Effective Academic Year 2009-2010.

All non-matriculating students must complete a Medical Status Form prior to the dates noted below:

Deadlines for Submission:
- Autumn 2009 Term: Friday, September 18, 2009
- Winter 2010 Term: Friday, January 15, 2010
- Spring 2010 Term: Friday, April 16, 2010

Please return the form to Student Health Center (SHC) at the address below:

BY PERSON:

Center for Advance Medicine (CAM) Building
17 East 102nd Street, East Tower, 5th floor - room 241, New York, NY 10029

The SHC is open
- Monday through Wednesday from 8:30 A.M. to 4:30 P.M.
- Thursday 8:30 A.M. to 3:30 P.M. (SUMMER HOURS)
- Thursday 10:00 A.M. to 5:45 P.M. (ACADEMIC YEAR)
- Friday 8:30 A.M. to 3:30 P.M.

If you have any questions, please feel free to contact Ms. Jeanine Burrell, R.N.C. at Tel: (212) 241-6023 or you may e-mail her at: jeanine.burrell@mssm.edu

BY FAX:

Fax:(212) 241-8008

BY MAIL:

Student Health Service
One Gustave L. Levy Place - Box 1260
New York, NY 10029
MOUNT SINAI SCHOOL OF MEDICINE MEDICAL STATUS FORM
Non-Matriculated (Non-Degree) Students

Program (please check):  □ Clinical Research Education Program  □ Master of Public Health

First Name:__________________________  Last Name:__________________________

Address:_______________________________________________________________________________

Telephone:__________________________  E-mail:___________________________________

Please have your health care provider fill out the form and return to:

Student Health Service
One Gustave Levy Place - Box 1260
New York, NY 10029

Fax: (212) 241-8008  Tel.: (212) 241-6023

1. Measles (Rubeola) or MMR  Dose #1___________  Dose #2___________  OR  (date)  (date)
   Confirmed Immunity by blood titer  Date of test: ____________  Results: ______________

2. German Measles (Rubella)  Dose #1___________  OR
   Confirmed Immunity by blood titer  Date of test: ____________  Results: ______________

3. Mumps  Dose #1___________  OR
   Confirmed Immunity by blood titer  Date of test: ____________

4. Varicella (Chicken-pox)  Dose #1___________  Dose#2___________
   History of disease   Yes__________       No__________

5. PPD (Mantoux Skin Test/Tuberculosis Testing)  Date Planted:___________  Date Read:___________
   PPD must be within one year
   Result: Negative ________ mm       Positive__________ mm  OR
   If history of Positive PPD- Dates of INH treatment: ____________ and or date of CXR ____________
   (Must be in last year)

Health Care Provider Signature:___________________________________  Date:________________________

Health Care Provider Name:_______________________________________ Telephone# __________________

Health Care Provider Address:__________________________________________________________________

Student Health use only:

Cleared______________           Not cleared_____________

Explanation:_______________________________________________________________________________________

Date:______________________  Signature:_____________________________________________________