

AKRON REGIONAL HOSPITAL ASSOCIATION

**ANNUAL TUBERCULOSIS/HEALTH ASSESSMENT STATUS FORM**

Please type in the information:

**PRINT NAME:** (Last) \_\_\_\_\_ (First) \_\_\_\_\_

In order to comply with the Department of Health and the Medical Staff policies and procedures, a Tuberculosis and Health Assessment verification must be completed annually for you no later than (date): \_\_\_\_\_

**ANNUAL TUBERCULOSIS SCREENING (Check all that apply)**

I had a Tuberculosis skin test on (date) \_\_\_\_\_ at (facility) \_\_\_\_\_

**Check all boxed that apply:**

<input type="checkbox"/> My skin test was negative
<input type="checkbox"/> My skin test was positive
<input type="checkbox"/> I have had a positive skin test in the past or history of BCG/Tuberculosis
<input type="checkbox"/> I had a chest x-ray on (date) _____
<input type="checkbox"/> I have not had a chest x-ray
<input type="checkbox"/> I have <b>NOT</b> had any unexplained Tuberculosis-compatible symptoms within the past year

**ANNUAL HEALTH ASSESSMENT (Required by Ohio Dept. of Health for neonatal, maternity, OB/GYN patient care.)**

- I attest that I have had a health evaluation completed by a licensed practitioner on (date) \_\_\_\_\_
- No, I have not had a health evaluation. I am scheduled for a health evaluation on (date) \_\_\_\_\_
- I attest that I have immunity to measles, mumps, rubella, chickenpox, and Hepatitis B. (It is only necessary for documentation of this to be provided once with the initial application. Need history of disease or record of immunization or titer.)
- I do not have any condition that predisposes me toward acquiring or transmitting infectious diseases.

**ARE YOU A NEONATAL RESUSCITATION PROVIDER?**

If yes, are you currently NRP certified?

- Yes
- No
- Yes
- No

**MARK AN "X" to the hospital you are submitting this form AND**

It is the applicant's responsibility to sign your name, print your name, date, and fax or mail this form to **EACH** and **EVERY** hospital in which you are currently practicing.

<u>HOSPITAL</u>	<u>FAX NUMBER</u>	<u>HOSPITAL</u>	<u>FAX NUMBER</u>
<input type="checkbox"/> Affinity Medical Center	330-830-6928	<input type="checkbox"/> Robinson Memorial Hospital	330-297-8463
<input type="checkbox"/> Akron General Health System		<input type="checkbox"/> Regency Hospital of Akron/Ravenna	330-564-2121
<i>Akron General Medical Center</i>	330-344-5799	<input type="checkbox"/> Select Specialty Hospital- Akron SHS	330-375-4218
<i>Lodi Community Hospital</i>	330-948-5545	<input type="checkbox"/> Summa Health System	330-375-4047
<i>Edwin Shaw Rehab</i>	330-784-4201	<input type="checkbox"/> <i>Akron City Hospital</i>	
<input type="checkbox"/> Akron Children's Hospital	330-543-3834	<i>St. Thomas Hospital</i>	
<input type="checkbox"/> Aultman Hospital	330-580-6696	<i>Barberton Hospital</i>	330-615-3112
<input type="checkbox"/> Medina Hospital	330-721-4902	<input type="checkbox"/> <i>Wadsworth Rittman Hospital</i>	330-335-6938
		<input type="checkbox"/> <i>Western Reserve Hospital</i>	330-971-7040

Please sign, print your name and fax to the hospital(s) listed above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print your name: \_\_\_\_\_