

PA STUDIES ANNUAL HEALTH ASSESSMENT

To be completed by student:

Name: _____ Date of Birth: _____
(First, Middle Initial, Last) (Month, Day, Year)

I understand and accept that

- the healthcare facilities that I may be assigned to for clinical rotations or other patient experiences, have immunization requirements for their healthcare workers as a condition of employment. As a guest in their facilities, the New York Institute of Technology Physician Assistant Studies (NYIT, PA Studies) program's student participants must comply with all healthcare screening and other requirements imposed as a condition of the healthcare affiliation agreement.
- if I am unable to confirm immunization status or unable to obtain immunizations due to personal, religious or medical* reasons, NYIT's PA Studies program cannot guarantee placement at a clinical site, and this may limit my ability to successfully complete and graduate from the program as completion of all clinical rotations is required for successful completion of the program.

*In some situations, the clinical site might accept certain medical reasons for not receiving a vaccination, but this will be at the discretion of the site.

Student's Signature (Required): _____ Date: _____

To be completed by health care provider:

An examination was performed on the above named individual. The following assessments were included:

- Complete history and physical examination.
- Test for Tuberculosis Infection (TTBI). Conducted with the approved methods listed below:

If patient has never received a BCG vaccination choose either the 1) **Two-step Tuberculin Skin Test (TST)** or 2) the **Blood based Tuberculosis infection screening test** (QuantiFERON®-TB Gold In-Tube test **OR** the T- SPOT®.) **to establish baseline TST status:**

Date of 1st Test: _____ Date Read: _____

Result: _____Negative _____Positive*

Date of 2nd Test: _____ Date Read: _____

Result: _____Negative _____Positive*

The following test is required if patient has received BCG vaccination, or is allergic to the TST

Blood based Tuberculosis infection screening test (QuantiFERON®-TB Gold In-Tube test **OR** the T- SPOT®.)

Date Tested: _____

Result: _____Negative _____Positive*

*IF TST AND QUANTIFERON TESTS ARE POSITIVE:

Further evaluation and clearance is required by a health care provider. Please attach supporting documents.

- Does patient have a normal chest x-ray? Yes – Date _____ No _____
- If treated with prophylactic medication: Date started _____ Date ended _____

I find him/her to be in good health. He/she is free of any health impairment which may pose a potential risk to personnel, patients or family, and which may interfere with the performance of clinical responsibilities. Habituation to alcohol or other drugs which may alter the individual's behavior has been considered in this evaluation. **To the best of my knowledge, this student is able to fully participate in clinical clerkship education at medical facilities.**

Signature of Examining PA, Physician or
Certified Nurse Practitioner

Physical Exam's
Date of Completion

Address Stamp of Provider/Health Facility
(Required)

Print or Type Name

Telephone Number