How to Obtain Clinical Clearance for Health Professions Programs

2020 SUNY Orange Wellness Center

SUNY ORANGE
WELLNESS CENTER
Mind ~ Body ~ Spirit

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Welcome to the SUNY Orange Health Professions Programs!

In this presentation, you will learn how to successfully complete the process to receive your clinical clearance aka "The Golden Ticket."

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About the Wellness Center

- The Wellness Center processes and maintains all medical records and clinical clearances for health professions students.
- Your health information is protected under federal law and will not be shared with anyone unless it is absolutely necessary.
- Our address: Wellness Center, SUNY Orange, 115 South Street, Middletown, NY 10940
- Our office is closed due to the COVID-19 pandemic.
- Phone: (845) 341-4870. Leave a voice message.
- email: wellnesscenter@sunyorange.edu.
- A nurse will return your query within 24-72 business hours. Note: In June and July the College is closed on Fridays.

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Why do you need a clinical clearance?

- New York State Health Laws require all healthcare professionals and students enrolled in health professions programs to meet specific standards of health and fitness, and immunity to several communicable diseases.
- These requirements are more stringent than those affecting general college admission.
- All students enrolled in a SUNY Orange Health Professions program must receive a clinical clearance in order to attend classes and clinical.
- The clearance is good for one year.
- Second year students must be re-issued a new clearance for the following year.

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First Steps

- At this point, the Urine Drug Screen and Background Check should already be completed through castlebranch.com.
  - If you have not done this yet do so IMMEDIATELY. Failure to comply could result in the loss of your seat in the program.
- The Wellness Center has access to this information so there is no need to provide us with copies of your test results.

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Important Dates

- Your clinical clearance must cover you for the entirety of your academic year.
- Therefore, the date of your physical and most recent tuberculosis test may not be prior to May 14th.
  - Exceptions:
    - PHYSICAL THERAPIST ASSISTANT students may not complete their physical forms and tuberculosis screening prior to June 11th.
    - RADIOLOGIC TECHNOLOGY students may not complete their physical forms and tuberculosis screening prior to July 31st.
- Physicals and tuberculosis tests completed before these dates will NOT be accepted.

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Important Dates

Deadlines to submit physicals are as follows:

PROGRAM	NO SOONER THAN	NO LATER THAN
MEDICAL LABORATORY TECHNICIAN Incoming Second Years	May 14th July 1st	June 17th July 31st
PHLEBOTOMY	May 14th	June 17th
NURSING Semester 3&4 Semester 1&2	May 14th May 14th	June 24th July 9th

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Important Dates

Deadlines to submit physicals are as follows:

PROGRAM	NO SOONER THAN	NO LATER THAN
OCCUPATIONAL THERAPY ASSISTANT	May 14th	July 2nd
DENTAL HYGIENE Incoming Second Years	May 14th July 31st	July 31st August 15th
PHYSICAL THERAPIST ASSISTANT	June 11th	August 4th
RADIOLOGY TECHNOLOGY	July 31st	August 13th

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The Official College Physical Form

- We consider completion of the physical form your first test as a health professions student.
- We understand that many of our students may not have completed such an extensive form before, and it can be intimidating and confusing.
- We have done our best to simplify the form, but sometimes students have questions.
- Do not hesitate to call or email us with your questions.
  - Phone: (845) 341-4870. Leave a voice mail.
  - Email: wellnesscenter@sunyorange.edu
- A nurse will respond to your query in 24-72 business hours.

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The Official College Physical Form

- The Wellness Center only accepts physicals submitted on the Official College Physical Form.
- Photocopies or faxes are NOT accepted.
- ALL sections of the form must be addressed and completed.
- Make sure your name is clearly written at the top of each page.
- Use black ink only.

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The Official College Physical Form

- You may choose your own healthcare provider to complete your form.
- This may be a medical doctor, doctor of osteopathy, nurse practitioner, or physician's assistant.
- If you do not have a healthcare provider or health insurance, your packet includes a list of practitioners who offer our students a discount.

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Orange County Community College
HEALTH PROFESSIONS STUDENT
Physical Examination for Clinical Participation

Please return completed form to: Orange County Community College
WELLNESS CENTER – Shepard Student Center – 2nd Floor
115 South Street, Middletown, NY 10940
Phone: (845) 341-4870

NOTE: ONLY THIS PHYSICAL EXAMINATION FORM WILL BE ACCEPTED – USE BLACK INK ONLY

SECTION I: Student Information

Program________________ Semester 1 2 3 4 (Circle one) A#________________

Last Name First Name Middle Initial Date of birth (MM/DD/YY) __/__/__

Street Address City State Zip code

Home Phone Number / Cell Phone Number E-Mail Address

Name, relationship of Person to be Notified in Case of Emergency Home or Cell Phone Business Phone

Personal Physician Address Phone

SECTION II: Personal Health History – to be completed by student Please check "YES" or "NO" if you have or ever had any of the following:

Yes	No	
		1. Lung Disease
		2. Chronic Cough
		3. Asthma
		4. Shortness of Breath
		5. Hay Fever
		6. Heart Disease
		7. Heart Murmur
		8. Rheumatic Fever
		9. Palpitations
		10. Chest Pains
		11. High Blood Pressure
		12. Neurologic Impairment
		13. Seizure Disorder
		14. Dizziness/Fainting
		15. Migraine Headaches
		16. Visual Disturbances
		17. Hearing Impairment

Yes	No	
		18. Speech Defect
		19. Kidney disease
		20. Intestinal Disease
		21. Ulcers
		22. Gastric Reflux
		23. Hernia
		24. Food/Drug Allergies
		25. Latex Allergy
		26. Endocrine Disorders
		27. Thyroid Problems
		28. Diabetes
		29. Immune Disorder
		30. Skin Conditions
		31. Orthopedic Problems
		32. Back Problems
		33. Knee or Foot Problems
		34. Mobility Impairment

Yes	No	
		36. Physical Disability
		37. Cancer
		38. Immunity Suppressed
		39. Anemia
		40. Anxiety/Panic Disorder
		41. Depression
		42. Eating Disorder
		43. Drug/Alcohol Dependency
		44. Tobacco Usage
		45. Are you pregnant? EDC:
		46. Surgeries
		47. Hospitalizations
		48. Injuries
		49. Daily Medications
		50. Other Medical Conditions

Please comment on next page on all items checked "YES". Specify number and give details.

Orange County Community College is an equal opportunity/affirmative action institution. In accordance with Federal regulations, the New York State Human Rights Law and Section 504 of the Rehabilitation Act of 1973, Orange County Community college does not discriminate on the basis of age, color, religion, creed, disability, marital status, veteran status, national origin, race, gender or sexual orientation in employment or in the educational programs and activities which it operates.

Page One

- **Section I: Student information**
  - **Be sure to include your Program.**
  - **Be sure to include which semester you're enrolled in.**
    - If you are starting your program, you're in semester 1.

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Program________________ Semester 1 2 3 4 (Circle one) A#________________

Last Name / First Name / Middle Initial / Date of birth (MM/DD/YY) __/__/__

Street Address / City / State / Zip code

Home Phone Number / Cell Phone Number / E-Mail Address

Name, relationship of Person to be Notified in Case of Emergency / Home or Cell Phone / Business Phone

Personal Physician / Address / Phone

SECTION II: Personal Health History – to be completed by student Please check "YES" or "NO" if you have or ever had any of the following:

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		9. Palpitations
		10. Chest Pains
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		13. Seizure Disorder
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Please comment on next page on all items checked "YES". Specify number and give details.

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Page One

- Be sure to include your email address and cell phone number.
- Be sure to include the name and cell phone number of an emergency contact.

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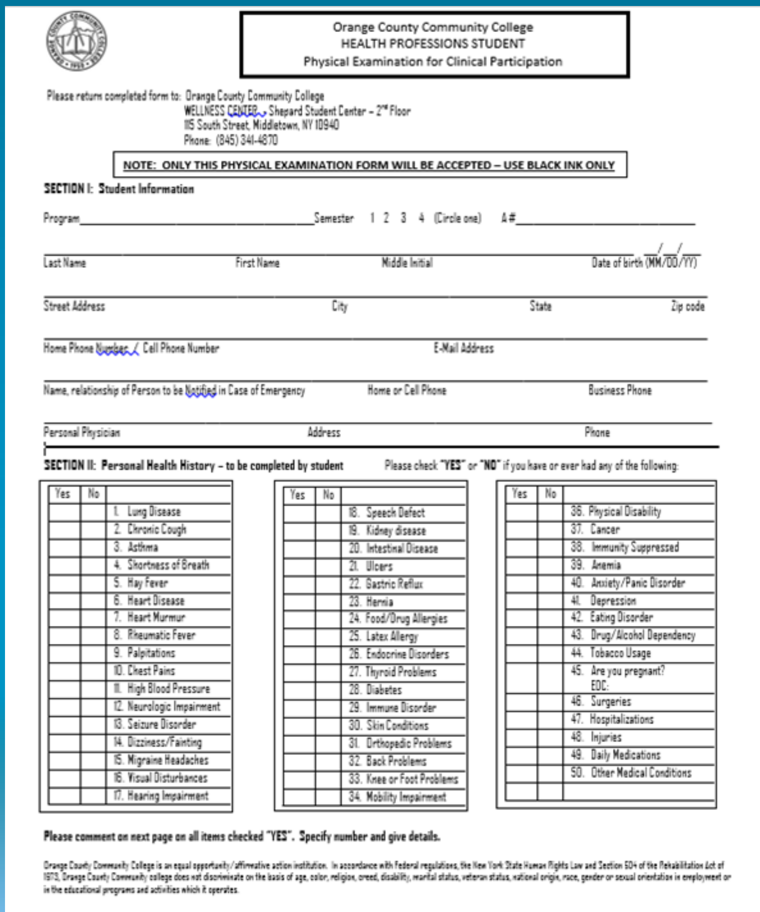
Page One



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		50. Other Medical Conditions

Please comment on next page on all items checked "YES". Specify number and give details.

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- **Section II: Personal Health Information**
  - Review all potential health conditions and answer "yes" or "no."
  - Do not draw a line down either column.
  - If you answer "yes" to any of these concerns you must explain why on the top of page 2.

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Page Two

NAME: ____________________ Page 2

Personal Health History continued: Use the space below to explain any items to which you answered "YES" on page 1. Be sure to list all medications you take regularly, indicate any acute or chronic medical conditions, allergies to medications, food, Latex, or other substances, and past history of surgical/medical illness. If currently under a doctor's care, give reason and name of provider.

AUTHORIZATION FOR RELEASE OF INFORMATION

I understand that the information contained herein is for the purpose of determining my eligibility to participate in the clinical practice portion of my Health Professions program. I give permission for release of this information to Orange County Community College Wellness Center, and authorize Orange County Community College Wellness Center to release this information to my Department chair, and to the clinical sites where I am assigned, if requested. I certify that the information contained herein is true and correct to the best of my knowledge.

STUDENT SIGNATURE ____________________

(Parent signature if student is under 18 years of age)

SECTION III –TUBERCULOSIS SCREENING - ***Annual Tuberculosis screening is required. This can consist of a QuantiFERON-TB Gold blood test (QFT-G) [attach a copy of blood test*] or 2 PPD's.***

All "**NEW**" Health Professions students require Tuberculosis Screening. This can consist of boosting with two consecutive PPD's done at least one week apart. If student provides proof of a negative PPD in the past 12 months, only one new PPD is needed now. Your most recent PPD must extend through the end of the semester to be acceptable. 2nd year students need "one" PPD or if Quantiferon was done year one, student needs another Quantiferon or 2 PPD's.

PPD #1 Administered__/__/__ Site_____ Product Mfg. _____ Lot #_______

Administered by (Signature) ________

Date Interpreted __/__/__ Signature__________ (within 48-72 hours)

Induration_______ mm Interpretation_________

Second PPD should be done no sooner than one week after first.

NOTE: After baseline is established, only one annual PPD is required for continuing students is subsequent years.

PPD #2 Administered__/__/__ Site____ Product Mfg. _____ Lot #_______

Administered by (Signature) ________

Date Interpreted __/__/__ Signature__________ (within 48-72 hours)

Induration_______ mm Interpretation_________

OR

QuantiFERON-TB Gold Blood (QFT-G) Test Result: ____________

***PLEASE ATTACH A COPY OF LAB REPORT**

If PPD or QuantiFERON-TB Gold Blood (QFT-G) is **Positive**, a negative chest x-ray report is required. **PLEASE ATTACH A COPY OF X-RAY REPORT.**

CXR Date __/__/__ Result: ____________

Was Chemoprophylaxis ordered? ____________

Please complete clinical evaluation if PPD is Positive.

CLINICAL EVALUATION FOR THOSE WITH HISTORY OF POSITIVE PPD or POSITIVE Quantiferon-Gold (QFT-G):

Repeat radiographs are not required for those with a history of positive PPD and recent negative chest X-ray on file. However, an Annual Clinical Evaluation by a health care professional for signs and symptoms of active TB is required.

Clinician should medically assess and counsel for the following signs and symptoms of active TB:

	YES	NO
Persistent Cough		
Fever		
Hemoptysis		
Anorexia		
Night Sweats		
Weight Loss		

I have performed the above evaluation and find no evidence of active Tuberculosis at this time. A negative CXR is on file.

Signature of Examining Physician, NP or PA ____ Date

- **Be sure to SIGN where indicated.**
  - **Note: Your signature gives the Wellness Center permission to release your medical information (immunizations and TB screening) to the chair of your department and to clinical sites where you are assigned.**

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Page Two

NAME____ Page 2

Personal Health History continued: Use the space below to explain any items to which you answered "YES" on page 1. Be sure to list all medications you take regularly, indicate any acute or chronic medical conditions, allergies to medications, food, Latex, or other substances, and past history of surgical/medical illness. If currently under a doctor's care, give reason and name of provider.

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STUDENT SIGNATURE____________________________________
(Parent signature if student is under 18 years of age)

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PPD #1 Administered__/__/__ Site_____ Product Mfg. _____ Lot #________

Administered by (Signature)__________

Date Interpreted __/__/__ Signature__________ (within 48-72 hours)

Induration_______ mm Interpretation__________

Second PPD should be done no sooner than one week after first.
NOTE: After baseline is established, only one annual PPD is required for continuing students is subsequent years.

PPD #2 Administered__/__/__ Site____ Product Mfg. _____ Lot #________

Administered by (Signature)__________

Date Interpreted __/__/__ Signature__________ (within 48-72 hours)

Induration_______ mm Interpretation__________

OR

QuantiFERON-TB Gold Blood (QFT-G) Test Result________________

***PLEASE ATTACH A COPY OF LAB REPORT**

- -

If PPD or QuantiFERON-TB Gold Blood (QFT-G) is **Positive**, a negative chest x-ray report is required. **PLEASE ATTACH A COPY OF X-RAY REPORT.**

CXR Date __/__/__ Result________________
Was Chemoprophylaxis ordered?________________

Please complete clinical evaluation if PPD is Positive.

CLINICAL EVALUATION FOR THOSE WITH HISTORY OF POSITIVE PPD or POSITIVE Quantiferon-Gold (QFT-G):

Repeat radiographs are not required for those with a history of positive PPD and recent negative chest X-ray on file. However, an Annual Clinical Evaluation by a health care professional for signs and symptoms of active TB is required.

Clinician should medically assess and counsel for the following signs and symptoms of active TB:

	YES	NO
Persistent Cough		
Fever		
Hemoptysis		
Anorexia		
Night Sweats		
Weight Loss		

I have performed the above evaluation and find no evidence of active Tuberculosis at this time. A negative CXR is on file.

Signature of Examining Physician, NP or PA Date

- **Section III: Tuberculosis Screening**

  All students must submit proof of tuberculosis screening.

  You may obtain 2 PPDs a minimum of one week apart, or a Quantiferon TB Gold Test.

  The Orange County Health Department's TB Clinic offers PPD testing for $10 each (see schedule included in your packet.)

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NAME: ____________________ Page 2

Personal Health History continued: Use the space below to explain any items to which you answered "YES" on page 1. Be sure to list all medications you take regularly, indicate any acute or chronic medical conditions, allergies to medications, food, Latex, or other substances, and past history of surgical/medical illness. If currently under a doctor's care, give reason and name of provider.

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PPD #1 Administered__/__/__ Site_____ Product Mfg. _____Lot #________

Administered by (Signature) __________

Date Interpreted __/__/__ Signature__________ (within 48-72 hours)

Induration________ mm Interpretation__________

Second PPD should be done no sooner than one week after first.

NOTE: After baseline is established, only one annual PPD is required for continuing students in subsequent years.

PPD #2 Administered__/__/__ Site____ Product Mfg. _____Lot #________

Administered by (Signature) __________

Date Interpreted __/__/__ Signature__________ (within 48-72 hours)

Induration________ mm Interpretation__________

OR

QuantiFERON-TB Gold Blood (QFT-G) Test Result: ____________________

***PLEASE ATTACH A COPY OF LAB REPORT**

If PPD or QuantiFERON-TB Gold Blood (QFT-G) is **Positive**, a negative chest x-ray report is required. **PLEASE ATTACH A COPY OF X-RAY REPORT.**

CXR Date __/__/__ Result: ____________________

Was Chemoprophylaxis ordered? ____________________

Please complete clinical evaluation if PPD is Positive.

CLINICAL EVALUATION FOR THOSE WITH HISTORY OF POSITIVE PPD or POSITIVE Quantiferon-Gold (QFT-G):

Repeat radiographs are not required for those with a history of positive PPD and recent negative chest X-ray on file. However, an Annual Clinical Evaluation by a health care professional for signs and symptoms of active TB is required.

Clinician should medically assess and counsel for the following signs and symptoms of active TB:

	YES	NO
Persistent Cough		
Fever		
Hemoptysis		
Anorexia		
Night Sweats		
Weight Loss		

I have performed the above evaluation and find no evidence of active Tuberculosis at this time. A negative CXR is on file.

Signature of Examining Physician, NP or PA Date

Page Two

- **Note: If you have a Quantiferon TB Gold Test in year one, you will need to do the same test the following year or obtain 2 PPDs.**

  If you have 2 PPDs in year one you only need one PPD (or a Quantiferon TB Gold Test) in year two.

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Page Two

NAME______________________________ Page 2

Personal Health History continued: Use the space below to explain any items to which you answered "YES" on page 1. Be sure to list all medications you take regularly, indicate any acute or chronic medical conditions, allergies to medications, food, Latex, or other substances, and past history of surgical/medical illness. If currently under a doctor's care, give reason and name of provider.

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PPD #1 Administered__/__/__ Site_____ Product Mfg. _____ Lot #________

Administered by (Signature)_________

Date Interpreted __/__/__ Signature__________ (within 48-72 hours)

Induration_______ mm Interpretation_________

Second PPD should be done no sooner than one week after first.

NOTE: After baseline is established, only one annual PPD is required for continuing students is subsequent years.

PPD #2 Administered__/__/__ Site____ Product Mfg. _____ Lot #________

Administered by (Signature)_________

Date Interpreted __/__/__ Signature__________ (within 48-72 hours)

Induration_______ mm Interpretation_________

OR

QuantiFERON-TB Gold Blood (QFT-G) Test Result________________

***PLEASE ATTACH A COPY OF LAB REPORT**

If PPD or QuantiFERON-TB Gold Blood (QFT-G) is **Positive**, a negative chest x-ray report is required. **PLEASE ATTACH A COPY OF X-RAY REPORT.**

CXR Date __/__/__ Result________________

Was Chemoprophylaxis ordered?________________

Please complete clinical evaluation if PPD is Positive.

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Night Sweats		
Weight Loss		

I have performed the above evaluation and find no evidence of active Tuberculosis at this time. A negative CXR is on file.

Signature of Examining Physician, NP or PA Date

If your PPD or Quantiferon TB Gold test is POSITIVE or if have a HISTORY of a positive PPD:

- **Your healthcare provider must order a chest X-Ray and you must attach a copy of the X-Ray report to your physical.**
- **Your healthcare provider must complete the clinical evaluation on the bottom right of page 2.**
- **Be sure your healthcare provider signs and dates this section.**

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NAME:____ Page 3

SECTION IV: REQUIRED IMMUNIZATIONS and SEROLOGIES

This document must be signed below by a licensed Health Care Practitioner. **Proof of immunity is required regardless of age and previous immunization history.** Also acceptable is an attached signed/stamped Immunization record from your practitioner. *Pregnant women SHOULD NOT be immunized and must submit M.D. note indicating EDC (due date).*

REQUIRED IMMUNIZATIONS	DOSE #1	DOSE #2	TITERS Date + Results
MMR (Measles, Mumps, Rubella) 2 Doses required **ON** or **AFTER** 12 months of age. The second MMR vaccine must be 28 days after the first vaccine. MMR requirement is only for those born on or after 01/01/57. After 01/01/68 – vaccines must be "LIVE"			**ATTACH ALL LAB RESULTS**
OR			
Measles (Rubeola) – *2 doses required*			**Date:**
			Result:
Mumps – *2 doses required*			**Date:**
			Result:
Rubella (German Measles) – *1 dose required*			**Date:**
			Result:
VARICELLA (Chickenpox) – *2 doses required*			**Date:**
			Result:

Tetanus (TDAP): (recommended within past 10 years) Immunization Date: ____________________

Meningitis (A or B): (recommended every 5 years) Immunization Date and Type: ____________________

Hepatitis B: **Vaccine series either completed, started, or signed waiver required.**
If waiving vaccine, waiver must be signed each year. Hepatitis B Vaccine is strongly recommended for all Health Professions students.
Students who DO NOT wish to receive the Hepatitis B vaccine are REQUIRED to sign the waiver below.

Hepatitis B Vaccine: Dose #1__________ Dose #2__________ Dose #3__________
Hepatitis B Antibody Titer: Date:__________ Results:__________

(**NOTE:** The CDC recommends healthcare workers have Hep B antibody titer 6-8 weeks after dose three.) **-OR-**

Hepatitis B Waiver: As a student in one of the Health Professions programs, I am aware of my increased risk of exposure to blood and other potentially infections materials. I understand that this may place me at increased risk of acquiring Hepatitis B, a vaccine preventable disease. Nonetheless, I decline to be vaccinated at this time. I understand that I may revoke this waiver and begin the vaccine series at any future date.

Student Signature________________________ **Date**____________

PRINT NAME OF HEALTHCARE PROVIDER COMPLETING THIS FORM:____________________

HEALTHCARE PROVIDER'S SIGNATURE:____________________ **DATE**__________

Page Three

- **Required Immunizations:**
  - **All health professions students are required to submit proof of 2 MMRs (Measles, Mumps, Rubella) and 2 Varicella (Chickenpox) vaccines**
  - **OR proof of POSITIVE titers (a blood test.)**
    - **If using titers, you must submit the lab report.**

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Page Two

NAME:____ Page 3

SECTION IV: REQUIRED IMMUNIZATIONS and SEROLOGIES

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OR			
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			Result:
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Tetanus (TDAP): (recommended within past 10 years) Immunization Date: ________________

Meningitis (A or B): (recommended every 5 years) Immunization Date and Type: ________________

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(**NOTE:** The CDC recommends healthcare workers have Hep B antibody titer 6-8 weeks after dose three.) **-OR-**

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Student Signature____________________ **Date**__________

PRINT NAME OF HEALTHCARE PROVIDER COMPLETING THIS FORM:____________________

HEALTHCARE PROVIDER'S SIGNATURE:____________________ **DATE**__________

- **It is recommended but not required that students receive the Hepatitis B series.**
- **Please submit proof of three vaccines or a positive titer.**
- **If you have not received this vaccine and do not intend to you must sign the Hepatitis B waiver at the bottom of page 3.**
- **Vaccines are available at the Orange County Department**
  - **$65 each, Goshen clinic only**
  - **You must schedule an appointment: (845) 360-6587**

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Page Three

- Recommended immunizations
  - It is recommended but not required that students receive a TDAP vaccine within the last ten years.
  - Students are required to complete the Meningitis Response Form which is available on our website: https://sunyorange.edu/wellness/forms.html

NAME:____ Page 3

SECTION IV: REQUIRED IMMUNIZATIONS and SEROLOGIES

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Student Signature______________________ **Date**__________

PRINT NAME OF HEALTHCARE PROVIDER COMPLETING THIS FORM:______________________

HEALTHCARE PROVIDER'S SIGNATURE:______________________ **DATE**__________

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The Flu Vaccine

- Seasonal Flu Vaccine is strongly recommended as most clinical sites require it.
- The flu vaccine is the best way to prevent influenza. Vaccines become available in late August-early September, long after most physicals are due.
- The Wellness Center will host flu clinics in Middletown and Newburgh in September if classes resume on campus. If not, you will be able to obtain the vaccine from your healthcare provider or pharmacy.

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The Flu Vaccine

- NURSING STUDENTS: Please provide documentation of flu vaccine for the 2020-2021 flu season to the Wellness Center by October 1st, 2020.
- Failure to do so will result in a $25 late fee, a hold placed on your student account, and possibly lost clinical time.
- All other Health Professions students: Please provide documentation of immunization by November 1st.
- Keep a copy of your flu vaccine for your own records

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NAME:______________________________ Page 3

SECTION IV: REQUIRED IMMUNIZATIONS and SEROLOGIES

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Tetanus (TDAP): (recommended within past 10 years) Immunization Date: ______________

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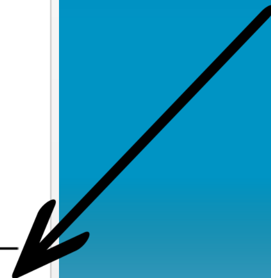
Student Signature______________________________**Date**__________

PRINT NAME OF HEALTHCARE PROVIDER COMPLETING THIS FORM:______________________________

HEALTHCARE PROVIDER'S SIGNATURE:______________________________**DATE**__________



Page Three

- **If your healthcare provider writes anywhere on this page, make sure he or she signs off and dates at the bottom.**

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Page Four

Section V: Physical Examination and Clinical Clearance

- Your healthcare provider completes this section.
- Be sure each area is addressed.
- Be sure each of the four questions in the center of the form are addressed.
- Be sure your provider signs, dates, and stamps the form.

SECTION V: PHYSICAL EXAMINATION and CLINICAL CLEARANCE FOR HEALTH PROFESSIONS STUDENTS Page 4

SEX: [ ] M [ ] F

LAST NAME FIRST NAME MIDDLE AGE

NOTE: Both Page 3 and 4 of this form must be completed and signed by examining Physician, NP or PA

Vision – Uncorrected: Right 20/_______ Left 20/_______ Height ____________inches Weight ____________lbs.
Vision – Corrected: Right 20/_______ Left 20/_______ Overweight ________Underweight______ Eating Disorder________
Does he/she wear contact lenses? Yes______NO_______
Gross Hearing:______________________________ Blood Pressure_________/_________ Pulse___________

HEENT______________________ **HEART**______________________
SKIN______________________ **LUNGS**______________________
MOUTH-TEETH______________________ **BREASTS**______________________
NEURO______________________ **ABDOMEN – GI**______________________
MUSCULOSKELETAL______________________ **GU – KIDNEYS**______________________
EXTREMITIES______________________ **ENDOCRINE**______________________
MEDICAL HISTORY (Chronic Illnesses/Hospitalizations: **SURGICAL HISTORY:**

REQUIRED EVALUATION FOR CLINICAL PARTICIPATION – To be completed by examiner:

- Is there loss or serious impairment of any paired organ? [ ] **NO** [ ] **YES**______________________
- Is there any limitation in normal activity? [ ] **NO** [ ] **YES** (e.g., ability to lift, walk, sit or stand for prolonged periods). If **"YES"**, please clearly indicate the nature of the limitation and the length of time you estimate it will exist, using specific dates:______________________
- Is there any evidence of mental health disorder? [ ] **NO** [ ] **YES**. If **"YES"**, please describe nature of disorder. Do you recommend further investigation or treatment? ______________________

[ ] **YES**, I have performed a complete medical examination as indicated on the above named student and found to the best of my knowledge that he/she is free from any physical or mental impairment which would impose a potential risk to patients or 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 individual's behavior.

[ ] **NO**, the following active problems were identified which may interfere with the performance of his/her duties. ______________________

SIGNATURE and STAMP OF EXAMINING PHYSICIAN, NURSE PRACTITIONER OR PA.

Signature______________________
Address:______________________
City, State, Zip Code:______________________
Phone:______________________
Date:______________________

STAMP

FOR OFFICE USE ONLY:
Date Received ____________ Reviewer ____________ Date Entered ____________ Initials__________

https://poweredtemplate.com/00083/0/index.html

Submitting your Physical Form

- When your physical form is complete, MAKE A COPY OF EACH DOCUMENT FOR YOUR OWN RECORDS.
- Put the original documents in an envelope.
- Make sure your mailing address is on the envelope.
- Make sure you affix sufficient postage to your envelope.
- MAIL the entire packet to:

Wellness Center
SUNY Orange
115 South Street
Middletown, NY 10940

https://poweredtemplate.com/00083/0/index.html

Submitting your Physical Form

- **NOTE: The Wellness Center and the College are not responsible for documents lost or damaged in transit, thus having a copy is *imperative*.**
- **You do not want to be the student who's physical was destroyed or "lost in the mail" and there's no copy.**

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Submitting your Physical Form

- Do NOT wait until the deadline to submit your form in case there are discrepancies or errors which may delay your clinical clearance and interfere with starting the program or attending clinical.
- A $25 late fee will be imposed on any physicals submitted after the deadline.
- Call or email the Wellness Center IMMEDIATELY if you experience any difficulties or delays meeting your deadline or completing the form. A nurse will respond to your query within 24-72 hours.

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Submitting your Physical Form

- A Wellness Center Nurse will visit the mailroom on Mondays to pick up and process the physicals.
- If there are any discrepancies with your physical or accompanying paperwork you will be notified either by email or phone.
- The nurse may request a phone interview or a Zoom session to discuss any issues.
- If your physical is incomplete, unsigned, or missing components the entire package will be mailed back to you.

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Receiving Your Clinical Clearance

- **Once your physical form and other documents are received, reviewed, accepted, and documented in your student record the nurse will EMAIL you your clinical clearance. This may take 7-10 business days.**

- **We recommend you print a copy and carry it with you to class and clinical. Save the digital document in a safe place on your computer, phone, tablet, etc. You may need to produce this form throughout your academic year.**

https://poweredtemplate.com/00083/0/index.html

Reasons Forms Are Rejected

- Student did not put their name and/or personal identifying information on page one.
- Student did not complete the Personal Health History on pages one and two.
- Student did not sign the form on page two.
- Student did not attach supporting documentation, i.e. lab reports or immunization records.
- Student was not reimmunized after negative titers.
- Lines on page four are left blank.
- The provider did not sign, date, or stamp on page four.

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Latex Allergies and Sensitivity

- Students with a history of Latex Allergy or Sensitivity must complete the Latex Allergy Action Plan.
- Students may obtain this form on our website: https://sunyorange.edu/wellness/forms.html
- Nursing students: Your healthcare provider must complete and sign this form due to the latex-rich environment in the simulation lab.
- All other Health Professions students may complete this form independently.

https://poweredtemplate.com/00083/0/index.html

Change in Health Status

- If for any reason you experience a change in health status during your program (i.e. illness, accident, pregnancy) you must be re-evaluated by your healthcare provider and the Wellness Center.
- Obtain a Change in Health Status Form from your program chair, Wellness Center, or on our website: https://sunyorange.edu/wellness/forms.html.
- See your healthcare provider ASAP.
- Failure to comply in a timely manner may result in lost class and/or clinical time.

https://poweredtemplate.com/00083/0/index.html

Tips

- Schedule your physical immediately. Procrastinating may result in difficulty securing an appointment within the prescribed timeframe.
- You may get your first PPD at any time. The second one must be within the prescribed timeframe.
- Use the checklist provided to monitor your progress during this process. This helps ensure your form is completed as required prior to submission.

https://poweredtemplate.com/00083/0/index.html

Tips

- Before you leave your healthcare provider's office make sure all areas of your physical form are properly addressed.
- Make copies of all records! You may need them during your program and after graduation.
- Call or email the Wellness Center if you encounter any issues ASAP! We want to help.
- Phone: (845) 341-4870. Leave a voice message.
- Email: wellnesscenter@sunyorange.edu
- A nurse will return your call or email within 24-72 business hours.

https://poweredtemplate.com/00083/0/index.html