Spark! Challenge Program #: _____.

Employee Health Services Medical Clearance

☐ Shadowing/Observation Participants & Visiting Staff ☐ Rotating Residents

Name: _____ Current Hospital/School: _____
(First Name, Last Name)

DOB: ____ /____ /____ Telephone: ( ) _____ Email: _____

TO BE COMPLETED AND SIGNED BY YOUR HEALTHCARE PROVIDER OR FACILITY

Tuberculosis (TB) Screening:

Tuberculin Skin Testing (TST/PPD) or Blood Assay

TB screening must be within the past 12 months or check the positive box below if the individual has a history of a positive tuberculin skin test.
☐ Negative – Date completed: ___ / ___ / ___ ☐ Positive - **Complete Positive TST/PPD Section Below**

OR Blood Assay (within 12 months) Attach Lab Report: Date complete: ___ /___ /___ Results: ☐ Negative ☐ Positive

Positive TST/PPD: If you have a history of a positive TST/PPD, complete the chest x-ray and signs and symptoms section below.

You **must have had a chest x-ray** with no active disease

Chest X-Ray Date: ___ / ___ / ___ Results: ☐ No Active Disease TB Treatment given: Date(s): _____
☐ Other _____

Tuberculosis Signs and Symptoms Evaluation
Date of Review: ___ / ___ / ___ Results: ☐Negative ☐Positive

Vaccination History	Vaccine #1 Date	Vaccine #2 Date		Lab reports Attached
MMR Vaccine Two doses of MMR	___ / ___ / ___	___ / ___ / ___		☐
OR				
Measles *(Rubeola):* Two immunizations	___ / ___ / ___	___ / ___ / ___	**OR**	☐
Mumps: Two immunizations	___ / ___ / ___	___ / ___ / ___		☐
Rubella: *(German Measles)* One immunization	___ / ___ / ___	*Intentionally left blank*		☐
Varicella: Two immunizations or Disease History Date: ___ /___ /___	___ / ___ / ___	___ / ___ / ___		☐
Tdap/DTaP: Pertussis containing vaccine within last 10 years	___ / ___ / ___	*Intentionally left blank*		
Influenza: Vaccinated within the current flu season.	___ / ___ / ___	☐ Declined Vaccinated		*Intentionally left blank*
Hepatitis B*: Complete Hepatitis B Section for individuals that have Direct Patient Care Contact.*	☐ Immune Lab report attached	☐ Declined Vaccination ☐ Initiated Series		

Health Assessment: The above individual has been evaluated in the past 12 months. The results of our evaluation is of sufficient scope to ensure 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, other drugs or substances which may alter the individuals behavior. ***The office that is completing this form will be responsible for maintaining updated records for the duration of participant's and/or faculty's interactions within Northwell Health facilities and provide appropriate supporting documentation upon request.***

Health Care Provider or Facility: _____ Phone: _____
(Please Print) (School designee if applicable)

Health Care Provider or Facility Signature: _____ Date: _____

Provider/Facility Stamp with Address and Telephone Number: OFFICE STAMP

For Office Use Only: Department: Workforce Readiness Updated April 2017

Program Name: Spark! Challenge Northwell Health Program Contact Name: Lauren Pearson

Program Contact Phone: 516-535-9290 Start Date: 11 / 1 / 19 End Date : 12 / 18 / 19

Medical Clearance to be sent to (Email address): SparkChallenge@northwell.edu

Northwell Health EHS Reviewer Signature: _____ Date: ____ /____ /____