Email the completed form in PDF format to the program Chair and Director of Clinical Education

PA STUDIES
HEALTH CLEARANCE FORM
CLINICAL YEAR

NEW YORK INSTITUTE OF TECHNOLOGY
School of Health Professions

To be completed by student:

Name: _____ Date of Birth: _____
(First, Middle Initial, Last) *(Month, Day, Year)*

I understand and accept that

- the healthcare facilities that I may be assigned to for clinical rotations or other patient experiences, have health clearance and immunization requirements for their healthcare workers as a condition of employment. As a guest in their facilities, the New York Institute of Technology Physician Assistant Studies (New York Tech, PA Studies) program's student participants must comply with all healthcare screening and other requirements imposed as a condition of the healthcare affiliation agreement.
- if I am unable to obtain a health clearance or immunizations due to personal, religious or medical* reasons, New York Tech's PA Studies program cannot guarantee placement at a clinical site and this may limit my ability to successfully complete and graduate from the program as completion of all clinical rotations is required for successful completion of the program.

*In some situations the clinical site might accept certain medical reasons for not receiving a vaccination but this will be at the discretion of the site.

Student's Signature (Required): _____ Date: _____

To be completed by health care provider:

I have performed an evaluation of the above named individual and reviewed their recent laboratory tests.

I find him/her to be in good health. He/she is free of any health issues or impairment which may pose a potential risk to personnel, patients or family, and which may interfere with the performance of clinical responsibilities. Habituation to alcohol or other drugs which may alter the individual's behavior has been considered in this evaluation. **To the best of my knowledge, this student is able to fully participate in clinical clerkship education at all medical facilities.**

Address Stamp of Provider/Health Facility (Required)

_____ _____
Signature of Evaluating PA, Physician or Certified Nurse Practitioner *Health Evaluation's Date of Completion*

_____ _____
Print or Type Name *Telephone Number*