NuHealth Together through life. Nassau University Medical Center

2201 Hempstead Turnpike • East Meadow, NY 11554

Employee Health Services: Physician Attestation for Non-Employees

Name print last/first: _____/_____

Address print**:** _____

_____

Date of Birth: _____/_____/_____ Phone #: (_____) _____

Below to be **completed**, signed and **stamped** by a Licensed Practitioner: **Attach copy of laboratory results**.

Proof of **immunity** to **Measles, Mumps, Rubella (***Required)*

Rubella vaccine _____ Rubella virus IgG Ab titer (results attached) _____

Measles vaccine #1_____#2_____ or Rubeola virus IgG Ab titer (results attached) _____

Mumps vaccine #1_____#2_____ Mumps virus IgG Ab titer (results attached) _____

Or

MMR vaccine #1 _____#2_____

Proof of **immunity** to **Varicella** ***If declined, declination form must be signed***

Varicella vaccine #1 _____#2_____ or Varicella virus IgG Ab titer results (attached) _____

Proof of **immunity** to **Hepatitis B** ***If declined, declination form must be signed***

#1 Hepatitis B vaccine _____ or Hep B SAb titer (results attached) _____

#2 Hepatitis B vaccine _____ Refused Hepatitis B vaccine series _____

#3 Hepatitis B vaccine _____

Td / Tdap: (circle) **Date _____** (within 10 years)

Influenza vaccine Date: _____ Provide proof of vaccination or a signed declination

TWO-STEP Tuberculin Skin Test r**equired for initial appointment** (one yearly thereafter)

TST #1 Date _____ **TST #2** (within 6 months of application) Date _____

Date evaluated _____ Date evaluated _____

Result: _____ mm induration Result: _____mm induration

Or ☐ Quantiferon TB Gold result:_____ Date: (within 6 months)_____

☐ **Has a positive reaction to the TST.** A normal chest X-Ray report **within three years** is required (attach report).

Review of symptoms: persistent cough, fever, chills, unexplained weight loss, night sweats, coughing up blood, loss of appetite, prolonged fatigue

Does the above named have any of these symptoms? (Please check) □NO □YES

***** I have performed a physical examination of sufficient scope to ensure that the above named person is free from health impairment which is of potential risk to the patient or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior (per N.Y.S. Code 405.3(b)).

Practitioner's signature: _____ License #: _____State_____

Practitioner's name (print):_____ Phone #: (_____) _____

Address: _____

Date this certificate was completed: _____/_____/_____ **Practitioner's Stamp**:

Barcode EM4410