WEILL MEDICAL COLLEGE OF CORNELL UNIVERSITY
HEALTH STATEMENT FOR VISITING INTERNATIONAL MEDICAL STUDENTS

This form must accompany the application for all electives at all affiliated hospitals of the Weill Medical College.

Name of Applicant: ____

Date of last physical examination: ____
(Month /Day/Year)
Statement regarding general health: ____

Applications for rotations including clinical experience at affiliated hospitals of the Weill Medical College of Cornell University must present the following information.

Results of tests and x-rays:

1.**Tuberculin Test:** Note: if previously negative, PPD must be repeated within **1 year** prior to beginning of the rotation. Test should be P.P.D. 0.0001mg. Mantoux technique.

Date: ____________________________________ Result: ____
(Month/Day/Year)
Negative tuberculin test- No chest x-ray required. Positive tuberculin test- Chest x-ray required.

Date of x-ray _____________________________________ Result: ____________________________________
(Month/Day/Year)

2.Varicella titer done: Date ________________________ Result: _____________________________________
(Month/Day/Year)

3. **Rubella titer done:** Date _________________________ Result: _____________________________________
(Month/Day/Year)
(If negative, rubella vaccine must be given, unless contraindicated on medical grounds)
Rubella vaccine administered unless contraindicated: Date: ______________________ Result: ________________
(Month/Day/Year)

4. **Measles titer done:** Date _________________________ Result: _____________________________________
(Month/Day/Year)
(If negative, measles vaccine must be administered in two doses at least 30 day apart:
1) Dose #1 Date: ________________________________ 2) Dose #2 Date: _______________________________

5. **Mumps:** Date: ____________________________________ Result: ___________________________________
(If negative, mumps vaccine must be given, unless contraindicated on medical grounds)
Rubella vaccine administered unless contraindicated: Date: ______________________ Result: ________________
(Month/Day/Year)
6. **Hepatitis B titer done:** Date: _______________________ Result: ___________________________________
(Month/Day/Year)
(If negative, three doses of vaccine must be given or a signed declination provided:)
Hep B vaccine administered: Dose #1: ___________________ Dose #2 ________________ Dose #3 ____________
(Month/Day/Year) (Month/Day/Year) (Month/Day/Year)

or I decline to take Hepatitis B Vaccine: ________________________________ ______________________________
Applicant's Signature Date:

Signature of Physician: ____ Date: _________________________

Print Name: _____________________________________Title: _____________ License # ______________________

Address: ____