NYS DOH Veterans Homes
Mandatory Annual Health Reassessment Form

Name: (Last) _____ (First) _____ (MI) _____

Department: _____ Contact Phone #: _____

Allergies:

☐ I have no known allergies.
☐ I have the following allergies: _____

Medical Conditions:

☐ I have not had any medical conditions/illnesses over the past year that required repeated visits to my medical provider(s) and/or required hospitalization.
☐ I have had medical conditions/illnesses over the past year that required repeated visits to my medical provider(s) or required hospitalization. These include:

_____

_____

Infections and Rashes:

☐ I have no current infectious diseases and/or infected skin lesions.
☐ I currently have the following infectious diseases and/or infected skin lesions:

_____

Injuries or Limitations:

☐ I have no known injuries or limitations that affect my performing the duties of my job.
☐ I have the following known injuries or limitations that affect my performing the duties of my job:

_____

Accommodations:

I can perform the job tasks and functions essential to my job:
☐ without accommodations.
☐ with accommodations*.

*If you have or need to request an accommodation, please indicate what specific accommodations are needed and the reason why they are necessary:

_____

_____

_____

_____

_____ _____
Signature Date

Employee Health Team Review and Education:

☐ Key infection control related protocols reviewed (e.g., not reporting to work when ill with communicable illness; reporting exposures to communicable illnesses such as COVID-19, influenza, and RSV; compliant hand hygiene performance to prevent the spread of germs; etc.).

☐ Annual tuberculosis education provided.

☐ Immunization status (e.g., influenza; COVID-19; pneumococcal) reviewed and offered as indicated.

☐ Annual respirator medical questionnaire review and fit testing completed (if respirator use is applicable to the employee's role).

☐ Employee health chart reviewed and updated as indicated.

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_____ _____

Signature Date

Medical Provider Review/Comments (if indicated):

☐ I have reviewed the employee's responses and employee health team documentation.

☐ The employee denies health concerns or significant changes in health that would interfere with the performance of assigned occupational tasks or pose a risk to residents or personnel.

☐ I have advised the employee to follow up with their PCP to discuss identified health concerns and/or immunization recommendations.

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Signature Date