Memorial Sloan Kettering Cancer Center

Medical Clearance (Outside Provider) Instructions

Updated: 09/06/2023

Dear MSK New Hire,

It is our great pleasure to welcome you to Memorial Sloan Kettering (MSK) Cancer Center. Employee Health provides occupational health services to employees, volunteers, trainees, and other staff.

This letter contains instructions on how to complete Medical Clearance so that you can begin work at MSK.

1. **COVID-19 Vaccine:** MSK staff are required to be fully vaccinated for COVID- 19 (i.e, completion of a primary COVID-19 vaccination series or at least one dose of the bivalent COVID-19 vaccine). Exceptions from the COVID-19 vaccine requirement are permitted for those who request and receive an MSK approved medical exemption. Requests for medical exemption can take up to two weeks to review. Vaccination or an approved medical exemption is required to start work.
2. **Seasonal Influenza Vaccination (Fall through Spring, Yearly):** MSK staff are required annually to either receive an influenza vaccination or obtain a medical or religious exemption. Vaccination or an approved exemption is required to start work. Requests for exemption can take up to two weeks to review. All personnel who have not received the vaccine due to an approved medical or religious exemption must wear a mask covering their nose and mouth at all times in patient areas throughout the entirety of flu season.
3. Complete all sections of the **Pre-Placement Evaluation** Form. You must complete Section 1 and give it to your doctor/ primary care provider to review and complete along with the **Physical Exam Form**.
4. Gather **laboratory (blood) test and vaccination records**. Vaccinations and laboratory (blood) tests must be official documentation from your primary care provider, school, or previous employer.
5. Upon completion, **email documentation to EHWS@mskcc.org** as a PDF attachment. Include your MSK Employee ID Number and Full Name in the Subject Line.

Please note medical clearance can only occur after you have submitted all necessary paperwork. This review can take approximately two weeks so start early. If any additional follow-up is needed, the process can take longer. **Failure to complete the above steps in advance will result in a delay of your start date.**

If you have any questions, please contact Employee Health at EHWS@mskcc.org. We look forward to providing a smooth transition into your new responsibilities and supporting your health and wellness as a part of our work community.

Sincerely,
Employee Health

New York State (NYS) and New Jersey State (NJS) Public Health Laws, federal regulations through Occupational Safety and Health Administration (OSHA), and Memorial Sloan Kettering (MSK) Cancer Center policy require employees/contingent workers to complete an initial health assessment (i.e. medical clearance process). Medical clearance is required to ensure employees/contingent workers are not at risk for transmitting disease to patients or coworkers, adequately protected against communicable disease, and free from any condition (including drugs or other chemicals) that may affect job performance and the health and safety of patients, visitors, as well as fellow staff members. Complying with the requirements and regulations is a responsibility of every employee/contingent worker at MSK and a condition of continued affiliation with MSK.

Submit Documentation as a PDF attachment to EHWS@mskcc.org and include your full name & MSK Employee ID in subject line

Memorial Sloan Kettering Cancer Center

Health Requirements

Updated: 09/06/2023

ITEMS TO SUBMIT

In addition to Pre-Placement Evaluation Form and Physical Exam Form, submit immunizations and tests as official documentation from primary care provider, school, or previous employer.

Laboratory Test / Immunization History

- Measles (Rubeola) Titer (Laboratory Test Result) or Proof of Two (2) Doses of MMR Vaccines
- Mumps Titer (Laboratory Test Result) or Proof of two (2) Doses of MMR Vaccines
- Rubella Titer (Laboratory Test Result) or Proof of two (2) Doses of MMR Vaccines
- Varicella Titer (Laboratory Test Result) or Proof of two (2) Doses of Varicella Vaccines
- Hepatitis B Surface Antibody (Laboratory Test Result)
- Hepatitis Surface Antigen (Laboratory Test Result)
- Tetanus-Diphtheria-Pertussis (Tdap) Vaccination with in the last 10 years
- Seasonal Influenza Vaccination (Fall through Spring, Yearly)
- COVID-19 Vaccination **(Please refer to page 1 for complete COVID-19 vaccine requirements)*

Additional immunization records

- Employee Health will review submitted documentation. If additional vaccinations are required, please have vaccination history available upon request so as not to delay your start date.
- Staff or volunteers working in animal research facilities (RARC) may require additional vaccinations and/or testing based on research protocol.

Tuberculosis Screening (Two-step PPD skin test or QuantiFERON Gold Blood test)

1: Baseline Tuberculin skin test (i.e., PPD) within 12 months prior to your start date. Please submit official documentation with date administered, date of result with measurement in millimeters(mm).

AND

2: Second Tuberculin skin test (i.e., PPD) must be at least seven (7) days after your Baseline test. Please submit official documentation with date administered date of result with measurement in millimeters(mm).

OR

Official documentation (Laboratory report) for QuantiFERON Gold blood test within 12 months prior to your start date in lieu of two-step PPD skin test.

Complete the following only if you have had POSITIVE history of PPD skin test or QuantiFERON Gold blood test:

1: Submit documentation of Positive PPD skin test with measurement in millimeters (mm) or Positive QuantiFERON Gold blood test

2: Complete electronic Health Assessment for Symptoms of Active TB (HAFSATB) Questionnaire:
Click link to access questionnaire: HAFSATB

3: Chest X-ray (PA and Lateral) report within 12-months prior to your start date.

4: If you have received the BCG vaccine in the past, QuantiFERON Gold blood test is required, and it must be within 12 months prior to your start date. If QuantiFERON is negative, you do not need to provide a chest x-ray.

5: Submit documentation from a medical provider if you have received counseling or treatment for Latent Tuberculosis Infection.

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Pre- Placement Evaluation Form

Updated: 09/06/2023

SECTION 1. Employee Information (to be filled out by the new hire)

Personal Information

Minor (under 18 years old) ☐ Yes ☐ No

Last Name: _____ First Name: _____ MI _____ Date of Birth _____ Age _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

MSK Employee ID Number*: _____ Phone #: _____ Gender: _____

Job Location*: _____ Department*: _____

*For information regarding Employee ID number, Job Location and Department, please refer to the information sent by Human Resources or the Volunteer department.

Country of Birth _____ If you were not born in the USA, when did you arrive? _____

Health History

Are you currently taking any medications? Circle: YES NO

If "yes," please indicate which ones and list frequency.

Have you smoked at least 100 cigarettes in your lifetime? Circle: YES NO NOT SURE

Do you currently smoke or use any other tobacco products (cigars, e-cigarettes, vape pens, Juul, cigarillos, pipe, smokeless tobacco, hookah, etc.)? Circle: YES NO

NYS Health Code Title: Section 405.3(10) requires that personnel are "free from a health impairment which is of potential risk to the patient, 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 individual's behavior."

Do you drink alcohol? Circle: YES NO

If so, how many drinks do you have on one occasion? Circle: 1 2 3 4 5 6 or more N/A

Are you currently addicted to other drugs such as stimulants, depressants, or opioids for pain? Circle: YES NO

Do you have a history of struggling with a substance misuse disorder or addiction? Circle: YES NO

If "yes," please explain in the box below:

Are you allergic to latex? Circle: YES NO

Do you have drug allergies? Circle: YES NO

If "yes," please explain in box below:

Are you allergic to animal fur? Circle: YES NO

Do you have any other non-drug allergies? Circle: YES NO

If "yes," please explain in box below:

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Pre- Placement Evaluation Form

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Surgical History and Current Symptoms/Medical History: (Y-yes, N-no, NS- not sure)

Surgical History:

1. Hernia repair	Y	N	NS
2. Gastrointestinal/Abdominal	Y	N	NS
3. Back or neck	Y	N	NS
4. Extremities (shoulders, elbows, wrists, hands, hips, knees, ankles, feet etc.)	Y	N	NS
5. Heart/Lung	Y	N	NS
6. Other (*please specify*)			

Infectious Disease:

1. Tuberculosis, night sweats (non-menopausal), fevers/chills, coughing up blood	Y	N	NS
2. Unreported needlesticks	Y	N	NS
3. Other current infectious conditions/illnesses or contagious conditions/illnesses	Y	N	NS
4. Other chronic (long-term) infections			

Endocrine:

1. Diabetes	Y	N	NS
2. Low blood sugar	Y	N	NS
3. Thyroid disease	Y	N	NS

Skin:

1. Open sores, skin rashes	Y	N	NS
2. Other skin conditions (*please specify)*	Y	N	NS

Cardiac:

1. Anemia, bleeding disorders	Y	N	NS
2. Heart disease, heart attack	Y	N	NS
3. High blood pressure	Y	N	NS
4. Chest pain, heart palpitations	Y	N	NS
5. Leg/feet swelling	Y	N	NS

Neurologic/Mental Health:

1. Weakness/fatigue	Y	N	NS
2. Fainting/passing out, dizziness	Y	N	NS
3. Severe headaches	Y	N	NS
4. Seizures, tremors	Y	N	NS
5. Difficulty walking, difficulty using arms/hands	Y	N	NS

Head, Ears, Eyes, Nose, Throat:

1. Changes in vision, color blindness, double vision	Y	N	NS
2. Other eye problems	Y	N	NS
3. Difficulty hearing, need for hearing aids, ringing in the ears	Y	N	NS
4. Other ear problems (*please specify*)	Y	N	NS

Respiratory:

1. Long-term cough, shortness of breath, wheezing	Y	N	NS
2. Lung problems (emphysema, chronic bronchitis, etc.)	Y	N	NS
3. Asthma or Chronic Obstructive Pulmonary disease (COPD)	Y	N	NS

Gastrointestinal (GI)/Kidney:

1. Gastritis, heart burn, other GI issues	Y	N	NS
2. Unintentional weight loss	Y	N	NS
3. Black or bloody stools	Y	N	NS
4. Hernias	Y	N	NS
5. Hepatitis, jaundice, other liver issues	Y	N	NS
6. Kidney disease	Y	N	NS

Musculoskeletal:

1. Arthritis, joint swelling, joint pain	Y	N	NS
2. Back or neck current or chronic pain	Y	N	NS
3. Extremity current or chronic pain	Y	N	NS
4. Numbness/tingling in hands or feet	Y	N	NS
5. Previous back/neck or extremity injury (please specify)_____	Y	N	NS
6. Stroke or transient ischemic attack	Y	N	NS
7. Mood/thought disorders	Y	N	NS
8. Anxiety, difficulty concentrating, sleep problems	Y	N	NS
9. Head or brain injuries/illnesses or concussions	Y	N	NS
10. Previous hospitalization for nervous or mental health condition?	Y	N	NS

Any other current symptoms or medical history (if yes, please specify?_____

Any current or past restrictions, limitations,
or disabilities due to previous musculoskeletal injuries (if yes, please specify)? _____

Any other current restrictions, limitations, or disabilities at present (if yes, please specify)?_____

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Physical Exam Form

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Must complete identifiers on each page:

Employee Last Name: _____ First Name: _____ MI ____

Date of Birth: _____ Phone #: _____

SECTION 2. Medical Examination (to be filled out by the Primary Care Provider)

HEALTH HISTORY REVIEW

Review and discuss pertinent patient answers and any available medical records. Comment on the patient's responses to the "Health History" questions in the Pre-Placement Evaluation Form that may affect the patient's ability to perform any job-related responsibilities.

TESTING

Pulse: _____ Respiratory Rate: _____ Height: ____ feet ____ inches Weight: _____ pounds Temperature: _____

VISION

Acuity	Uncorrected	Corrected
Right Eye:	20/	20/
Left Eye:	20/	20/
Both Eyes:	20/	20/
Referred to ophthalmologist or optometrist?	*Yes*	*No*

Blood Pressure

Blood Pressure	Systolic	Diastolic
Sitting		
Second reading *(optional)*		

TUBERCULOSIS SCREENING (TWO-STEP PPD SKIN TEST OR QUANTIFERON GOLD BLOOD TEST)

TUBERCULIN TEST (PPD)	Test #1 (PPD skin test) *Within 12 months of start date*	Test #2 (PPD skin test) *At least 7 days after first test*
Date Administered		
Date of result (48-72 hours after administered)		
Result with measurement in millimeters "mm"	_____mm	_____mm
QUANTIFERON GOLD BLOOD TEST ***(Within 12 months of start date with supporting laboratory report)***	Test Date:	Test Result:

Did your patient have a Positive Tuberculosis Screening by history and/or testing? Yes ☐ No ☐

Complete and submit the following if the patient has had POSITIVE history of PPD skin test or QuantiFERON Gold blood test:

1. Positive PPD skin test with measurement in millimeters (mm) or Positive QuantiFERON Gold blood test
2. Chest X-ray (PA and Lateral) report within twelve months prior to the patient's start date at MSK
3. If you have received the BCG vaccine in the past, QuantiFERON Gold blood test is required, and it must be within 12 months prior to your start date. If QuantiFERON is negative, you do not need to provide a chest x-ray
4. Documentation from a medical provider if the patient has received counseling or treatment for Latent Tuberculosis Infection.

PROVIDE LABORATORY REPORT AND/OR IMMUNIZATION RECORDS FOR THE FOLLOWING:

- Hepatitis B antibody titer & Hepatitis B antigen titer
- Measles, Mumps & Rubella antibody titers or proof of two (2) MMR vaccines
- Varicella Titer (Blood Test Result) or Proof of two (2) Doses of Varicella Vaccines
- Tetanus-Diphtheria-Pertussis (Tdap) Vaccination within the last 10 years
- Seasonal Influenza vaccination (Fall through Spring, Yearly)
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Physical Exam Form

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Must complete identifiers on each page:

Employee Last Name: _____ First Name: _____ MI ____

Date of Birth: _____ Phone #: _____

To be completed by Provider: Examining provider must review Pre-Placement Evaluation Form before completing this Physical Exam Form

PHYSICAL EXAM

NL= NORMAL AB=ABNORMAL NE=NOT EXAMINED

	NL	AB	NE	Comment
General Appearance				
Skin				
Head, Eyes, Ears, Nose and Throat				
Neck				
Chest and Lungs				
Cardiovascular				
Abdomen				
Genito-Urinary (including hernias)				
Back/Spine				
Extremities				
Gait				
Other Body systems				

Attestation: By signing your name you attest that you have reviewed all information provided by the patient in the Pre-Placement Form and determined the patient, whose name is listed above, is fit for the job or volunteer service.

Provider Name: _____ Provider Signature: _____

Provider stamp or NPI Number: _____ Date of Physical Exam: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax number: _____ Email address (optional): _____

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