

CATHOLIC HEALTH

--- **Provider Annual Health Assessment, Tuberculosis Screening & Fit Testing** ---

This Medical Evaluation shall be requested annually as required by the NYS Department of Health

Provider Name (Please Print): _____

AS REQUIRED, ALL INFORMATION MUST BE PROVIDED

A. TUBERCULOSIS SCREENING:

1. In the past year, are you aware of being exposed to anyone with active Tuberculosis? Yes No
2. Have you been treated for active or latent Tuberculosis? Yes No
 - a. If yes, when was it treated? _____
 - b. If yes, where were you treated? _____
3. Have you had any of the following symptoms of Tuberculosis? Yes No
 - Unplanned weigh loss of more than 10 pounds?
 - New cough for more than three (3) weeks?
 - Blood in your sputum?
 - Night Sweats?
 - Unexplained Fevers?
 - Loss of appetite?
 - Unexplained hoarseness of voice?

If the answer to questions 1 and/or 2 or 3 is "yes", and/or any of the above symptoms are indicated, it will require further review by a Catholic Health Associate Health nurse to determine if a PPD is warranted.

B. RESPIRATOR FIT TESTING (Affiliate Staff & Telemedicine Only Providers Exempt):

Have you had a respirator fit test in the last year? Yes No

If yes, please provide a copy with this form

Respirator Fit Testing is an annual requirement for any credentialed provider on the medical staff. Please visit any employee health location to complete testing and submit with your health assessment. Your health assessment is not complete without the fit test documentation.

PROVIDER SIGNATURE: _____ **DATE:** _____

ANNUAL MEDICAL EVALUATION STATEMENT:

I have determined, to the best of my knowledge, that the above-named provider is free from any health impairment which is of potential risk to patients 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 individuals behavior.

[Signature of the examining Practitioner]

(Note: Providers Cannot Sign for Themselves)

[Date]

[Typed or Printed Name of Examining Practitioner]

Please fax completed document to the Medical Staff Office of your
Primary CH Facility:

- Mercy Hospital of Buffalo: (716) 828-3472
- Sisters of Charity Hospital/SJC: (716) 862-1871

- Kenmore Mercy Hospital: (716) 447-6340
- Mount St. Mary's Hospital: (716) 298-2001



Associate Health Services Site Contacts

Site Staff					
Carol Baughman	Sisters Hospital 1 st Floor – HR Dept Ph: 862-1408 Fax: 862-1315 cbaughman@chsbuffalo.org				
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Paul Noeson	Kenmore Mercy Hospital 4 th floor – Rm #4036 Ph: 447-6518 Fax: 447-6847 pnoeson@chsbuffalo.org				
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