Cayuga MEDICAL CENTER
A Member of Cayuga Health System

Volunteer Medical Requirements

Cayuga Medical Center requires volunteers to have the following completed before they begin:

1. A physical exam within the previous 12 months

2. Proof of immunity to Measles, Mumps, and Rubella. This is done by showing documentation of 2 MMR vaccinations **or** positive titers for each.

3. Proof of immunity to Varicella (Chickenpox). This is done by showing documentation of 2 Varivax vaccinations **or** a positive titer **or** by stating a history of Chickenpox Disease.

4. Tuberculosis Screening. This is done by having **2 PPD skin tests.** Two are recommended by the Centers for Disease Control and Prevention as the most thorough way of screening for tuberculosis in a health care setting. PPD skin tests may be obtained through your Primary Care Provider, College Health Service, or at the Cayuga Medical Center Employee Health Office.

The above requirements may be documented on the CMC form titled "Health Clearance Certificate Required for Volunteers and Students at Cayuga Medical Center" or on forms from your Primary Care Provider or College Health Center. Please fax all forms to 607-252-3004, attention Tina Rappleye, Infection Control RN. Please note on the fax cover sheet that you are a volunteer.

You can print out this Health form below and have your physician fill in the data.(or)
Gannett Health Center is set up to assist you in meeting these medical requirements.

HEALTH CLEARANCE CERTIFICATE REQUIRED FOR VOLUNTEERS AND STUDENTS AT CAYUGA MEDICAL CENTER

NAME: _____

ADDRESS: _____ **PHONE:**_____
_____

CIRCLE ONE: Volunteer / Student

School/ College currently attending:_____

REQUIRED TWO- STEP TUBERCULIN SKIN TEST—MUST BE PPD/MANTOUX ONLY (2 PPDs done in past year)

_____**mm Induration Date Interpreted:**_____ **Person Interpreting Test:** _____ **If PPD Positive:** **Date of Chest X-RAY:**_____ **Results:** _____	_____**mm Induration Date Interpreted:**_____ **Person Interpreting Test:** _____ **If PPD Positive:** **Date of Chest X-RAY:**_____ **Results:** _____

REQUIRED PROOF OF VACCINATION

RUBELLA (German Measles) & RUBEOLA (Measles) & MUMPS

PROOF OF ONE OF THE FOLLOWING (Vaccinations or titers for all the following):

☐ Date **TWO (MMR)** vaccinations after 12 months of age: _____
_____

OR

☐ Date of **Rubella Titer**: _____ Results: _____ AND

☐ Date **of Rubeola Titer**: _____Results:_____ AND

☐ Date of **Mumps Titer**:_____ Results: _____

CHICKEN POX (Varicella) **ONE OF THE FOLLOWING:**

☐ History of disease Date: _____ **OR**

☐ Date of **TWO Varivax** vaccinations _____
_____

OR

☐ Date of **Varicella (Chicken Pox) Titer**:_____ Results: _____

REQUIRED ANNUAL PHYSICAL EXAM

_____ **has had a physical examination on**

_____ **(date)** and **DOES NOT have any communicable diseases** or **other conditions that would prevent him/her from entering the Hospital environment**.

Health Limitations? ☐ **NO** ☐ **YES** If yes, please, explain/comment:

_____

If physical exam date is not within the past year- date when Annual Health assessment completed _____

This form must be completed and signed by a medical practitioner (MD, NP, OR PA).

DATE **Print Practitioner's Name** **Practitioner's Signature**

_____ _____

Practitioner's Phone **Practitioner's Address**

_____

PLEASE RETURN THIS COMPLETED MEDICAL FORM TO:

Tina Rappleye - Infection Control:
Cayuga Medical Center @ Ithaca
101 Dates Drive Ithaca, NY 14850

Phone no. 607-274-4301 or 607-274- 4129 **fax no. 607- 252-3004**