addiction to depressants, stimulants, narcotics, alcohol, or other drugs or substances, which may alter behavior Per NYS DOH 405.3.
- Pregnant employees and employees with disabilities who require accommodations in order to perform the essential functions of their jobs should contact Human Resources.

| | | | |
|---|---|---|---|
| Employee Signature | | Date | |

# Employee Health Provider Section

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|---|
| Name: |
| Date of Birth: |

**PPD (if applicable): THIS AREA FOR EHW / Health Care provider placing and/orreading PPD** N/A

Date Placed:_____Location Placed:_____LFA / RFA Lot #:_____Manufacturer: _____

PPD 5 TU 0.1cc ID Expiration Date:_____

Administered By: _____

Date Evaluated:_____Result:_____mm Induration Interpretation _____

Read by: Printed name_____
MD, DO, PA or CNP/ Employee Health Nurse, PPD trained RN

Signature:_____Please include your title: _____

License # _____

**EMPLOYEE HEALTH SERVICE DETERMINATION**

Based on the information provided for the purposes of the annual assessment, it is my opinion that this individual has completed their annual Employee Health requirements.

Authorized Employee Health Practitioner Signature: _____

Printed Name:_____Comments:_____

License #_____Date: _____

_____

_____

Additional lines provided for comments, if needed.