



Pre-Placement Physical

Welcome to Stony Brook University Hospital (SBUH). To be in compliance with New York State Public Health Code Title 10, 405.3, SBUH Policy, and relevant OSHA and NYSDOH regulations, medical requirements for employment/staff privileges shall include, at minimum:

- 1. Medical History
2. Physical Examination by licensed health practitioner
3. Compliance with TB control program, including REQUIRED two step PPD skin testing (or Quantiferon Gold/T-Spot blood test within 3 months of hire date), symptom review, and chest x-ray, if indicated.
4. Medical clearance for respirator wear (if designated by the department).
5. Documentation of immunity or vaccination against Rubella, Measles, and Mumps.
6. Documentation of varicella (chicken pox) immunity.
7. Documentation of vaccination against Hepatitis B or signed declination.
8. Documentation of completed COVID-19 vaccination series.

Legal Name (print): Last First MI

Preferred Name (print):

E-Mail: Cell Phone: ()

Date of Birth: Place of Birth:

Mailing Address: Phone: ()

Have you lived outside of the U.S.? Yes No If yes, specify dates and location:

Emergency Contact: Relationship: Phone: ()

Supervisor's Name: Phone: ()

Your Department: Job Title: Phone: ()

I understand that Stony Brook University Hospital is a smoke free environment. Signature

REQUIRED: Please attach lab report of antibody titers and vaccine documentation

Yes No

- 1. Varicella (Chicken Pox): Lab report of positive titer or documentation of 2 dose series of varicella vaccine.
2. Measles (Rubeola): Lab report of positive antibody titer OR documentation of 2 doses of MMR vaccine required.
3. Mumps: Lab report of positive antibody titer OR documentation of 2 doses of MMR vaccine required.
4. Rubella (German measles): Lab report of positive antibody titer OR documentation of 1 dose of MMR vaccine required.
5. Hepatitis B: Documentation of 3 dose series of Hepatitis B vaccine or signed Hepatitis B declination page is required. Please attach lab report of post-vaccination Hep B surface antibody titer if available.
6. RECOMMENDED: Tetanus (Td or Tdap) vaccine within 10 years: please attach documentation.
7. For food service 2 doses Hepatitis A.
8. COVID: Fully vaccinated for COVID-19.



Legal Name (print): Preferred Name (print):

Medical History and Review of Systems:

Have you ever had or do you have any of the following?

Table with columns: Infectious Diseases, Respiratory/Lungs, Cardiovascular/Heart, Neurologic. Rows include: Chicken Pox or Shingles, Measles, Mumps, Tuberculosis or positive IGRA or PPD test, Chronic Bronchitis/Emphysema/COPD, Asthma/Wheezing, Asbestosis, Silicosis, Pneumoconiosis, Pneumonia, Pneumothorax (collapsed lung), Broken ribs or chest injury/surgery, Coughing up phlegm or blood, Shortness of breath or chest tightness, Heart Attack, Chest pain/Angina, Heart failure, Irregular heart rhythm or palpitations, High blood pressure, Edema (swelling of legs/feet), Stroke, Seizures or Epilepsy, Numbness, weakness or paralysis of arms or legs, Head injury or concussion, Severe headaches or migraines, Dizziness or fainting spells, Other neurologic disorder, Sleep apnea or other sleeping disorder.

Table with columns: Gastrointestinal and Kidney, Skin, Endocrine, Severe Allergic Reaction, Vision and Hearing, Musculoskeletal, Miscellaneous, Surgeries or hospitalizations. Rows include: Stomach or intestinal problem, Hepatitis or other liver disease, Kidney disease or kidney stones, Hernia, Blood in urine, Chronic rash or eczema, Diabetes, Thyroid or other endocrine problem, Allergic reactions that affect breathing, Wear glasses or contacts, Eye disorder (e.g. glaucoma, macular degeneration, cataracts, etc.) or injury, Color blindness, Hearing loss or tinnitus (ringing in ears), Back/neck injury or pain, Arthritis/gout, Other bone/joint problem or injury- please specify: Anemia, Cancer, Immune system disorder, Bleeding or clotting disorder, Trouble smelling odors, Claustrophobia or anxiety, Psychiatric illness (e.g. depression, bipolar), Reason:

Please provide details, including dates, for any items marked yes above. Please note any other medical conditions not listed above.

Medications: Please list your current medications (prescription and over the counter, including vitamins/supplements):

Table with columns: Allergies: please specify, Yes, No. Rows include: Medications, Latex, Other (e.g. foods, animals, etc.):



Legal Name (print): _____ Preferred Name (print): _____

Social and Work-Related Health History:				Yes	No
Social History					
Alcohol Use (Circle # of Drinks per Week): None 1 to 5 6 to 14 15 or more					
Tobacco Use (Circle one): Never Former Current (specify #packs/day and #years):					
Do you use any other substances or recreational/street drugs?					
Have you ever received treatment for substance use or abuse?					
Work-Related Health History					
Have you ever used a respirator? Please specify type:					
Have you ever experienced any problems when wearing a respirator?					
Have you ever been refused employment for health reasons or had to leave a job for health issues?					
Do you have visual, hearing or other physical limitations? Please specify:					
Do you have any conditions or disabilities that may prevent you from performing the essential functions of your job or which require accommodation? Please specify:					
Have you ever had a work-related injury or illness? Please specify:					

Tuberculosis (Tb) Screening:

Symptom Review: Fever, sweats, cough, weight loss or hemoptysis (spitting up blood): Yes (circle all that apply) No

If History of Positive Screening Test: If you have ever had a positive PPD or Quantiferon/T-Spot test, one chest x-ray is REQUIRED. (No additional PPD or blood test needed). Please complete the information below:

Date of positive PPD or blood test: ____/____/____ Chest x-ray date: ____/____/____ (Must attach x-ray report)

Treated with INH: Yes, for ____ months No History of BCG Vaccine: Yes No

If NO History of Positive Screening Test: A two-step PPD test is required. The two PPD tests must be at least one week apart but not greater than 12 months apart. The most recent test must be within the last 3 months. Lab report of a negative Quantiferon Gold or T-Spot test within the last 3 months may be submitted in place of the two step PPD.

I certify that the information on this form is correct and complete to the best of my knowledge. I further understand that the results of this examination will be used to identify any medical condition(s) which might interfere with my ability to perform work duties. My employer will be made aware only of my fitness status. I also certify that I am free from habituation or addiction to alcohol, drugs or other substances which may alter behavior or affect my ability to perform work-related duties.

Employee Signature

Date

To be completed by healthcare provider. PPDs must be read by an Attending Physician, NP or PA. Self-reading is not acceptable

1.) Date placed: ____/____/____ Manufacturer _____ Lot# _____ Exp. Date ____/____/____ Date read: ____/____/____ Result Neg ____mm Pos ____mm Signature: _____ Print Name _____ License # _____
2.) Date placed: ____/____/____ Manufacturer _____ Lot# _____ Exp. Date ____/____/____ Date read: ____/____/____ Result Neg ____mm Pos ____mm Signature: _____ Print Name _____ License # _____

OR I am submitting a Quantiferon Gold/T-spot lab report in place of two-step PPD



Legal Name (print): _____

Pre-Placement Physical

Pulse: _____ Blood Pressure: _____ Height: _____ Weight: _____

Ishihara Color Test _____ Pass Fail

Within Normal Limits

Abnormal

	Within Normal Limits	Abnormal
General Appearance		
Mental Status		
Skin		
Nodes		
Eyes		
Ears, Nose, Oral Cavity, Throat		
Neck, Thyroid		
Heart		
Chest, Lungs		
Abdominal		
Extremities		
Neurologic		
Spine/Back		
Others		

Please explain any abnormal findings: _____

Note any recommended limitations or accommodations: _____

A. Mandatory medical clearance for N95 respirator use is required for all employees with patient care contact. After physical exam and review of medical history, I find the above named fit for respirator use:

Yes No Fit with restrictions: _____

B. After physical examination and review of past medical history, I find the above named to be free from health impairment which might interfere with the performance of his/her duties as required by NEW YORK Health Code (Title 10, Section 405.3).

Signature of Examining MD, DO, PA, or NP

Date

Print Name of Examining MD, DO, PA, or NP

Lisc. # & Issuing State

C. Upon review of past medical history, vaccination records and/or titer results, I find the above named free from Tuberculosis and to show immunity to Rubella and Rubeola as required by New York State Health Code (Title 10, Section 405.3). As per SBUH Policy HR008 the above named shows immunity to Mumps.

Signature of Examining MD, DO, PA, or NP

Date

Print Name of Examining MD, DO, PA, or NP

Lisc. # & Issuing State