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
(718) 270 4552 / (718) 270 7592 (fax)

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On-line Form

Health Statement Form for Visiting Medical Students

(**Note: This form, the International Visiting Medical Student Application and the Letter of Eligibility or Long Term Clerkship Certificate must be printed, filled out and mailed with the money order(s) to the address above. Please print your full name on the top of every printed page.**)

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 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: ____/____/____

Elective at SUNY: _____ Elective Dates: ___/___/___ to ___/___/___

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:
_____
_____

3. **PROOF OF IMMUNITY TO MEASLES, MUMPS, AND RUBELLA IS REQUIRED BY NEW YORK STATE LAW.** Two (2) Doses Of Live Mumps And Rubella Vaccines After the First Birthday or immune titers satify this requirement

MMR vaccine:	___/___/___ #1 date		___/___/___ #2 date
Measles Titer:	_____ POS	_____ NEG	___/___/___ Date
Mumps Titer:	_____ POS	_____ NEG	___/___/___ Date
Rubella Titer:	_____ POS	_____ NEG	___/___/___ Date

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

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

5. **HISTORY OF VARICELLA?**
☐ YES ☐ NO OR TITER _____

IF NO HISTORY OF VARICELLA AND NEGATIVE TITER,
VARICELLA VACCINE IS REQUIRED.

DATES: ___/___/___ dose 1 ___/___/___ dose 2

6. **TUBERCULIN TEST** (if known negative, Mantoux test must be administered within 6 months prior to elective)
Date: ___/___/___ Result: _____ mm induration Manufacturer & Lot # _____

CHEST X-RAY (Required if mantoux test is positive): Date: ___/___/___ Result: _____

I certify that the above statements are true and that this student has received the mandatory education as per OSHA regulation.

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 (718) 270-7592. Failure to do so will delay the processing of your application.