NORTH COUNTRY COMMUNITY COLLEGE
THE STATE UNIVERSITY OF NEW YORK

Transmittal Checklist

☐MMR Vaccine **(Required)**

☐Rubeola **(Required in the Absence of MMR)**

☐Mumps **(Required in the Absence of MMR)**

☐Rubella **(Required in the Absence of MMR)**

☐Tetanus/Diphtheria: **(Required)**

☐PPD/Chest/X-Ray: **(Required)**

☐Varicella Vaccine: **(Required)**

☐Physical Examination **(Required)**

☐ Influenza vaccine (**Required**, annual each Fall Semester)

Students who have a medical exemption, must have their provider complete the Department of Health Medical Exemption Statement and will be required to wear a mask in all patient care areas.

☐Hepatitis B Vaccine: (Recommended but not required)

☐Meningococcal Vaccine: (Recommended but not required)

☐ Covid (Required secondary to clinical placements)**.**

Two doses of Moderna or Pfizer, or one dose of J&J. A booster is also strongly recommended.

☐CPR **(Required): <u>American Heart Association</u>**: BLS for the Healthcare Provider

Or

<u>Red Cross</u>: CPR/AED for the **<u>Professional Rescuer and Healthcare Provider</u>**

☐Student Professional Liability Insurance **(Required)**

Please complete the checklist, sign and date once complete, before noted deadline on welcome letter.

Student signature_____ Date_____

NORTH COUNTRY COMMUNITY COLLEGE
Nursing Program

TO: Nursing Students and Faculty

Subject: **Hepatitis B Information Sheet**

I understand that, due to my attendance in clinical experience, exposure to blood or other potentially infectious materials is a very real possibility. As a result of a possible exposure, I may be at risk of acquiring Hepatitis B Virus (HBV) infection. North Country Community College has recommended that I receive the series of Hepatitis B vaccinations as an effective way of protecting myself from acquiring this infection. I understand that it is, however, my choice to make and that whatever I decide will not affect my status at NCCC.

I further understand that if I make the decision to decline the series of HBV vaccinations, I continue to be at risk of acquiring Hepatitis B, a serious disease. I also understand that my risk may be decreased by maintaining certain behaviors in the clinical setting and that these behaviors will be taught to me prior to entry into the clinical practicum. I further understand that learning these behaviors and maintaining these techniques and behaviors in the clinical setting are primarily my responsibility. I fully understand, however, that total protection can only be achieved by having active immunity for Hepatitis B.

In the event that I choose not to receive the series of HBV vaccinations, I take full responsibility for my decision and will not hold NCCC or the clinical agency in which I learn and practice my skills responsible if I should acquire the Hepatitis B virus. If I do choose to receive the series of HBV vaccinations, I understand that I (not NCCC) am responsible for any and all expenses incurred as a result of my decision to receive these vaccinations and/or titers.

To be permitted to enter a clinical area, all Allied Health Program faculty and students must read, complete, date and sign this form.

MY DATED SIGNATURE BELOW INDICATES THAT I HAVE READ AND UNDERSTAND THE PRECEDING INFORMATION ABOUT ***HEPATITIS B*** AS IT RELATES TO MY STATUS AS FACULTY OR STUDENT IN AN ALLIED HEALTH PROGRAM, THAT I MUST MAKE A DECISION TO**:**

☐ **SUBMIT A COPY** OF THE SERIES OF HBV VACCINATIONS **(3 shots)**

OR

☐ **SUBMIT A COPY** OF LAB RESULTS SHOWING A POSITIVE TITER

OR

☐ **DECLINE** THE SERIES OF HBV VACCINATIONS

_____

Print Name

_____ _____

Signature Date

CONTROL OF HEPATITIS INFECTION

a. Personnel who are suspected of being infected with hepatitis A virus (HAV) should not take care of patients until 7 days after the onset of jaundice. CATEGORY III

b. Screening for evidence of prior infections with hepatitis B virus (HBV) in personnel who work in dialysis centers or other high-risk areas should be done only when needed to institute appropriate control measures. CATEGORY I

c. Personnel who are known carries HbsAg should be counseled about precautions to minimize their risk of infecting others. CATEGORY I

d. 1) Personnel who have no exudative lesions on the hands and who are acutely infected with HBV, are known to be carries of HbsAg, or have hepatitis non A/non B (NANB) should not be restricted from patient-care responsibilities, unless there is evidence of disease transmission. CATEGORY I

   2) Personnel who have no exudative lesions on the hands and who are acutely infected with HBV, are known to be carries of HbsAg, or have hepatitis NANB should wear gloves for procedures that involve trauma to tissues or direct contact with mucous membranes or non-intact skin. CATEGORY II

e. Personnel with exudative lesions on the hands who are HbsAg-positive should either wear gloves for all direct patient contact and when handling equipment that will touch mucous membranes or non-intact skin or abstain from all direct patient care. CATEGORY I

f. Dental personnel should consider routine use of gloves, masks, and protective eyewear when performing dental procedures. CATEGORY III

These suggestions are not meant to restrict hospitals from using additional precautions.

Rev. 3/18 SG

NORTH COUNTRY COMMUNITY COLLEGE

MMR Immunization Validation Form

Name: _____ Other Names Used: _____

Address: _____ Date of Birth _____

NY State Public Health Law 2165 requires all post-secondary students born on or after January 1, 1957, and enrolled in six or more credit hours, to provide proof of immunity to measles, mumps, and rubella. Appropriate documentation must include ONE of the following:

- Documentation of TWO (2) MMR vaccinations. To be considered valid, the first vaccination cannot be administered any more than four days prior to the student's first birthday, and the second dose must be given at least 28 days after the first dose.
- Documentation of TWO (2) doses of the measles vaccination, ONE (1) dose of the mumps vaccination, and ONE (1) dose of the rubella vaccination. To be considered valid, neither vaccination can be administered any more than four days prior to the student's first birthday, and the SECOND dose of the measles vaccination must be given at least 28 days after the first dose.
- POSITIVE blood titer results for measles, mumps, and rubella. Copies of a lab report(s) validating these results must be submitted.

To assist with documenting one of the above options, you may choose to have your health care provider complete this form. Please note that, if you are able to obtain a copy of your immunization record from another source (high school, another college, etc.), it is NOT necessary to complete this form. However, it is necessary to submit the "Meningococcal Disease Response Form" contained in this packet.

To be completed by a health care provider, NOT the student or student's parent/guardian

OPTION 1	OPTION 2
Date of MMR #1 _____ Date of MMR #2 _____ OR Date of Measles #1 _____ Date of Measles #2 _____ Date of Mumps #1 _____ Date of Rubella #1 _____	Date of **POSITIVE** Blood Titers *A copy of lab report must be attached to verify results.* + Measles Blood Titer Date _____ + Mumps Blood Titer Date _____ + Rubella Blood Titer Date _____

The above vaccination(s) have been validated by:

Health Care Provider name (printed) _____ Telephone Number

Address _____ _____
Street City State Zip

HCP's Signature _____

The medical office's stamp validating this information can be used in lieu of the provider's signature.

Date _____

Please fax this completed form to 518-891-4236 OR Email to healthrecords@nccc.edu

NORTH COUNTRY COMMUNITY COLLEGE
Nursing Program

TO: Nursing Students and Faculty

Subject: **Varicella (Chicken Pox) and Zoster (Shingles)**

☐ I have had a Varicella Titer (please submit evidence of titer with this form.)

OR

☐ I have received the immunization series (**2 shots**) for varicella/chickenpox (Submit appropriate evidence of immunizations with this form).

I understand that if I do not have immunity to Varicella, I could contract the disease in the form of Shingles (Zoster) or Chicken Pox (Varicella). I also understand that if I do contract either disease, I could spread it to patients (particularly those with a decrease in immunity) unknowingly during the prodromal stage of the disease which may run from 10 days post exposure to the end of the incubation period of 21 days post exposure.

Therefore, I understand that if I do not have a positive Varicella titer, I would be professionally negligent in reporting to a clinical area in the event that I do become exposed to either disease.

I further understand that if I do contract Varicella or Zoster, I will not return to patient care until all lesions have dried and crusted.

MY DATED SIGNATURE BELOW INDICATES THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT, IF I DO NOT HAVE A POSITIVE TITER FOR VARICELLA OR AM NOT POSITIVE THAT I HAVE IMMUNITY TO VARICELLA, I WILL COMPLY WITH THE ABOVE POLICY.

CDC Guidelines Nosocomial Infections

8. PERSONNEL EXPOSED TO VARICELLA OR ZOSTER
   a. After exposure to varicella (chickenpox) or zoster (shingles) personnel not known to be immune to varicella (by history or serology) should be excluded from work beginning on the tenth day after exposure and remain away from work for the maximum incubation period of varicella (21 days).
   CATEGORY I

   b. Personnel who have onset of varicella should be excluded from work at least until all lesions have dried and crusted.

These suggestions are not meant to restrict hospitals from using additional precautions. **Return signed form to: Nursing Medical Records**

Print Name: _____

Signature: _____ Date:_____

Rev.3/18 SG

NORTH COUNTRY COMMUNITY COLLEGE

Meningococcal Disease Response Form

Students Name: _____ Other Names Used: _____

Address: _____ Date of Birth _____

NY State Public Health Law 2167 requires all post-secondary students enrolled in six or more credit hours to submit a "Meningococcal Disease Response Form". This law also requires all post-secondary institutions to distribute information about meningococcal disease and immunization to all students (or parents/guardians of students under the age of 18). There is no age differentiation regarding meningococcal disease.

This is NOT a required immunization, therefore, this requirement can be met by signing and dating the declination statement on the bottom of this form.

*[Note: The Advisory Committee on Immunization Practices recommends that all first-year college students up to age 21years should have at least one dose of the meningococcal vaccine **not more than five years before enrollment**, preferably on or after their 16th birthday, and that young adults aged 16-23 years may choose to receive the meningococcal B vaccine series. College students should discuss the meningococcal B vaccine with a healthcare provider.]*

I / My child (for students under the age of 18) have:

- ❒ Had a meningococcal vaccination **within the last 5 years**. (check the choice that applies)
  - ❒ Documentation of this vaccination is attached to this form.
  - ❒ Administration of this vaccination has been validated by a health care provider as indicated below:

To be completed by a health care provider, NOT the student or student's parent/guardian

Date of Meningococcal Vaccination #1 _____ Date of Meningococcal Vaccination #2 _____

Type of Vaccination _____ Type of Vaccination _____
(i.e., Menactra, Menveo, Menomune) *(i.e., Menactra, Menveo, Menomune)*

The above vaccination(s) have been validated by:

Health Care Provider name (printed) _____

Address _____ _____
Street City State Zip *Telephone Number*

HCP's Signature _____

Date _____

The medical office's stamp validating this information can be used in lieu of the provider's signature.

❒ MENINGOCOCCAL VACCINATION DECLINATION

I have read, or have had explained to me, information regarding meningococcal disease. I understand the risks of not receiving this vaccination, and have decided that I (my child) will **not** obtain immunization against meningococcal disease.

Student's Signature _____ Date _____
(or parent if student is under 18 years of age)

Please fax this completed form to 518-891-4236 or E-mail to healthrecords@nccc.edu

SLO: Fall 2021

NORTH COUNTRY COMMUNITY COLLEGE
THE STATE UNIVERSITY OF NEW YORK

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

Today's Date:_____ **Your Name:** _____

Your Height:_____Ft._____In. **Your Weight:**_____Lbs. **Your Job Title:**_____

PART A -- Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please check "yes" or "no").

1.	**Do you currently smoke tobacco, or have you smoked tobacco in the last month?**	☐ **Yes**	☐ **No**
2.	**Have you ever had any of the following conditions?**		
a.	Seizures (fits)	☐ **Yes**	☐ **No**
b.	Diabetes (sugar disease)	☐ **Yes**	☐ **No**
c.	Allergic reactions that interfere with your breathing	☐ **Yes**	☐ **No**
d.	Claustrophobia (fear of closed-in places)	☐ **Yes**	☐ **No**
e.	Trouble smelling odors	☐ **Yes**	☐ **No**
3.	**Have you ever had any of the following pulmonary or lung problems?**		
a.	Asbestosis	☐ **Yes**	☐ **No**
b.	Asthma	☐ **Yes**	☐ **No**
c.	Chronic bronchitis	☐ **Yes**	☐ **No**
d.	Emphysema	☐ **Yes**	☐ **No**
e.	Pneumonia	☐ **Yes**	☐ **No**
f.	Tuberculosis	☐ **Yes**	☐ **No**
g.	Silicosis	☐ **Yes**	☐ **No**
h.	Pneumothorax (collapsed lung)	☐ **Yes**	☐ **No**
i.	Lung cancer	☐ **Yes**	☐ **No**
j.	Broken ribs	☐ **Yes**	☐ **No**
k.	Any chest injuries or surgeries	☐ **Yes**	☐ **No**
l.	Any other lung problem that you've been told about	☐ **Yes**	☐ **No**
4.	**Do you currently have any of the following symptoms of pulmonary or lung illness?**		
a.	Shortness of breath	☐ **Yes**	☐ **No**
b.	Shortness of breath when walking fast on level ground or walking up a slight hill or incline	☐ **Yes**	☐ **No**
c.	Shortness of breath when walking with other people at an ordinary pace on level ground	☐ **Yes**	☐ **No**
d.	Have to stop for breath when walking at your own pace on level ground	☐ **Yes**	☐ **No**
e.	Shortness of breath when washing or dressing yourself	☐ **Yes**	☐ **No**
f.	Shortness of breath that interferes with your job	☐ **Yes**	☐ **No**
g.	Coughing that produces phlegm (thick sputum)	☐ **Yes**	☐ **No**
h.	Coughing that wakes you early in the morning	☐ **Yes**	☐ **No**
i.	Coughing that occurs when you are lying down	☐ **Yes**	☐ **No**
j.	Coughing up blood in the last month	☐ **Yes**	☐ **No**
k.	Wheezing	☐ **Yes**	☐ **No**
l.	Wheezing that interferes with your job	☐ **Yes**	☐ **No**
m.	Chest pain when you breathe deeply	☐ **Yes**	☐ **No**
n.	Any other symptoms that you think may be related to lung problems	☐ **Yes**	☐ **No**
5.	**Have you *ever* had any of the following cardiovascular or heart problems?**		
a.	Heart attack	☐ **Yes**	☐ **No**
b.	Stroke	☐ **Yes**	☐ **No**

c. Angina ☐ Yes ☐ No

d. Heart failure ☐ Yes ☐ No

e. Swelling in your legs or feet (not caused by walking) ☐ Yes ☐ No

f. Heart arrhythmia (heart beating irregularly) ☐ Yes ☐ No

g. High blood pressure ☐ Yes ☐ No

h. Any other heart problem that you've been told about ☐ Yes ☐ No

6. **Have you *ever* had any of the following cardiovascular or heart symptoms?**

a. Frequent pain or tightness in your chest ☐ Yes ☐ No

b. Pain or tightness in your chest during physical activity ☐ Yes ☐ No

c. Pain or tightness in your chest that interferes with your job ☐ Yes ☐ No

d. In the past two years, have you noticed your heart skipping or missing a beat ☐ Yes ☐ No

e. Heartburn or indigestion that is not related to eating ☐ Yes ☐ No

f. Any other symptoms that you think may be related to heart or circulation problems ☐ Yes ☐ No

7. **Do you *currently* take a medication for any of the following problems?**

a. Breathing or lung problems ☐ Yes ☐ No

b. Heart trouble ☐ Yes ☐ No

c. Blood pressure ☐ Yes ☐ No

d. Seizures (fits) ☐ Yes ☐ No

8. **If you've used a respirator, have you ever had any of the following problems? (<u>If you've never used a respirator, check the following box and go to question 9</u>.)**

☐ Never used a respirator before.

a. Eye irritation ☐ Yes ☐ No

b. Skin allergies or rashes ☐ Yes ☐ No

c. Anxiety ☐ Yes ☐ No

d. General weakness or fatigue ☐ Yes ☐ No

e. Any other problem that interferes with your use of a respirator ☐ Yes ☐ No

9. **You have reviewed this questionnaire with your medical provider** ☐ Yes ☐ No

My signature indicates that the above named student may be fit tested and wear an N-95 mask

Provider's Signature and credentials: _____

Part B - Fit Test: To be Complete on Campus

Test Type: ☐ **Qualitative (Bitrex/Saccharin)** ☐ **Quantitative (Portacount)**

Respirator Type: N95 Disposable Particulate Filter Respirator

☐ **Halyard/KC Orange "Duckbill"** ☐ **3M Round (White/Teal)** ☐ **ENVO** ☐ **BYD-Teal** ☐ **Other**_____

☐ **Small** ☐ **Medium** ☐ **Regular** ☐ **One size**

Sensitivity Test: ☐ **10** ☐ **20** ☐ **30** ☐ **>30 unable to test**

Fit test: ☐ **5** ☐ **10** ☐ **15**

(Initial as per sensitivity test, then ½ number every 30 seconds for duration of test)

☐ **Pass- no taste of bitrex/saccharin** ☐ **Fail-tasted bitrex/saccharin**

(try alternate mask style)

If N95 Fit Test Failure, use of Hepa-Mate 12 is required. Hepa-Mate 12 education provided? ☐ **Yes** ☐ **No**

Fit Tester Signature: _____Date: _____

Student Signature: _____Date: _____

CONFIDENTIAL **I. PERSONAL HEALTH REPORT** **CONFIDENTIAL**

To be completed by Student/Faculty

Year_____ ☐ Fall ☐ Spring Date of Birth: _____

Name_____
Home Phone E-mail Address

Home Address_____
& Street City State Zip

Address while attending NCCC **(if same as above, write "SAME"):**

_____
& Street City State Zip

Person to Notify in Case of Emergency:

_____
Day Phone Evening Phone Relationship

Address_____
& Street City State Zip

Family Physician: **(If none please write in none)** _____
Name Phone Number

Physician's Address: _____
& Street City State Zip

CONFIDENTIAL **II. PERSONAL HISTORY** **CONFIDENTIAL**

Place an "X" in the appropriate box (es):

- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma/shortness of breath
- ☐ Back Problems
- ☐ Bleeding Disorders
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Bowel Problems
- ☐ Broken bones/joint dislocations
- ☐ Chest pains on exertion or deep breathing
- ☐ Chronic cough/bronchitis/ bloody sputum
- ☐ Chronic pain in
  - ☐ neck ☐ arms
  - ☐ back ☐ legs
  - ☐ shoulders ☐ other
- ☐ Chronic skin problems (rash, infection)
- ☐ Concussion (within last yr)
- ☐ Continuing use of alcohol, drugs, or medicines
- ☐ Depression
- ☐ Diarrhea (recurrent)
- ☐ Difficulty urinating/burning or pain on urination/ frequency in urinating.
- ☐ Digestive Problems
- ☐ Dizziness/Fainting
- ☐ Ear Trouble
- ☐ Eye Trouble
  - ☐ Glasses
  - ☐ Contact Lenses
- ☐ Food Intolerances
- ☐ Frequent nausea or vomiting
- ☐ Headaches/ migraines (recurrent)
- ☐ Hearing Problems
  - ☐ Hearing aid
- ☐ Heart Defect/Disease
- ☐ Heartburn/GERD
- ☐ Hepatitis
- ☐ Hernia
- ☐ History of diabetes
- ☐ IBS
- ☐ Immune System Disorder
- ☐ Joint disease (injury)
  - ☐ pain
  - ☐ swelling } w/o injury
  - ☐ stiffness
- ☐ Kidney Disease
  - ☐ Infection
  - ☐ Stones
- ☐ Kidney Disorder
- ☐ Liver Disorder
- ☐ Mental Illness or disorder
- ☐ Motion Sickness
- ☐ Pneumonia
- ☐ Problems w/ teeth
  - ☐ dentures
  - ☐ bridge
- ☐ Serious sprains/weakness of muscles
- ☐ Seizures
- ☐ Severe injury to head/ chest/internal organs
- ☐ Severe menstrual cramps/bleeding
- ☐ Sinusitis
- ☐ Sore Throat (frequent)
- ☐ Thyroid trouble
- ☐ Traumatic Brain Injury
- ☐ Tuberculosis
- ☐ Ulcerative Colitis / Crohn's
- ☐ Other (specify):

_____

_____

If checked <u>any of the above</u>, please explain below. Be specific. Use additional paper if necessary.

_____

_____

_____

Please list any allergies to foods, drugs, etc._____

_____

Do you take any medications regularly? ☐Yes ☐No If "Yes", please list drug(s) and dosage(s) _____

_____

Please list any serious injuries, illnesses, fractures, dislocations and surgery:_____

_____

(PERSONAL HISTORY CONTINUED ON NEXT PAGE)

Do you have any disability or impairment of which we should be aware? ☐Yes ☐No
If "Yes", please explain: _____

_____

Are you currently receiving treatment at a clinic or by a physician (other than regular checkups)? ☐Yes ☐No
If "Yes", please explain: _____

_____

Are you or have you ever been under the care of a psychologist, psychiatrist or psychiatric clinic? ☐Yes ☐No
If "Yes", please explain: _____

Date of last Tetanus/Diphtheria/Pertussis booster-Tdap (must be within 10 years) _____

RELEASE AUTHORIZATION

NURSING STUDENTS / FACULTY ONLY **CONFIDENTIAL**

I affirm that I have completed Sections I and II of the Health Report completely and accurately. By signing this form, I hereby authorize NCCC to disclose, as needed, any and all of my health-related records to: clinical and community facilities and agencies that I will be assigned to; College program faculty, staff and administrators who have legitimate educational interest in this information; and emergency and other medical personnel in a medical or medical emergency situation. I also assume full responsibility for my participation in clinical and community experiences, releasing the College from any and all liability. I further understand that if at any time during the semester my health conditions change or I am involved in an accident that affects my ability to provide care, I will notify NCCC Records Office immediately.

_____ _____

Date: _____

Name (Please Print) **Required** Student / Faculty Signature **Required**

Physician's Evaluation

Please print or type all information. Thank you.

CONFIDENTIAL **III. PHYSICAL EXAMINATION** **CONFIDENTIAL**

PPD Test must be completed every 12 months: 2 step PPD below-

Step 1. Tuberculin Skin Test (PPD) Date: Administered_____

Date Read_____Results _____ Read by_____

Step 2. Tuberculin Skin Test (PPD) Placed 7 days **after** first PPD**, no later than 21 days**. Date: Administered_____

Date Read_____ Results _____ Read by _____

(Must be read in mm induration, not simply as negative or positive)

➔ SIGNATURE AND TITLE OF HEALTH CARE PROFESSIONAL READING THE PPD (MANTOUX):

_____ _____ _____

Signature/Title Date Name *(please print)*

Address_____

Phone Number (with area code) _____

If positive, a chest x-ray must be provided Date: _____ Results: _____

Did patient have treatment for the positive skin test? ☐Yes ☐No

Drug:_____ Date started:_____ Date completed:_____

B. FOR ALL APPLICANTS — CONFIDENTIAL

Name of student: _____ Date of Birth:_____ (mm/dd/yyyy)

★ PHYSICIANS: Please complete **ALL** sections of this form. **It cannot be accepted unless completed.**

Sex: ☐Male ☐Female	Height:	Weight:	Blood Pressure:

CLINICAL EXAMINATION Check each item in proper column.	**NORMAL**	**ABNORMAL**	**NOTE:** Give details of each abnormality. Enter N.E. if not evaluated.
Metabolic Endocrine System			
Musculoskeletal System			
Neuropsychiatric System			
Abdomen / Pelvic			
Respiratory			
Cardiovascular System			
Gastrointestinal System			
Head			
Neck			
Eyes			
Ears			
Nose			
Throat & Teeth			
Breasts			
Genito-Urinary			
Extremities			
Skin			

RECOMMENDED:

Lab tests at Physician's discretion:	***Hemoglobin or Hematocrit:***	***Urinalysis:***	***Other:***

Is this student able to participate in all physical activity to include one or more of the following: Clinical Hospital Experience, Extended Wilderness Trips and Camping Experiences, Physical Education, Intramural or Intercollegiate Sports Competition.
☐Yes ☐No If "No" what activities are to be eliminated?

_____

Is there (or has there ever been) evidence of anxiety or emotional instability?
☐Yes ☐No If so, please indicate how the College may be of help to this student.

_____

After considering the history and physical examination, what is your professional opinion of this applicant's ability to meet the physical and emotional demands of college life?

_____

Do you recommend further investigation or treatment?
☐Yes ☐No If "Yes" please explain.

NAME OF EXAMINING PHYSICIAN (PLEASE PRINT)		PHONE	
STREET	CITY	STATE	ZIP
➔ **SIGNATURE OF PROVIDER**		**DATE**	