

--- **Provider Tuberculosis Screening, COVID-19 Documentation & Annual Health Assessment** ---

Provider Name (Please Print): _____

ANNUAL TUBERCULOSIS SCREENING: Please complete Item A and Item B below.

A. TUBERCULOSIS SCREENING TEST	
1.	In the past year, are you aware of being exposed to anyone with active Tuberculosis? <input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Have you been treated for active or latent Tuberculosis? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Unplanned weigh loss of more than 10 pounds?
	<input type="checkbox"/> New cough for more than three (3) weeks?
	<input type="checkbox"/> Blood in your sputum?
	<input type="checkbox"/> Night Sweats?
	<input type="checkbox"/> Unexplained Fevers?
	<input type="checkbox"/> Loss of appetite?
	<input type="checkbox"/> 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.	
Provider Signature: _____ Date: _____	

B. COVID - 19 VACCINATION STATUS	
Have you received a COVID-19 Vaccine within the last year? Yes___ No___ If yes, Date _____	

ANNUAL PROVIDER HEALTH ASSESSMENT 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 your Practitioner]**(Note: Providers Cannot Sign for Themselves)**_____
[Date]_____
[Typed or Printed Name of your 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