MEDICAL STUDENTS
PRE-PLACEMENT EVALUATION INSTRUCTIONS

Pre-placement medical screening and clearance is required by New York State law as well as by MSKCC rules and regulations. This includes the following:

1. Medical history **(Student completes pages 1-3 of pre-placement form included with this packet – leave ID# and CC# blank).**
2. A complete physical exam done within the last 12 months by a physician at your current facility or by your primary care physician **(Examining physician completes Page 4 of pre-placement form included with this packet).** Please note that the examining physician may **NOT** be a relative of the examinee (e.g. the examining physician may **NOT** be a first degree relative, spouse, significant other, or partner). The physical exam must be signed by the examining physician and include the name, address and telephone number of the examining physician.
3. Documentation of **REQUIRED** laboratory tests (see below) must be official laboratory test results or from official Occupational Health records.

   Hepatitis B Surface Antibody **Measles Antibody**
   Rubella Antibody **Varicella Antibody**
   Mumps Antibody

   If your titers indicate susceptibility (no immunity), we will contact you regarding required vaccination(s).

4. Two most recent PPD tests: **(PPD Mantoux)** TB skin test 5 US test units (TU) Per test

   The most recent tuberculin skin test (PPD) results must be within 6 months prior your start date. Documentation of the actual measurement in millimeters (mm), must be official and provided on the healthcare provider's stationary with name, address and phone number. If PPD was previously positive, send a copy of the PPD test results, chest x-ray report and official documentation of treatment for Latent Tuberculosis Infection [LTBI]) by health care provider. If no treatment for LTBI was received, the chest x-ray report must be within 6 months prior your start date.

Respiratory Fit Testing Form

a. Leave Employee Number, Department, and Job Title blank
b. If you do not know what type of respirator you will be using, please leave this section blank. Please provide answers to the remaining questions (1-9).

The medical information you provide will be kept in your health medical record on-file at Employee Health & Wellness Service. EH&WS medical staff cannot assume responsibility for ongoing medical care of your previously existing illness(es).

Memorial Sloan-Kettering Cancer Center

Pre Placement Evaluation
Outside MSKCC

Employee/NonEmployee ID# _____ Dept./CC# _____

Complete pages 1 - 3. Examiner will complete page 4.

This form is used by E.H.&W.S. to make recommendations regarding physical qualifications to perform specific work.

❑ Student ❑ Volunteer ❑ Summer Relief ❑ Agency Temp ❑ Attending ❑ Fellow/Resident ❑ Other _____

Date: _____ **Please Circle Applicable Title:** MD RN NP PhD Sex: ❑ M ❑ F

Name LAST: _____ FIRST: _____ MI: ____ Age: _____

Street: _____ City: _____ State: _____ ZIP: _____

Home Phone: (____)_____ Marital Status: _____ Email: _____

Cell Phone: (____)_____ MSKCC Work Phone: (____)_____

Date expected to start: _____ Job Title: _____

Dept. Name: _____ Job Location: _____

Date of Birth: _____ Place of Birth: City: _____ State: _____ Country: _____

Emergency Contact: _____ Relationship: _____ Phone: (____)_____

Family Doctor: _____ Phone: (____)_____

Street: _____ City: _____ State: _____ ZIP: _____

Country: _____

Immunization Dates: Measles _____ Mumps _____ German Measles (Rubella) _____

Tdap/Tetanus _____ Smallpox _____ Rabies _____

Hepatitis B _____ How many doses? _____ Hepatitis A _____

Chickenpox _____ How many doses? _____

Have you ever had Chicken Pox? ❑ Yes ❑ No

Last Tuberculin (PPD) Test Date _____ ❑ Positive* ❑ Negative* ❑ Never Tested ** must provide documentation*

Last Quantiferon Test Date _____ ❑ Positive* ❑ Negative* ❑ Never Tested

Received BCG: ❑ Yes ❑ No When? _____

If PPD or Quantiferon positive, INH or Rifampin taken? ❑ Yes ❑ No If yes, how Long? _____

Last Physical Exam: _____ Last Chest Xray Date: _____ ❑ Normal ❑ Abnormal

Drug Allergies: Penicillin ❑ Yes ❑ No Sulfa ❑ Yes ❑ No

Other Drug Allergies: _____

Non-Drug Allergies: Hay Fever ❑ Yes ❑ No Latex ❑ Yes ❑ No Animal Fur ❑ Yes ❑ No

Other Non-Drug Allergies: _____

Smoking History: ❑ Never ❑ Cigarettes ❑ Cigars ❑ Pipe

No./day _____How many years____ Date quit _____

Alcohol History: ❑ Never ❑ Occasionally ❑ Daily Date quit _____

Substance Abuse History: ❑ Never ❑ Other _____

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Medications taken regularly: 1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

PAST MEDICAL HISTORY: CHECK "NO" OR FILL IN APPROXIMATE DATES WHERE THEY APPLY:

Operations:			Medical Illness:		
	Tonsils	No ❑ _____		Diabetes	No ❑ _____
	Appendix	No ❑ _____		Tuberculosis	No ❑ _____
	Hernia Repair	No ❑ _____		Thyroid Disease	No ❑ _____
	Gallbladder	No ❑ _____		Arthritis	No ❑ _____
	Stomach	No ❑ _____		Anemia	No ❑ _____
	Ob/Gyn	No ❑ _____		Heart Disease	No ❑ _____
	Back	No ❑ _____		GI Problems	No ❑ _____
	Hemorrhoids	No ❑ _____		Hepatitis	No ❑ _____
	Breast	No ❑ _____		Venereal Disease	No ❑ _____
	Chest	No ❑ _____		Urinary Problems	No ❑ _____
	Cancer	No ❑ _____		Cancer	No ❑ _____
	Other	No ❑ _____		Other	No ❑ _____

Have you ever been hospitalized for a nervous or mental condition? ❑ Yes ❑ No

Please specify: _____

Please check if you have any of the following:			Are these being managed by your doctor or other health care provider?	
Change in weight	❑ Yes	❑ No	❑ Yes	❑ No
Weakness/fatigue	❑ Yes	❑ No	❑ Yes	❑ No
Night sweats (not menopausal)	❑ Yes	❑ No	❑ Yes	❑ No
Fevers/chills	❑ Yes	❑ No	❑ Yes	❑ No
Fainting/dizziness	❑ Yes	❑ No	❑ Yes	❑ No
Change in vision	❑ Yes	❑ No	❑ Yes	❑ No
Difficulty hearing	❑ Yes	❑ No	❑ Yes	❑ No
Hoarseness	❑ Yes	❑ No	❑ Yes	❑ No
Frequent cough	❑ Yes	❑ No	❑ Yes	❑ No
Coughing up blood	❑ Yes	❑ No	❑ Yes	❑ No
Shortness of breath	❑ Yes	❑ No	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	❑ Yes	❑ No
Chest pain	❑ Yes	❑ No	❑ Yes	❑ No
High blood pressure	❑ Yes	❑ No	❑ Yes	❑ No

Please check if you have any of the following:		Are these being managed by your doctor or other health care provider?
Diarrhea	❑ Yes ❑ No	❑ Yes ❑ No
Change in bowel habits	❑ Yes ❑ No	❑ Yes ❑ No
Black or bloody stools	❑ Yes ❑ No	❑ Yes ❑ No
Jaundice	❑ Yes ❑ No	❑ Yes ❑ No
Hepatitis	❑ Yes ❑ No	❑ Yes ❑ No
Back pain/injury	❑ Yes ❑ No	❑ Yes ❑ No
Burning/blood in urine	❑ Yes ❑ No	❑ Yes ❑ No
Hernia	❑ Yes ❑ No	❑ Yes ❑ No
Seizures	❑ Yes ❑ No	❑ Yes ❑ No
Tremors	❑ Yes ❑ No	❑ Yes ❑ No
Unsteadiness of gait	❑ Yes ❑ No	❑ Yes ❑ No
Open sores, skin rash	❑ Yes ❑ No	❑ Yes ❑ No
Unreported needlesticks	❑ Yes ❑ No	❑ Yes ❑ No
Mood/thought disorder	❑ Yes ❑ No	❑ Yes ❑ No

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Memorial Sloan-Kettering Cancer Center

Pre Placement Evaluation
Outside MSKCC

GENERAL APPEARANCE:

	NL	AB	NE	Comment on any abnormality
Skin	❑	❑	❑	
Head	❑	❑	❑	
Eyes	❑	❑	❑	
Ears	❑	❑	❑	
Nose	❑	❑	❑	
Throat	❑	❑	❑	
Teeth	❑	❑	❑	
Nodes	❑	❑	❑	
Neck	❑	❑	❑	
Thyroid	❑	❑	❑	
Back	❑	❑	❑	
Chest	❑	❑	❑	
Breast	❑	❑	❑	
Heart	❑	❑	❑	
Lungs	❑	❑	❑	
Abdomen	❑	❑	❑	
Genitalia	❑	❑	❑	
Hernia	❑	❑	❑	
Rectal	❑	❑	❑	
Extremities	❑	❑	❑	
Neurological	❑	❑	❑	

Temp _____

BP. _____

P

R

Hgt.

Wgt. lbs./kg

EYE EXAM

UNCORRECTED

Both 20/ ____

O.D. 20/ ____

O.S. 20/ ____

CORRECTED

Both 20/ ____

O.D. 20/ ____

O.S. 20/ ____

Clinical Nurse: _____

Date: _____

NL = NORMAL AB = ABNORMAL NE = NOT EXAMINED

EXAMINER'S COMMENTS: _____

PPD (if applicable) Date Placed: _____ Date Read: _____ Result/Measurement (mm) _____

Examiner Signature: _____ MD/NP Date of Exam: _____

Examiner Stamp: _____ Phone: (____)_____

Street: _____ City: _____ State: _____ ZIP: _____

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Memorial Sloan-Kettering Cancer Center

Employee Health & Wellness Services
Medical Clearance For Respiratory Fit Testing

Note: This questionnaire will e reviewed by a Health care Professional at Employee Health Service for the purpose of assessing your ability to wear a respirator as part of the Personal Protective Equipment that is provided.

Can you read? Yes_____ No_____

Employee Name: _____Employee Number:_____ Date: _____

Department:_____ Job Title: _____

Date of Birth: _____ Sex: ____ Height: _____ft. _____in. Weight: _____lbs.

Home Phone:(___)___-_____ Business Phone:(___) ____-_____ Ext:___ Best time:_____

Have you worn a respirator before ?_____If "yes", please specify the type(s). _____

What type(s) of respirator will you be using at MSKCC?
____Disposable (Note: Specific filter classification and efficiency are noted on the fit test results)
____Half Face, Cartridge Type
____Full Face, Cartridge Type
____Powered Air Purifying ____Supplied Air ____Self Contained Breathing Apparatus

Please answer the following questions and circle any items that apply under each section listed.

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

2. Have you **ever had** any of the problems listed below when using a respirator? No___Yes___
   Please circle all that apply.
   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:_____

3. Have you **ever had** any of the **medical conditions** listed below? No___Yes___
   Please circle all that apply
   a. Seizures
   b. Diabetes (sugar disease)
   c. Allergic reactions that interfere with your breathing
   d. Claustrophobia (fear of closed-in-places)
   e. Trouble smelling odors

4. Have you **ever had** any of the pulmonary or lung **problems** listed below? No___Yes___
   Please circle all that apply
   a. Asbestos
   b. Asthma
   c. Chronic Bronchitis
   d. Emphysema
   e. Pneumonia
   f. Tuberculosis
   g. Silicosis
   h. Pneumothorax
   i. Lung Cancer
   j. Broken Ribs
   k. Any chest Injuries or surgeries
   l. Any other lung problems that you've been told about: _____

5. Do you **currently** have any of the **symptoms** of pulmonary or lung illness that are listed below? **Please circle all that apply** No___Yes___
   a. Shortness of breath
   b. Shortness of breath when walking fast on level ground or up a 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
   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:_____

6. Have you **ever had** any of the cardiovascular or heart **problems** listed below? No___Yes___
   Please circle all that apply
   a. Heart Attack
   b. Stroke
   c. Angina
   d. Heart Failure
   e. Swelling in your legs or feet
   f. Heart Arrhythmia
   g. High Blood Pressure
   h. Any other heart problems:_____

7. Have you **ever had** any of the cardiovascular or heart **symptoms** listed below? No___Yes___
   Please circle all that apply
   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. Have you noticed that your heart is skipping or missing a beat (over the last 2 years)
   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:_____-

8. Do you **currently** take **medication** for any of the problems listed below? No___Yes___
   Please circle all that apply
   a. Breathing or Lung problems
   b. Heart Trouble
   c. Blood Pressure
   d. Seizures

9. Would you like to talk to the healthcare professional who will review this questionnaire? No___Yes___

Employee Health Service may be reached at 222 E. 70th St, NYC, N.Y. (646) 888-4000.

For EHS use only:

Cleared____ Not cleared____ Reason not cleared_____

EHS physician/NP/Nurse Signature _____ Date _____

Entered into CONNECT? Yes_____ No_____ Date_____ Initials _____