

Physician Attestation of Medical Fitness To Provide/Observe Patient Care For 90 Days or Less

Ple	Submit to Workforce Please print legibly	Health & Safety
	Physician Name:	Circle one: (Attending/Fellow/Resident)
Da	Date of Birth://Email:	Phone:
Ca	Campus Affiliation	
Vis	Visit start date:/ & end date:// (f	or 90 days or less)
Dir	Direct Supervisor's Name for the visit:	and Department Name:
Dir	Direct Supervisor's Email:	and Phone:
	In support of my application for temporary privileges, I atte 1. During this visit I will be (check one): □ observing patient care □ providing patient care directly (visitors hosted	
ab	If providing patient care directly, I currently possess a licen able to practice medicine in New York pursuant to an exen Law section 6526 (a copy of which is set forth on the back c	nption listed in, and as limited by, New York Education
2.	 I am immune to the following infectious diseases become received vaccination or have a positive titer:	
3.	3. I do not have active tuberculosis and regularly participa	te in a workforce tuberculosis surveillance program.
4.	 I have been offered Hepatitis B vaccination and (check on a completed the series of H □ have accepted and completed the series of H □ declined Hepatitis B vaccination and signed the series of H 	epatitis B vaccinations
5.	 I am fully able to adhere to standard precautions respiratory hygiene/cough etiquette and safe infection 	
6.	 I do not take prescribed or unprescribed drugs that main such a way that could pose a hazard to patients. 	ay impair my cognition, judgment, or physical dexterity
7.	7. I have the following other past medical history not men	tioned above:
8.	the vaccine or are exempt for religious reasons. a. For this flu season I have (check one):	of last flu vaccination:// And I will obtain New

□ Have a documented medical contraindication to the vaccine or are exempt for religious reasons, and I agree to adhere to standard precautions, when applicable: personal protective equipment, respiratory hygiene/cough etiquette and safe infection practices.

9. Regarding the COVID-19 vaccine, are you **fully vaccinated** (e.g. 2 doses of Pfizer/Moderna primary series or 1 dose J&J Janssen vaccine)? □ YES □ NO

11. COVID-19 vaccine is required, unless you have a documented medical contraindication to the vaccine. Please list your COVID-19 vaccine information below. Note: If you received the Johnson & Johnson vaccine you must have one dose documented (and getting a booster is recommended), whereas for Moderna & Pfizer, two doses must be documented (and getting a booster is recommended):

COVID-19 vaccine name:	; dose #1 date://; Lot#
COVID-19 vaccine name:	; dose #1 date://; Lot#
And optional Booster COVID-19 vaccine name:	Date:/; Lot#

□ Have a documented medical contraindication to the vaccine, and I agree to adhere to standard precautions, when applicable: personal protective equipment, respiratory hygiene/cough etiquette and safe infection practices.)

I, Dr. ______, understand that to be granted temporary privileges at New York-Presbyterian Hospital, I must be free of any health impairment, including habituation or addiction to alcohol or drugs or other behavior altering substances, that could pose a potential risk to patients or impede my ability to perform my duties. I hereby attest that I am free of any such impairment.

Physician Signature *Date cannot be earlier than 3 months prior	Date*: • to your start date.				
		:=====		====	
WHS Reviewer Name:	_Signature:		Date reviewed:	/	_/

New York State Education Law

§ 6526. Exempt persons

The following persons under the following limitations may practice medicine within the state without a license:

1. Any physician who is employed as a resident in a public hospital, provided such practice is limited to such hospital and is under the supervision of a licensed physician;

2. Any physician who is licensed in a bordering state and who resides near a border of this state, provided such practice is limited in this state to the vicinity of such border and provided such physician does not maintain an office or place to meet patients or receive calls within this state;

3. Any physician who is licensed in another state or country and who is meeting a physician licensed in this state, for purposes of consultation, provided such practice is limited to such consultation;

4. Any physician who is licensed in another state or country, who is visiting a medical school or teaching hospital in this state to receive medical instruction for a period not to exceed six months or to conduct medical instruction, provided such practice is limited to such instruction and is under the supervision of a licensed physician;

5. Any physician who is authorized by a foreign government to practice in relation to its diplomatic, consular or maritime staffs, provided such practice is limited to such staffs;

6. Any commissioned medical officer who is serving in the United States armed forces or public health service or any physician who is employed in the United States Veterans Administration, provided such practice is limited to such service or employment;

7. Any intern who is employed by a hospital and who is a graduate of a medical school in the United States or Canada, provided such practice is limited to such hospital and is under the supervision of a licensed physician; or

8. Any medical student who is performing a clinical clerkship or similar function in a hospital and who is matriculated in a medical school which meets standards satisfactory to the department, provided such practice is limited to such clerkship or similar function in such hospital.

9. Any dentist or dental school graduate eligible for licensure in the state who administers anesthesia as part of a hospital residency program established for the purpose of training dentists in anesthesiology.