



Dear Student,

Northwell Health congratulates you on your acceptance. As we welcome you into this academic and healthcare environment, New York State Department of Health (NYS DOH) and Northwell Health requires that certain medical evaluations are completed prior to starting your clinical school education.

Prior to beginning school or completing the medical clearance requirements at our office, you are required to visit your local LabCorp which will provide the necessary bloodwork and drug screening. Completing the bloodwork and drug screening prior to your Northwell Health Employee Health Services (EHS) medical clearance appointment is a mandatory requirement. EHS will provide you with the LabCorp requisitions to obtain the lab services free of charge. After you complete your visit to LabCorp, please contact Northwell Health EHS to schedule your medical clearance appointment. This EHS appointment will include the following evaluations:

- Physical Examination including color vision screening
- Respirator Fit Testing
- Vaccinations as necessary

All of these services will be provided to you free of charge. Any services obtained outside of the Northwell Health EHS office or LabCorp will not be reimbursed. Here is a complete list of requirements that will need to be completed by each student. The following page will give you step by step instructions on how to complete each requirement.

## MEDICAL CLEARANCE REQUIREMENTS

### Physical Exam

- **Physical Exam and Health History** within the past year.

### Drug Screening Tuberculosis Screening Proof of Immunity

- **Drug Screening, Tuberculosis Screening, Screening for Measles, Mumps, Rubella, Varicella, Hepatitis B Surface Antibody and Hepatitis B Surface Antigen** must be drawn at a LabCorp location at least 5 business days before your EHS appointment. EHS will email you TWO lab requisitions to take to your local LabCorp to be screened. You must use the EHS requisitions when being screened.

### Tetanus/Diphtheria/Pertussis Meningococcal vaccine

- **Proof of Tdap vaccination within the last 10 years.**
- **Proof of vaccination against the Meningococcal Disease** or documented acknowledgment of the disease risks and refusal.

### Respirator Medical Evaluation and Fit Testing

- **Respirator Fit Testing :** Students with facial hair that interferes with the respirator's seal to your skin cannot be fit tested with the respirator. Be sure that facial hair in those areas are removed prior to fit testing.

### Color Vision Testing

- **Color Vision** screening via Ishihara test.



# Here is what you need to do to ensure your medical clearance is completed on time:

## Section 1: Complete & Submit Medical Clearance Documents

- Complete the Hofstra University Medical Record form, Northwell Health EHS Demographic Profile/Medical Evaluation Acknowledgement, Respirator Medical Evaluation & Tuberculosis Screening Questionnaire's, Physical Examination and Immunization Record.
- **Deadline:** All forms must be completed and emailed to [StudentsEHS@northwell.edu](mailto:StudentsEHS@northwell.edu) before **June 27, 2016**

## Section 2: Schedule Bloodwork & Drug Screening

- Complete the required blood draw and drug screening at your local LabCorp location before scheduling your EHS medical clearance appointment.
- **Deadline:** All bloodwork and drug screening must be completed no later than **June 27, 2016**.

## Section 3: Schedule Appointment

- Schedule your medical clearance appointment at Northwell Health EHS.
- **Deadline:** All students must call EHS to schedule an appointment before **July 11, 2016**. Appointment's will be scheduled during the following time period: June 27, 2016 to July 25, 2016, please plan appropriately. Appointments are limited, call ASAP to secure an appointment date.

### Reminders:

- **Bloodwork and drug screening must be completed before you schedule your medical clearance appointment at EHS.**
- **Bring valid unexpired identification to your medical clearance appointment.**

Please feel free to contact us if you have any questions or concerns regarding any of the medical requirements.

**Employee Health Services**  
410 Lakeville Road, Suite 206 New Hyde Park, NY 11042  
Phone: (718) 470-5350  
Fax: (718) 470-4282  
Hours of Operation M,Tu,W,F 7:30am to 6pm Th 7:30am to 2pm  
Email: [StudentsEHS@northwell.edu](mailto:StudentsEHS@northwell.edu)



# Section 1

## TO BE COMPLETED BY THE STUDENT

- Hofstra University Medical Record Form**
- Northwell Health Employee Health Services Demographic Profile & Medical Evaluation Acknowledgement**
- Respirator Medical Evaluation Questionnaire**
- Tuberculosis Screening Questionnaire**
- Physical Examination to be completed by your private physician** *(If you are unable to get the physical examination done, we will perform the physical examination at your Northwell Health EHS appointment)*

**Instructions:** Complete and submit all of the above documents before your Northwell Health EHS Appointment.

**Submission:** [StudentsEHS@northwell.edu](mailto:StudentsEHS@northwell.edu)

**Deadline:** **Submit Before June 27, 2016**



# Hofstra Medical Record

TO THE STUDENT: THIS INFORMATION WILL BECOME PART OF YOUR CONFIDENTIAL HEALTH RECORD.

- Print Name \_\_\_\_\_  
Last First Middle
- Address \_\_\_\_\_  
Street/Apt. # City State Zip Code
- Date of Birth \_\_\_\_\_ Country of Birth \_\_\_\_\_ Hofstra ID # \_\_\_\_\_
- Person to identify in case of emergency \_\_\_\_\_  
 Parent  Guardian  Spouse  
 Other \_\_\_\_\_  
Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Street/Apt. # City State Zip Code
- Home Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_ Email Address \_\_\_\_\_@\_\_\_\_\_
- Name of Health Insurance Carrier \_\_\_\_\_ I.D. No. \_\_\_\_\_  
Address of Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_  
Subscriber/Cardholder Name \_\_\_\_\_  Parent  Guardian  Self  Spouse
- Indicate Student Status:  Undergraduate  Graduate  Law  
 Full time  Part Time  Medical
- Are you a member of an athletic team?  Yes  No If yes, indicate sport: \_\_\_\_\_
- Consent for Treatment:

**REQUIRED OF ALL STUDENTS OR PARENT/GUARDIAN FOR STUDENTS UNDER THE AGE OF 18:**

I \_\_\_\_\_ hereby consent to the following:  
Hofstra's Health and Wellness Center may hospitalize me (my child) or may perform any medical or surgical procedures or tests deemed necessary in my (my child's) care and treatment. Hofstra's Health and Wellness Center may present information concerning my (my child's) medical condition to the other responsible University officials when deemed necessary. Hofstra's Health and Wellness Center may forward any and all of my (my child's) medical records to physicians and/or hospitals when deemed necessary for my (my child's) proper care and treatment.

\_\_\_\_\_  
Signature of Student or Parent/Guardian Date

**10. REQUIRED BY NEW YORK STATE LAW:  
TO BE COMPLETED AND SIGNED BY STUDENT OR PARENT/GUARDIAN FOR STUDENT UNDER THE AGE OF 18.  
CHECK ONE ONLY**

\_\_\_\_\_ I (my child) had the meningococcal meningitis immunization within the past 10 years. Month \_\_\_\_\_ / Year \_\_\_\_\_

\_\_\_\_\_ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I (my child) with obtain immunization against meningitis within 30 days of the beginning of the semester.

\_\_\_\_\_ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I (my child) understands the risks of not receiving the vaccine. I have decided that I (my child) will not obtain immunization against meningococcal disease.

\_\_\_\_\_  
Signature of Student or Parent/Guardian Date

# MEDICAL HISTORY TO BE COMPLETED BY STUDENT

**Confidential**

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_ Hofstra ID # \_\_\_\_\_

## FAMILY MEDICAL HISTORY

Check each item:	Yes	No	Relationship	Check each item:	Yes	No	Relationship
Tuberculosis (If yes, give details on additional sheet.)				Nervous or mental disorder			
Diabetes				Thyroid disease			
High blood pressure				Cancer			
Heart disease				Mother living?			
				Father living?			

## STUDENT'S MEDICAL HISTORY

Yes	No		Yes	No		Yes	No	
		Anemia (Including sickle cell anemia)			Glaucoma			Kidney or bladder infection or stone
		Anorexia or bulimia			Hearing loss (complete or partial)			Migraine headache
		Asthma, wheezing			Heart enlargement			Polyps of colon
		Bleed disorder			Heart murmur			Rheumatic fever
		Blindness (complete or partial)			Heart valve problem			Thyroid disorder
		Cancer (incl. leukemia, Hodgkin's disease)			Hepatitis or jaundice			Tuberculosis
		Chickenpox			High blood pressure			Stomach ulcer
		Cystic fibrosis			Immunodeficiency disorder			Urinary tract infection
		Diabetes			Infectious mononucleosis			Other _____
		Epilepsy or other seizure disorder			Inflammatory bowel disease or Crohn's disease			Surgery _____

Yes     No    **MEDICATIONS:** Check box to indicate whether you take any medications (including birth control pills, acne drugs, etc.) List medications, doses, and reason for taking them. (attach additional sheet if necessary)

Drug: \_\_\_\_\_ Dose: \_\_\_\_\_ Reason: \_\_\_\_\_

Yes     No    **ALLERGIES:** Check box to indicate whether you have allergies. If so, specify type:  
Medication (e.g., penicillin, sulfa drugs) (specify): \_\_\_\_\_

Environment (specify): \_\_\_\_\_ Food (specify): \_\_\_\_\_

Yes     No    **INJURIES:** Check box to indicate whether you have had any serious accidents or injuries. If so, specify type (include details and dates):

Broken bones(s), fractures(s): \_\_\_\_\_

Concussion or other head injury: \_\_\_\_\_

Back, Hip, Knee, or ankle injury: \_\_\_\_\_

Other: \_\_\_\_\_

Yes     No    **MENTAL HEALTH:** Check boxes to indicate whether:  
 You're academic and/or work activities have ever been interrupted because of mental or emotional problems.  
 You have ever been under the care of a psychiatrist or mental health professional.  
 You have ever been treated with any medication for psychiatric reasons. If so, provide details (medication, reason for taking it, dates, duration of treatment). \_\_\_\_\_  
 You have ever been hospitalized for mental or emotional problems. If so, provide details (date, place, diagnosis, length of stay). \_\_\_\_\_

Yes     No    You have ever had drug or alcohol dependency or addiction.

Yes     No    **WOMEN'S HEALTH:** Check boxes to indicate whether you have (or have had) any of these conditions. Provide details at right:  
 Removal of breast lump or cyst/breast cancer    Details: \_\_\_\_\_  
 Evaluation for hormone problem    \_\_\_\_\_  
 Missed periods more than four months    \_\_\_\_\_  
 Excessive or extra periods    \_\_\_\_\_  
 Pregnancy    \_\_\_\_\_

## MEDICAL HISTORY TO BE COMPLETED BY STUDENT (Continued)

Confidential

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_ Hofstra ID # \_\_\_\_\_

Yes

No

**WOMEN'S HEALTH CONT.:** Check boxes to indicate whether you have (or have had) any of these conditions. Provide details at right:  
Most recent Pap Smear: Date: \_\_\_\_\_ If abnormal, please provide details. \_\_\_\_\_

**MEN'S HEALTH:** Check boxes to indicate whether you have (or have had) any of these conditions. Provide details at right:  
Lump or mass in testicle Details: \_\_\_\_\_  
Prostate infection \_\_\_\_\_



# Employee Health Services Student Demographics Profile & Medical Evaluation Acknowledgement

Name: \_\_\_\_\_  Male  Female  
Last Name First Name Middle Initial

Address you will be using when attending school:

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Best phone number to contact you: \_\_\_\_\_  Home  Cell  Work

Email Address (*Do not provide a school email address – it will not be valid after you graduate. Please provide a valid email address to be used to send you the blood draw and drug screening requisitions*) \_\_\_\_\_

**1. Which school will you be attending:**

- Hofstra Northwell School of Medicine at Hofstra University
- Hofstra Northwell School of Graduate Nursing and Physician Assistant Studies
  - Nursing Student OR  Physician Assistant Student

**2. Are you currently employed or were an employee at Northwell Health formerly known as North Shore-LIJ Health System?**  Yes  No

- a. If yes, provide the month and year that you began employment: \_\_\_\_ / \_\_\_\_
- b. Provide your previous last name if applicable: \_\_\_\_\_

**3. Non-Employees: Have you ever received a medical clearance from one of the Northwell Health formerly known as North Shore-LIJ Health System Employee Health Services offices (Examples: Medically cleared as a Student or Volunteer)?**  Yes  No

- a. If yes, please provide the month and year that you were cleared: \_\_\_\_ / \_\_\_\_
- b. Provide previous last name if applicable: \_\_\_\_\_

**To be Read and Signed by Student:**

I acknowledge that I am participating in a pre-placement medical evaluation that may include; a physical examination, medical history review, collection of blood and/or bodily fluid specimens for testing, and administration of vaccinations, as required by Northwell Health and/or my prospective employer. The purpose of the evaluation is to ensure that I am free from health impairment which might be of potential risk to individuals that I service, work with, or which might interfere with the performance of my duties. I understand that this is a limited examination solely for the purpose of determining fitness for employment and/or service. This exam is not intended to be a comprehensive medical examination.

I also further acknowledge that I may be required to participate in a reassessment of my health status as frequently as necessary, but no less than annually, to ensure that I am free from health impairments which pose potential risk to patients or personnel or which may interfere with the performance of my duties.

I certify that I do not use illegal drugs, nor do I misuse controlled or other substances which may alter or impair my behavior and/or ability to function. I further understand that this medical evaluation may include a drug screen and that I may not be employed or be allowed to provide services if this screen reveals evidence of substance misuse.

I furthermore authorize my medical examiner, their staff, and my private medical physician (if applicable) to release any and all information obtained in the pre-placement medical evaluation or other work-related assessments to my prospective/current employer or affiliate for the purposes of determining my fitness for duty and/or services.

I understand that giving false or misleading information or failure to disclose requested medical information will be grounds for denying my application or for dismissal. I certify that I have disclosed all known current health conditions which might pose a risk to others or which might interfere with the performance of my duties. I understand and Northwell Health has agreed that it will not use or disclose any information obtained except for the purposes set forth above or as required by law.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date





## Respirator Medical Evaluation Questionnaire

Please include a phone number where you can be reached by the health care professional who reviews the questionnaire:

Area Code: (        ) \_\_\_\_\_ - \_\_\_\_\_

Indicate the best time to phone you at this number: \_\_\_\_\_ AM / PM

**PLEASE PRINT:**

Today's Date: Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: 20 \_\_\_\_

Your Name: (First) \_\_\_\_\_ (Last) \_\_\_\_\_

Job Title: \_\_\_\_\_ N/A \_\_\_\_\_ Dept./Division: \_\_\_\_\_ N/A \_\_\_\_\_

Home Phone number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age (to nearest year): \_\_\_\_\_

Sex: Male\_\_\_ Female\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_lbs.

**Have you ever completed the Northwell Health clearance process in the past as an employee, student or volunteer?** Yes\_\_\_No\_\_\_

If you are not sure of an answer below, you may leave it blank.

1. Check the type of respirator you will use (if applicable, you can check both "a" and "b"):

- a. \_\_\_\_\_ N, R, or P. disposable respirator (filter-mask, non-cartridge type only).
- b. \_\_\_\_\_ Other type (for example, half-or full facepiece type, powered air purifying, supplied air, self-contained breathing apparatus).

2. Have you worn a respirator (check one): Yes\_\_\_No\_\_\_

If "yes", indicate what type(s): \_\_\_\_\_.

**Questions 1 through 9 must be answered by every student who has been selected to use any type of respirator. Please check “yes” or “no”:**

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?

YES	NO

2. Have you had any of the following conditions:

	YES	NO
a. Seizures (fits):		
b. Diabetes (sugar disease):		
c. Allergic reactions that interfere with your breathing:		
d. Claustrophobia (fear of closed-in places)		
e. Trouble smelling odors		

3. Have you ever had any of the following pulmonary or lung problems:

	YES	NO
a. Asbestosis:		
b. Asthma:		
c. Chronic Bronchitis		
d. Emphysema:		
e. Pneumonia:		
f. Tuberculosis		
g. Silicosis:		
h. Pneumothorax (collapsed lung):		
i. Lung Cancer:		
j. Broken ribs:		
k. Any chest injuries or surgeries:		
l. Any other lung problems that you’ve been told about		

4. Do you currently have any of the following symptoms of pulmonary or lung illness:

	YES	NO
a. Shortness of breath:		
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline		
c. Shortness of breath when walking with other people at an ordinary pace on level ground:		
d. Have to stop for breath when walking at your own pace on level ground		
e. Shortness of breath when washing or dressing yourself:		
f. Shortness of breath that interferes with your job:		
g. Coughing that produces phlegm (thick sputum):		
h. Coughing that wakes you early in the morning:		
i. Coughing that occurs mostly when you are lying down:		
j. Coughing up blood in the last month:		
k. Wheezing:		
l. Wheezing that interferes with your job:		
m. Chest pain when you breathe deeply:		
n. Any other symptoms that you think may be related to lung problems		

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Respiratory Medical Evaluation  
Questionnaire**

5. Have you ever had any of the following cardiovascular or heart problems:

	YES	NO
a) Heart attack:		
b) Stroke:		
c) Angina:		
d) Heart Failure:		
e) Swelling in your legs or feet (not caused by walking):		
f) Heart Arrhythmia (heart beating irregularly):		
g) High Blood Pressure:		
h) Any other heart problem that you've been told about:		

6. Have you ever had any of the following cardiovascular or heart symptoms:

	YES	NO
a) Frequent pain or tightness in your chest:		
b) Pain or tightness in your chest during physical activity:		
c) Pain or tightness in your chest that interferes with your job:		
d) In the past two years, have you noticed your heart skipping or missing a beat		
e) Heartburn or indigestion that is not related to eating:		
f) Any other symptoms that you think may be related to heart or circulation problems		

7. Do you currently take medication for any of the following:

	YES	NO
a) Breathing or lung problems:		
b) Heart trouble:		
c) Blood pressure:		
d) Seizures (fits):		

8. If you have never used a respirator, check the following space: \_\_\_\_\_,  
and go to Question 9.

If you have used a respirator, have you ever had any of the following problems:

	YES	NO
a) Eye Irritation		
b) Skin allergies or rashes:		
c) Anxiety:		
d) General weakness or fatigue:		
e) Any other problem that interferes with your use of a respirator:		

9. Would you like to talk to the health care professional who will review this  
questionnaire about your answers to this questionnaire?

YES	NO

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Respirator Medical Evaluation  
Questionnaire**

---

---

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Dept/Div: \_\_\_\_\_ N/A \_\_\_\_\_ Title/Position: Student

This form outlines the results of the Occupational Safety and Health Administration (OSHA) Respirator Medical Evaluation. If you have any questions regarding this evaluation please call Employee Health Services.

**For Office Use Only**

**Based on the review of the OSHA Respirator Medical Evaluation Questionnaire this individual is:**

\_\_\_\_\_ **Medically approved to be fit tested for a respirator, with the exception of Full-Facepiece Respirators or Self Contained Breathing Apparatuses.**

\_\_\_\_\_ **Not approved to be fit tested for a respirator at this time. Follow-up medical evaluation is needed.**

**Date:** \_\_\_\_\_

**EHS Reviewer's Name (Print):** \_\_\_\_\_

**EHS Reviewer's Signature:** \_\_\_\_\_



# Tuberculosis Screening Questionnaire

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Employee ID (if applicable): \_\_\_\_\_

Date: \_\_\_\_\_

Please **circle** Yes or No

**1.) Do you have a history of positive Tuberculosis (TB) screening?** Yes No

If yes, which test was positive?

- Tuberculin Skin Test (TST/PPD)  
Month and Year of positive Test \_\_\_\_ / \_\_\_\_  
Size of induration?   mm
- Blood based TB Screen (i.e. QuantiFERON-TB Gold; T-Spot.TB)  
Month and Year of positive Test \_\_\_\_ / \_\_\_\_

**2.) Were you born in the United States?** Yes No

If no, what country were you born? \_\_\_\_\_  
Year of immigration to the US? \_\_\_\_\_

**3.) Have you received the BCG vaccine in the past?** Yes No

**4.) Have you ever taken or been advised to take medication for Tuberculosis because of a Positive TB Screening?** Yes No

**4a.) If medication was taken, please indicate what year it was taken and for how long.**

Year: \_\_\_\_\_  
Length: \_\_\_\_\_ months

**5.) Have you had a recent chest x-ray?** Yes No

If yes, please attach results. (Must be within the last 12 months)

For individuals who have had a **Positive** reaction in the past to TST/PPD circle all that applies:

- Cough greater than 3 weeks Yes No
- Coughing up blood Yes No
- Loss of appetite Yes No
- Unexplained weight loss Yes No
- Night sweats Yes No
- Hoarseness Yes No
- Persistent Fever Yes No
- Weakness or fatigue Yes No
- Chest Pain Yes No

Signature \_\_\_\_\_

Date \_\_\_\_\_



**Students,**

**Use the attached Physical Examination form and Vaccination record if you plan on being screened by your own healthcare provider prior to your EHS appointment.**

**To avoid delay, we highly recommend that you have the vaccination form completed or provide a copy of your vaccination record.**

Print Name \_\_\_\_\_ Hofstra ID # \_\_\_\_\_  
Last First Middle

**PHYSICIAN'S EXAMINATION**

**To the examining health care provider: Please correlate the student's medical history with your findings, and record below. All entries must be completed.**

1. Sex \_\_\_\_\_ Height \_\_\_\_\_ Blood Pressure \_\_\_\_\_  
Age \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_

2. Vision: Right 20/ \_\_\_\_\_ With Correction: Right 20/ \_\_\_\_\_ Right \_\_\_\_\_ /15  
Left 20/ \_\_\_\_\_ Left 20/ \_\_\_\_\_ Hearing: Left \_\_\_\_\_ /15

Check each item in proper column. Enter "N.E." if not evaluated Normal Abnormal Note: Give Details of each abnormality. Enter corresponding item number before each comment.

	Normal	Abnormal
3. Head, Neck, Face, and Scalp		
4. Nose and Sinuses		
5. Mouth, Teeth, Gingiva, and Throat		
6. Ears — General (Canals, Drums, etc.)		
7. Eyes — General (Lids, Pupils, Motions, etc.)		
8. Lungs, Chest, and Breasts		
9. Heart (include estimate of cardiac function)		
10. Vascular System (include varicosities)		
11. Abdomen and Viscera (include hernia)		
12. Anorectal and Pilonidal		
13. Endocrine System		
14. Genito-Urinary System		
15. Upper Extremities		
16. Lower Extremities (include feet)		
17. Spine, other Musculoskeletal		
18. Skin and Lymphatic (include acne)		
19. Neurological System		
20. Psychiatric		
21. If female, give menstrual history — specify if on medication.		
22. Urinalysis: Albumin Sugar Special tests used in clinical evaluation (Blood, EKG, X-ray, etc.):		
23. Does examinee need dental or eye care?		
24. Any medication allergies?		
25. Is this individual capable of normal physical activity (athletics, military training, physical education)? If not, give reasons and limitations.		

Comments: \_\_\_\_\_

Signature of health care provider is also required  
Under Tuberculosis Screening on Page 5

Signature \_\_\_\_\_

Please print, stamp or type name \_\_\_\_\_ Phone \_\_\_\_\_

Date of Examination \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_



Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Hofstra ID # \_\_\_\_\_

**IMMUNIZATION RECORD**

**To be completed and signed by health care provider.**

New York state law mandates this immunization record be on file prior to registration.

*All information must be provided in English.*

	MO/DAY/YR	MO/DAY/YR	MO/DAY/YR
*MMR (Measles, Mumps, Rubella) ( <b>Two doses with live vaccine required of all persons born after 12/31/56.</b> ) History of having measles or documentation of positive measles, mumps, rubella antibody titers			
OR *MEASLES (RUBEOLA) History of having measles, or <b><u>TWO immunizations with live measles vaccine after first birthday</u></b> , or documentation of measles antibody titer			
*MUMPS History of having mumps, or <b><u>immunization with live mumps vaccine after first birthday</u></b> , or documentation of mumps antibody titer			
*RUBELLA (German Measles) <b>History of having had rubella disease is NOT acceptable!</b> <b><u>Immunization with rubella vaccine</u></b> , or documentation of rubella antibody titer			
HEPATITIS B			
*Tdap (WITHIN 10 YEARS)			
POLIO (T.O.P.V.)			
MENINGOCOCCAL (one dose)			
*VARICELLA			

**\*required by New York State Department of Health and/or Northwell Health (OTHERS STRONGLY RECOMMENDED).**

I certify that the above-named student has received the immunizations listed above on the dates indicated.

Health Care Provider: \_\_\_\_\_ Phone No. \_\_\_\_\_  
(PLEASE PRINT.)

Health Care Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Health Care Provider Stamp/Office Stamp for Address and Telephone Number: \_\_\_\_\_



# Section 2

## **Mandatory**

## **BLOODWORK AND DRUG SCREENING**

**Northwell Health EHS will email you TWO lab requisitions once we receive your email contact information from your school:**

- **LabCorp Collection Authorization Form (Drug Screening)**
- **LabCorp Bloodwork Requisition**

### **Required Bloodwork and Drug Screening at LabCorp:**

The testing must be completed at a LabCorp location no less than 5 business days before your EHS appointment.

- The EHS department will email you TWO LabCorp requisitions which authorize you to be screened at a LabCorp location of your choice at NO charge.
- You **MUST** use the EHS requisitions to be screened at LabCorp.
- Please make sure you have provided an active working email address to your school to ensure that you receive the requisitions in your email account.
- **DO NOT** visit a LabCorp location prior to receiving the TWO requisitions.

Expect the EHS requisitions to come from the following email address: [StudentsEHS@northwell.edu](mailto:StudentsEHS@northwell.edu)

- Drug Screening Requisition – Subject: LabCorp Drug Screening Requisition
- Blood Work Requisition – Subject: LabCorp Blood Work Requisition

### **Instructions to schedule an appointment once you receive the requisitions:**

1. Go to [www.labcorp.com](http://www.labcorp.com)
2. Click on “Schedule an appointment”
3. Enter zip code and check off ‘Occupational urine drug screen collections’, click on Search
4. Select the location and click on “Schedule an appointment”
5. Enter “Reason for Test” from drop down menu (Select: Employment Drug Screen) (You **DO NOT** have to fast for these tests)
6. Schedule as First Available or by desired date.
7. Select your appointment and click on enter.
8. Complete the profile information.
9. Primary Insurance Provider – Select OTHER (We will email you the requisitions. You **DO NOT** need to use your insurance).

**Do not schedule the appointment at LabCorp until you receive the LabCorp forms from EHS.**

**Deadline: Complete bloodwork and drug screening no later than June 27, 2016**



# Section 3

## SCHEDULING EHS APPOINTMENT

Schedule your EHS appointment **after** you have completed your blood work and drug screening at LabCorp. You must call to schedule your EHS appointment no later than July 11, 2016.

EHS appointments will be scheduled during the following time period:  
June 27, 2016 to July 25, 2016.

**Northwell Health - Employee Health Services**

410 Lakeville Road, Suite 206 New Hyde Park, NY 11042

Phone: (718) 470-5350

Fax: (718) 470-4282

Hours of Operation M,Tu,W,F 7:30am to 6pm Th 7:30am to 2pm

Email: [StudentsEHS@northwell.edu](mailto:StudentsEHS@northwell.edu)

Visiting a LabCorp for screening and providing medical documentation of the requirements does not absolve you from scheduling an EHS appointment. To assist in expediting your medical clearance, please bring a copy of your immunization record to your appointment. All students must contact Northwell Health EHS to schedule an EHS appointment no later than July 11, 2016.



Employee Health Services  
410 Lakeville Road, Suite 206  
Lake Success, NY 11042  
718-470-7644

Hours:  
M,T,W,F: 7:30am to 6pm  
TH: 7:30am to 2pm

### **Driving Directions**

#### **Long Island Expressway – Westbound**

Exit 33 – Lakeville Road; proceed on service road to second traffic light; make left turn under Expressway overpass onto Lakeville Road; proceed south approx one mile. Entrance to Buildings 400, 410, and 420 will be on the right side.

#### **Long Island Expressway – Eastbound**

Exit 33 – Lakeville Road, from service road turn right onto Lakeville Road; proceed south one mile. Entrance to Buildings 400, 410, and 420 will be on the right side.

#### **Grand Central – Northern State Parkway – Westbound**

Exit 25 – Lakeville Road; exit under the underpass; bear right around cloverleaf (heading south); Entrance to Buildings 400, 410, and 420 on the right side.

#### **Grand Central –Northern State Parkway – Eastbound**

Exit 25 – Lakeville Road; make right turn on to Marcus Avenue and proceed to traffic light; make left turn onto Lakeville Road. Get in the right lane. Entrance to Buildings 400, 410, and 420 will be on the right side.

#### **Cross Island Parkway – Northbound or Southbound**

Exit onto Long Island Expressway (route 495) – eastbound or onto Grand Central Parkway; see above for instructions for exits.

#### **Union Turnpike – Eastbound**

Make left at Lakeville Road – proceed 3 blocks. Entrance to 400, 410, and 420 buildings will be on your left.

#### **Northern Blvd – Eastbound or Westbound**

Turn south onto Lakeville Road; proceed two miles to the entrance of buildings 400, 410 and 420 on the right.

*Parking is free*

## **Mass Transit**

**IND "E" or "F" train to the Union Turnpike (Kew Gardens)** express station, (25 minutes from Times Square). Use last car of the train and leave the station via the 78th Avenue exit. Take the City Line Q46 (LIJ Hospital/Lake Success) bus to the last stop at the LIJ Medical Center, (40 minutes)

**Metropolitan Surburban Bus Authority (Queens and Nassau)** — Weekday rush hour service:

**Route N26** Jamaica-Manhasset via Hillside Ave, Lakeville Road, New Hyde Park Road, Community Drive:

Eastbound — Buses depart Jamaica (165th St/Jamaica Bus Terminal) at 7:07am terminating at Great Neck LIRR Station and at 7:44 am and 7:57 am (terminating at Community Drive, Manhasset). At other times, take Route N22/22A Jamaica-Roosevelt Field-Hicksville and transfer to Route N25 Lynbrook-Great Neck at New Hyde Park Road and Hillside Ave, New Hyde Park

Westbound — Buses depart Community Drive, Manhasset, at 4:30 pm and 4:40 pm and terminate in Jamaica (165th Street/Jamaica Bus Terminal). At other times, take Route N25 Great Neck-Lynbrook and transfer to Route N22/22A at Hillside Avenue and New Hyde Park Road, New Hyde Park.

**Route N25 Lynbrook** — Great Neck via New Hyde Park Road:

Northbound - Buses depart Lynbrook LIRR Station

weekdays, 5:55 am - 7:45 pm

Saturdays, 6:45 am - 6:45 pm

Sundays, 10:45 am - 6:15 pm

Southbound - Buses depart Great Neck LIRR Station

weekdays, 6:45 am - 8:45 pm

Saturdays, 7:45 am - 6:45 pm

Sundays, 10:45 am - 6:15 pm

For MSBA schedules, call (516) 766-6722.

Please visit the following websites for specific Bus & Train directions:

[http://tripplanner.mta.info/MyTrip/ui\\_web/customplanner/tripplanner.aspx](http://tripplanner.mta.info/MyTrip/ui_web/customplanner/tripplanner.aspx)

or call 511

## Hofstra Northwell School of Medicine

&

## Hofstra Northwell School of Graduate Nursing and Physician Assistant Studies

### Frequently Asked Questions

- 1. Why do I need schedule an appointment with Employee Health Services (EHS) even though I went to LabCorp for my blood and drug screening tests?**
  - There are additional screenings such as Physical Examinations, Color Vision Screening, Respirator Fit Testing, and possible vaccinations as needed that will take place during your EHS appointment.
- 2. I have copies of my recent lab work I received at my personal physician's office but I am missing two of the results, why do I need to complete the other labs again?**
  - We have found that when students present labs that are completed outside of our office, they are often times incomplete OR the lab result does not meet the requirements of medical documentation needed during your clinical rotations.
- 3. My personal physician told me that my vaccination records can be used instead of the actual lab results. Is that correct?**
  - While proof of vaccination can be used as proof of immunity from a disease, it may not be sufficient proof to organizations or institutions that you will encounter during your clinical rotations. They may require proof of immunity via titer. A titer is a blood test that measures the level of specific antibodies to a specific disease in your blood.
- 4. I just went to my personal physician and he performed the drug screening in his office. Can I just bring the results to my appointment?**
  - Unfortunately, we cannot accept drug screening results from your personal physician. We can only accept the results of the drug screening that was performed using a Northwell Health Lab requisition from Employee Health Services at a LabCorp facility.
- 5. I currently work for Northwell Health or have been medically screened by one of your EHS offices in the past. I think I met all of these requirements when I had that EHS appointment. Why do I need to complete them again?**
  - Please email us at [EHSstudents@northwell.edu](mailto:EHSstudents@northwell.edu) to discuss your individual chart.

# Employee Health Services

## Frequently Asked Questions Continued

- 6. Since I will have my blood drawn at a LabCorp, should I still bring my vaccination records to my EHS appointment?**
  - Yes, besides having immunity to certain diseases, you are required to have had a Tdap vaccination within the last 10 years; accept, decline or provide proof of receiving the Hepatitis B and meningococcal vaccinations. Your vaccination records will need to be reviewed in our office during your appointment.
  
- 7. Do I need to bring my insurance card or pay for services at LabCorp?**
  - As long as you present both of the Northwell Health Lab requisitions to LabCorp, you will not have to pay for the screening or use your medical insurance. You will not be reimbursed for LabCorp services if you make a payment or use your insurance. The lab requisitions allow you to be screened for free.
  
- 8. After my EHS appointment is complete, how would I know if I am medically cleared to start school?**
  - EHS will be in direct contact with your school in regards to your medical clearance. If there is a delay in your medical clearance, you will be contacted before the school is notified. If you are not contacted by our office after your medical clearance appointment, you can assume that you are medically cleared.
  
- 9. I used my navigation to get your office and now I am lost.**
  - Please refer to the driving directions that can be found in the medical clearance packet. We are located adjacent to Long Island Jewish Medical Center. It may be helpful to use 270-05 76<sup>th</sup> Avenue, New Hyde Park, NY 11040 in your navigation device. The entrances to the hospital and to EHS are both located on Lakeville Road.
  
- 10. What can I do to prevent delays in my medical clearance?**
  - Visit your local LabCorp no less than 5 business days before your medical clearance appointment
  - Schedule your EHS medical clearance appointment as early as possible.
  - Bring all proof of vaccination documents to your scheduled appointment.