Physician's Health Certification

Name of Volunteer: (please print) ____

Date: _________________________________

To: The Physician of above named Volunteer

From: Employee Health Service of Highland Health System

The above named person has applied to be a volunteer for the Highland Health System. New York State codes require that all volunteers be certified that they have no health impairments which would pose a potential risk to patients or personne1. We are requesting this certification from you. This would include infectious diseases, psychiatric impairment, habituation or addiction, or any health condition that would interfere with his/her volunteer experience. Please include a copy of last physical (must be within the last twelve months), and if available, immunity status records.

Sincerely yours,

Employee Health Service
Highland Health System

I hereby authorize my physician to respond to this request by supplying the information requested on the reverse side.

____ ____________
(signature of volunteer OR guardian if under 18) (Date)

Call Employee Health with questions! 341-8017

TO BE COMPLETED BY PHYSICIAN
<u>Form can be faxed to:</u>
Employee Health, 341-8308

I HEREBY CERTIFY THAT ____ IS FREE FROM HEALTH IMPAIRMENTS WHICH COULD BE OF POTENTIAL RISK TO PATIENTS AND STAFF OF THE HIGHLAND HEALTH SYSTEM.

Limitations: _________ No ___________Yes

If yes, please list limitations:

____

____

Last physical exam on ______________
PLEASE ENCLOSE COPY OF LAST PHYSICAL

IMMUNIZATION RECORD (If known by your office)

*PPD	Date placed	Result By	Date Read
RUBELLA TITRE	Date of titre	Result	Date of Vaccine
RUBEOLA TITRE	Date of titre	Result	Dates of Vaccine #1 #2
HEPATITIS	#1	#2	#3
TETANUS	Date of last booster		
CIDCKEN POX	History of disease	No history	Don’t know

Physician's Signature ______________________________

Date _____________________

*You will need a PPD within 1 month of start date.