Catholic Health

CATHOLIC HEALTH

--- *Provider* Tuberculosis Screening, COVID-19 Documentation & *Annual Health Assessment* ---

Provider Name (Please Print): _____

ANNUAL TUBERCULOSIS SCREENING: Please complete Item A and Item B below.

A. TUBERCULOSIS SCREENING TEST

1. In the past year, are you aware of being exposed to anyone with active Tuberculosis? ❑ Yes ❑ No

2. Have you been treated for active or latent Tuberculosis? ❑ Yes ❑ No
   a. If yes, when was it treated? _____
   b. If yes, where were you treated? _____

3. Have you had any of the following symptoms of Tuberculosis? ❑ Yes ❑ No
   - ❑ Unplanned weigh loss of more than 10 pounds?
   - ❑ New cough for more than three (3) weeks?
   - ❑ Blood in your sputum?
   - ❑ Night Sweats?
   - ❑ Unexplained Fevers?
   - ❑ Loss of appetite?
   - ❑ Unexplained hoarseness of voice?

If the answer to questions 1 and/or 2 or 3 is "yes", and/or any of the above symptoms are indicated, it will require further review by a Catholic Health Associate Health nurse to determine if a PPD is warranted.

Provider Signature: _____ Date: _____

B. COVID - 19 VACCINATION STATUS *NOTE: AS PER REGULATORY REQUIREMENTS, IF YOU HAVE NOT PREVIOUSLY SUBMITTED A COPY OF YOUR VACCINE CARD, PLEASE BE SURE TO SUBMIT ALONG WITH THIS FORM

A. Have you received the COVID 19 vaccine? ❑ YES ❑ NO

B. Have you received the Booster vaccine? ❑ YES ❑ NO

ANNUAL PROVIDER HEALTH ASSESSMENT STATEMENT:

I have determined, to the best of my knowledge, that the above-named provider is free from any health impairment which is of potential risk to patients or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol, or other drugs or substances which may alter the individuals behavior.

_____ _____

[Signature of your Practitioner] *[Date]*

(Note: Providers Cannot Sign for Themselves)

_____

[Typed or Printed Name of your Practitioner]

Please fax completed document to the Medical Staff Office of your Primary CH Facility:

- **Mercy Hospital of Buffalo: (716) 828-3472**
- **Sisters of Charity Hospital/SJC: (716) 862-1871**
- **Kenmore Mercy Hospital: (716) 447-6340**
- **Mount St. Mary's Hospital: (716) 298-2001**

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