STATE UNIVERSITY OF NEW YORK
DOWNSTATE MEDICAL CENTER

Office of the Registrar

Basic Science Building 1-112, Box 98
450 Clarkson Avenue Brooklyn, NY 11203
Phone: (718) 270 4552 / Fax: (718) 270 7592

Health Statement Form for Visiting Medical Students

NOTE: This form, the International Visiting Student Medical Student Application, and the Letter of Eligibility or Long Term Clerkship Certificate must be printed, filed out, and mailed with the money order(s) to the address above.

Completion of this entire form is required of every student coming to SUNY Downstate Medical Center for electives. ***It must be submitted with your application.*** Please note that a recent Mantoux test or Quantiferon-Gold and chest xray (if needed), as well as immunity to measles, mumps, and rubella are required by New York State Health Code. In addition, as indicated in item 4, education and immunization for hepatitis B is required.

Name: _____	ID#: _____
School: _____	DOB: ____/____/____ mm/dd/yyyy
Elective at SUNY: _____	Elective Dates: ___/___/___ to ___/___/___ (mm/dd/yyyy) (mm/dd/yyyy)

In order to comply with Federal OSHA regulation, SUNY Downstate Medical Center requires that students receive education regarding exposure to blood, body fluids and other potentially infectious materials before coming to this Medical Center. I have participated in a OSHA Training Education program.
☐Yes ☐No

To the Health Provider:

1. Does this student have any acute or chronic health problems? If yes, please explain.

2. Date of last physical exam (must be no more than 1 year prior to start of elective): ___/___/___

Result of exam: (mm/dd/yyyy)

_____

_____

_____

_____

3. **PROOF OF IMMUNITY TO MEASLES, MUMPS, AND RUBELLA IS REQUIRED BY NEW YORK STATE LAW.** Two (2) doses of live measles, mumps and rubella vaccines are required, with the first dose on or after the first birthday, second dose on or after 15 months of age, and at least 30 days after the first dose. Immune titers satisfy this requirement:

MMR vaccine:	___/___/___ #1 date (mm/dd/yyyy)		___/___/___ #2 date (mm/dd/yyyy)
Measles Titer:	_____ POS	_____ NEG	___/___/___ Date (mm/dd/yyyy)
Mumps Titer:	_____ POS	_____ NEG	___/___/___ Date

			(mm/dd/yyyy)
Rubella Titer:	_____	_____	___/___/___
	POS	NEG	Date (mm/dd/yyyy)

Please include copies of LAB SLIPS.

4. Documentation of three doses of hepatitis B vaccine and/or positive hepatitis B antibody titer is required.

HBsAb	Date: ___/___/___ (mm/dd/yyyy)	Result: _____
Hepatitis B vaccine (3 doses required)	*List Dates:* ___/___/___ (mm/dd/yyyy) ___/___/___ (mm/dd/yyyy) ___/___/___ (mm/dd/yyyy)	_____ _____ _____

5. **HISTORY OF VARICELLA?**

☐ YES ☐ NO OR TITER _____

IF NO HISTORY OF VARICELLA AND NEGATIVE TITER, TWO DOSES OF VARICELLA VACCINE ARE REQUIRED.

DATES:	___/___/___	___/___/___
	dose 1 (mm/dd/yyyy)	dose 2 (mm/dd/yyyy)

6. **TUBERCULIN TEST** (if known negative, Mantoux test or Quantiferon-GOLD must be administered within 6 months prior to elective)

Date: ___/___/___ (mm/dd/yyyy)	Result: ____ mm induration	Manufacturer & Lot # _____
CHEST X-RAY (Required if mantoux test is positive):	Date: ___/___/___ (mm/dd/yyyy)	Result: _____

7. Tdap (preferred) or Td within the past 10 years

Tdap: Date: ___/___/___ (mm/dd/yyyy) Td Date: ___/___/___ (mm/dd/yyyy)

I certify that the above statements are true and that this student has received the mandatory education as per OSHA regulation. (Please note: International Visiting Students will complete OSHA training on site.)

Name of Health Care Provider:	_____
Signature of Health Care Provider:	_____
State and License #:	_____
Address:	_____
Telephone #:	_____
Date:	___/___/___

Return this form with your completed application to the Office of the Registrar, 450 Clarkson Avenue, Box 98 Brooklyn, NY 11203 or fax it to (718) 270 7592. Failure to do so will delay the processing of your application.