MEMORIAL SLOAN-KETTERING CANCER CENTER
WEILL MEDICAL COLLEGE OF CORNELL UNIVERSITY

HEALTH STATEMENT FOR VISITING MEDICAL STUDENTS

This form must accompany the application for all electives at The New York Presbyterian Hospital and other hospitals affiliated with Weill Medical College of Cornell University.

Name of Applicant: ____

Date of last physical examination:______________________________________
(to be completed within one year (Month) (Day) (Year)
prior to start of rotation)

Significant findings:

Statement regarding general health:

Results of tests and x-rays:

(1) Tuberculin Test: If previously negative, must be completed within 90 days prior to beginning of the rotation. Test should be P.P.D. 0.0001 mg., Mantoux technique.

Date of test: ______________________ Type of test: ________________
(Month) (Day) (Year)

Result of test:____

Negative tuberculin test: No chest x-ray required.
Positive tuberculin test: 1. Chest x-ray must be completed within 90 days prior to the beginning of the rotation if not previously tuberculin positive.
2. Chest x-ray required if tuberculin has been positive in the past and the individual is symptomatic.

Date of x-ray:____
(Month) (Day) (Year)

Result of x-ray:____

Applicants for rotations including clinical experience at The New York Presbyterian Hospital and other affiliated hospitals must present the following information:

(2) Varicella titer done:

Date:______________________

Result:____

(3) Rubella titer done: (If negative, rubella vaccine must be given, unless contraindicated on medical grounds.)

Date:______________________

Result:____

(4) Measles titer done:(If negative, measles vaccine must be given in two doses at least 30 days apart.)

Date:______________________

Result:____

(5) Mumps titer done:(If negative, mumps vaccine must be given in two doses at least 30 days apart.)

Date:______________________

Result:____

(6) Hepatitis B titer done: (If negative, three doses of vaccine must be given or a signed declination.)

Date:______________________

Result:____

Hepatitis B vaccine administered:

Dose #1 Date: ____________ Dose #2 Date: ____________ Dose #3 Date: ____________

OR

I DECLINE TO TAKE HEPATITIS B VACCINE ___________________________________

Signed:

___________________________________ Signature of Physician

___________________________________ Address

___________________________________ State of Licensure

________________________ Number of License

___________________________________ Date