ROSWELL PARK CANCER INSTITUTE

DOSIMETRY

Please Complete:

Start Date: _____

End Date: _____

RPCI Supervisor _____

Department: _____

HEALTH & FITNESS STATEMENT
-- RESIDENTS / FELLOWS / STUDENTS / TRAINEES --

NOTE: Section 1 of this form must by completed by the trainee. Section 2 needs to be completed by your health care provider (or student health office) before you start your affiliation at RPCI.

1a. **Fitness for duty:** My signature at the bottom of this page attests, that to the best of my knowledge, except as noted below, I am free from physical or mental impairments, including habituation or addiction to depressants, stimulants, narcotics, alcohol or other behavior altering substances which might interfere with the performance of my duties or would impose a potential risk to patients or personnel. I understand the risks of infection in health care settings and the potential to prevent disease via vaccinations.

I wish to disclose the following issues that might interfere with the performance of my duties:

□ request to discuss with Employee Health staff

1b. **Protection against Hepatitis B:** Exposure to Hepatitis B virus constitutes a serious occupational health hazard to health care workers. A Hepatitis B infection is an unpredictable disease that may cause severe illness lasting weeks or months and lead to serious complications. Health care workers are at 20 times greater risk of contracting the virus than the general public; 18,000 health care professional contract Hepatitis B every year. In addition, almost 4,000 persons die from Hepatitis B related cirrhosis every year.

Trainees in the health care fields are strongly urged to complete Hep B vaccination from their primary care physician or student health offices prior to starting clinical work. The vaccine against Hepatitis B is prepared from recombinant yeast cultures and is free of human blood or blood products.

Recommended groups for immunizations are: 1) Physicians and surgeons, dentists, oral surgeons and dental hygienists; 2) Nurses and other hospital personnel providing direct patient care and who frequently handle blood and other body fluids; 3) Laboratory staff in clinical labs or research labs handling blood/body fluids, and 4) **trainees in any of these groups**.

☐ Although I may have occupational exposure to Hepatitis B, I wish to decline the vaccine at this time. I understand that as a consequence of my occupational duties/training, I am at risk of contracting Hepatitis B, leading to potential long term health problems and even death. I decline to be vaccinated at this time.

☐ I have had Hepatitis B or am known to be positive for the antibody to the core antigen for Hepatitis B.

☐ I have previously received the vaccine and have proof.

1c. **Health care workers/trainees with direct patient contact:** Persons with direct patient contact are strongly encouraged to receive annual **influenza (flu) vaccines** to reduce the risk of becoming ill and to reduce transmitting infection to patients, co-workers and families. A one time booster dose to **Tetanus, diphtheria and acellular pertussis (Tdap) vaccine** is also recommended if it has been longer than 2 years since the last Td booster. Talk with your doctor about these vaccines.

_____ _____

Signature Date

_____ _____

Print Name date of birth

_____

Parental signature (if under age 18 yrs.)

CONTACT INFO: phone _____ - ____ - _____ e-mail _____

****continue to next page →*

_____
name

2. **INSTRUCTIONS**: Proof of immunization must be provided. Any vaccines given before 1968 must be proven to be live vaccine without gamma globulin. All dates should be recorded on this form and include month, date and year. Please type or print.

A. REQUIRED: Measles (Rubeola) Immunity. Must have one of the following:
1) TWO dates of Measles Immunization (1)_____(2)_____
Both must be given after 1967 and on or after the first birthday.
OR 2) Date of Measles Titer_____ and Result_____
OR 3) Date Physician Diagnosed Measles_____

B. REQUIRED: Rubella (German Measles Immunity). Must have one of the following:
1) Date of one Rubella Immunization after the first birthday_____
OR 2) Date and result of Rubella Titer_____
**History of this illness is not acceptable*

C. REQUIRED: Mumps Immunity. Must have one of the following:
1) Date of one Mumps Immunization _____
OR 2) Date and result of Mumps Titer_____
OR 3) Date Physician Diagnosed Mumps_____

D. REQUIRED: CHICKENPOX Immunity. Must have one of the following:
1) Dates two VZV Immunization 1) _____ 2) _____
OR 2) Date Physician diagnosed Chickenpox / zoster [circle one] _____
OR 3) Date and result of Varicella titer _____

E. REQUIRED: Tuberculin Skin Test (PPD) within the past year.
Date administered: _____ Date read_____ Result: _____
**If positive, please provide documentation of CXR or completion of treatment.*

F. Hepatitis B vaccine: required for patient contact or if working with human tissue.
1) _____ 2)_____ 3) _____
OR 2) Date of HBsAb Titer_____ and Result**:** _____
OR 3) Hep B vaccine declined

G. REQUIRED: Seasonal Influenza Vaccination Date: _____

H. Tdap Date: _____

The above information has been reported by: _____ **/** _____
Signature Date

_____
Print Name

Physician/Organization Name: _____

Address: _____

City/State/Zip Code: _____

Telephone #: _____

Completed forms can be returned via mail or fax to:

Educational Affairs
Roswell Park Cancer Institute
Elm & Carlton Streets
Buffalo, NY 14263
Telephone: 716/845-2339
FAX: 716/845-8178