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 IN ORDER TO BE CONSIDERED A COMPLETE HEALTH ASSESSMENT

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 CH Associate Health nurse to determine if a PPD is warranted.

B. RESPIRATOR FIT TESTING - Respirator Fit Testing is an annual requirement for all providers who treat patients in the hospital. Please visit any employee health office location to complete testing and submit with your annual health assessment. Your annual health assessment is not complete without the Fit Testing.

Have you had a respirator Fit Test in the last year?

- ❑ Yes – I have attached documentation of my annual Fit Testing. (Your annual health assessment is not complete without the Fit Testing documentation).
- ❑ No – I am an Affiliate Staff member or provide Telemedicine services and **DO NOT** treat patients in the hospital.

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 individual's behavior.

_____ _____

[Signature of the examining Practitioner] *[Date]*

(Note: Providers Cannot Sign for Themselves)

_____

[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**

Rev. 10/21/15, 5/2/18, 1/7/2021, 2/11/2021, 3/19/2021, 10/13/2021, 4/2/25; 3/16/26, 4/30/26

Associate Health Services
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