NewYork-Presbyterian

Updated April 2022

Health Care Industry Representative (HCIR)

Attestation of Medical Fitness and Confidentiality & Non-Disclosure Statement

Instructions for completing this form

1. Applicability

a. This form is to be completed by any HCIR planning to visit New York Presbyterian Hospital, NewYork-Presbyterian/Hudson Valley Hospital, NewYork-Presbyterian/Queens or NewYork-Presbyterian Brooklyn Methodist Hospital (each a "Hospital") for business purposes who is not required to register with Hospital's vendor credentialing service, currently Symplr, according to Hospital policy.

b. You may use this form to enter Hospital property if you meet the following criteria:
   i. You are a HCIR who will be visiting Hospital for a defined period of less than 30 consecutive days, or
   ii. You are a HCIR who will be visiting Hospital less than twelve (12) times per year, or
   iii. You are a HCIR visiting from a foreign country and meet the above criteria

c. HCIRs who may meet the above criteria and complete this form may include: educators, corporate officers, clinical trial monitors, engineers, consultants, visiting physicians, entertainers, temporary/substitute sales and/or service personnel.

2. Information Required

a. You must complete this form in its entirety and sign it. Incomplete forms will not be accepted.

b. You must include the exact date(s) of your expected visit. You will not be permitted access on any other date not included on this form.

c. All information provided is confidential. Completed forms will be filed with the Hospital's HCIR Credentialing Administration and Workforce Health and Safety Department.

d. Your signature is required as acknowledgement that the information you provide is complete and accurate and that you agree to the terms and conditions included with this form. Electronic signatures are not accepted.

3. Approval

a. You must obtain a signature from the Hospital or medical school department ("Host Department") that will be acting as your host during your visit. The Host Department will be responsible for your access to Hospital premises and your activity while you are on Hospital premises.

b. After the Host Department signs your form, it must be submitted to the HCIR Credentialing Administrator at vendorcred@nyp.org.

4. Expiration

Your access to Hospital premises expires on the earliest of the following to occur: (i) the latest date listed on this form for your visit, (ii) one year from the date of the influenza vaccination indicated on this form, or (iii) one year from the date of the tuberculosis screening indicated on this form.

5. Visiting NYPH

a. Upon arrival at Hospital premises, you must present a completed and signed copy of this form to Hospital Security at one of the designated HCIR entrances.

b. Hospital Security will issue you a dated day pass upon presentation of the signed copy of this form.

c. You will not be permitted access to Hospital premises on any dates not listed on the signed copy of this form.

d. You will be required to keep a signed copy of this form with you at all times while on Hospital premises.

6. Questions

Please e-mail the HCIR Administrator at vendorcred@nyp.org.

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This form must be completed and submitted to vendorcred@nyp.org at least three business days prior to your visit to the Hospital indicated below. You will receive a response within two business days.

I plan to visit the following Hospital:

☐ New York Presbyterian Hospital ☐ NewYork-Presbyterian/Hudson Valley Hospital

☐ NewYork-Presbyterian/Queens ☐ NewYork-Presbyterian Brooklyn Methodist Hospital

The purpose of my visit to the Hospital indicated above is to:

☐ To Provide Patient Care ☐ To Observe Patient Care ☐ To Provide Services Other Than Patient Care

I understand that in order to be granted temporary clinical privileges at, or access to, the Hospital based upon the above selected category, 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, staff, and/or visitors. I hereby attest that I am free of any such impairment. I also attest, acknowledge and agree that:

Medical Attestation

1. I am immune to the following infectious diseases because I have either contracted the disease(s) or have received vaccination (check all that apply):
   ☐ Measles ☐ Rubella ☐ Varicella

2. For the current flu season (check one):
   ☐ I have received the influenza vaccination. ***Date of last flu vaccination:*** _____
   ☐ I have declined the influenza vaccination, and if I declined vaccination I agree to wear a surgical mask in designated areas during the "masks on" period designated by the New York State Commissioner of Health.

3. I do not have active tuberculosis and:
   ☐ I participate in a regular workforce tuberculosis surveillance program and I have been screened for tuberculosis in the last 12 months. ***Date of last tuberculosis screening:*** _____
   ☐ I do not participate in a workforce tuberculosis surveillance program.

4. I do not have Hepatitis B and (check one):
   ☐ I have completed the series of vaccinations for Hepatitis B.
   ☐ I have declined Hepatitis B vaccination and signed the OSHA declination form.
   ☐ I have not been offered the Hepatitis B vaccination.

5. For COVID-19 (check one):
   ☐ I have received the COVID-19 vaccination.
   Date(s) of vaccination: _____ ***Date of booster (if eligible):*** _____
   ☐ I have a medical exemption and I have tested negative for COVID-19. ***Date of negative test:*** _____

6. I am fully able to adhere to standard precautions, when applicable: Personal Protective Equipment, Respiratory Hygiene/Cough Etiquette and Safe Injection Practices. Please also see Infection Control on this form.

7. I do not take prescribed or non-prescribed drugs that may impair my cognition, judgment, or physical dexterity in such a way that could pose a hazard to patients, staff, and/or visitors.

8. I have not traveled to a CDC designated Ebola Virus affected country in the past 21 days. For a list of affected countries please see the CDC website: http://wwwnc.cdc.gov/travel/notices.

HCIR must wear company ID, retain this document when on Hospital premises and present when asked to do so. Copy of this form to be sent to Hospital Workforce Health & Safety by Host Department for record retention. **Your access to Hospital premises expires on the earliest of the following to occur: (i) the latest date listed on this form for your visit, (ii) one year from the date of the influenza vaccination indicated on this form, or (iii) one year from the date of the tuberculosis screening indicated on this form.**

9. In the 7 days, I have not had a fever, chills/rigors, cough, shortness of breath, sore throat, myalgia, diarrhea, fatigue, nasal congestion, headache, anosmia (loss of smell), or altered sense of taste.

10. I am aware of the Personal Protective Equipment (PPE) required for my visit and I will supply it for my own use on the date(s) of my visit.

Confidentiality and Non-Disclosure Statement

I acknowledge that incidental to activities that I may participate in during my visit; I may view or have access to confidential patient information or other personally identifiable information such as patient name, diagnosis, medical history, names of family members or any other information reasonably identified by Hospital as confidential patient information. I agree to hold the information in the strictest of confidence, and will not divulge or release any confidential patient information or other personally identifiable information to any third party without the express prior written consent of Hospital and the patient. I also agree to review and abide by the Hospital terms and conditions on this form.

Signature (HCIR Provider or Observer)	Date(s) of Visit
Print Name (HCIR Provider or Observer)	Company Affiliation
Business Phone Number	Email Address

Mailing Address

Host Department and Responsible Person

Host Department Head Signature	Host Department Head Email	Date

PLEASE SUBMIT FULLY COMPLETED FORMS, INCLUDING ALL SIGNATURES. FAILURE TO DO SO WILL DELAY PROCESSING.

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Hospital Terms and Conditions

We are committed to the safety of our patients, staff and visitors. Before you begin your visit, we ask you to review the following important information and agree, as affirmed by your attestation and signature on this form, to abide by the restrictions and guidelines outlined below:

Patient Centered Care/Principles of Behavior

We ask that all HCIRs provide service that is at the same standard that we expect of all of our employees. We ask you to be courteous and to show compassion and respect to all of our patients and their families, and our staff and visitors. We ask that you be mindful and respectful of cultural differences. We ask you to be collegial with all individuals and to accept and comply with direction given to them by staff who are designated as their supervisors.

Infection Control

We and our staff are vigilant about keeping our hospital clean and safe. We have extensive procedures to assure that we are doing all we can to prevent hospital acquired infections in our patients. Infection control is a critical issue for staff and all who visit our hospital!

Please be mindful of and observe the following:

- If on the day of your visit you are aware that you are ill with a communicable disease – even a cold – we ask that you forgo working with us on that day.
- Please observe our procedures regarding hand hygiene and universal precautions. Staff will show you where you can wash your hands. This must be done after every patient contact, after restroom visits and whenever your hands are soiled. If a patient is on any sort of isolation protocol, please do not enter the room until you have been instructed regarding any protective gear you should wear.

These procedures are critical for your safety and the safety of our patients, staff and visitors!

Safety Issues

We have an extensive fire safety program. Our staff are highly trained in what to do in case of fire. If you see smoke or fire in your work area, notify staff immediately and follow their instructions. We also have a program to promote patient and staff safety with regard to the use of chemicals and other agents. It is unlikely that you will encounter a chemical spill, but if you do, notify staff immediately and follow their instructions.

Accident/Incident Procedure

If you encounter an accident or witness an incident, or if you are involved in an accident or incident, whether or not an injury occurs, we ask that you notify staff immediately. Incidents will be documented using hospital forms and procedures by hospital staff. This is to promote all of our safety. If you are unsure as to whether an incident should be reported, notify staff and they will help decide if a report should be filed.

Security

We want you and your belongings to be safe while you are here. Please store your items in the location as instructed by staff. Keep your valuables with you or ask staff to have them secured in a safe place during your visit.

Patient Confidentially & HIPAA

Hospitals are governed by strict state and federal laws and regulations regarding the protection of patients' privacy and confidentiality. As a result of your visit, you may learn about patients' confidential medical and personal information. You are strictly prohibited from sharing any such information with anyone else, except those directly involved in caring for the patient. Please observe this rule at all times. Be mindful of where you are having conversations (e.g. elevators, corridors, etc.).

We also ask that you help us to preserve our patients' dignity and privacy. When working with patients, make sure that they are comfortable and covered. Help to keep curtains drawn and doors closed when necessary to preserve confidentiality and privacy. If you are uncertain about what to do, notify our staff.