# Annual Self-Health Assessment Form

In order to comply with New York State Department of Health Regulation 766 *"an **annual**, or more frequent if necessary, health status assessment is required to assure that all personnel are free from any health impairment that is of potential risk to the patient, family or to employees or that may interfere with the performance of duties. The assessment shall be of sufficient scope that no person shall assume his/her duties unless he/she is free from a health impairment which is of potential risk to the patient or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior*. "

The purpose of the **Annual Self-Health Assessment** is to ensure both your safety and our consumer's safety while performing the essential functions of your job. It is critical that you inform RCIL of any changes in your health status that could endanger you or the consumer(s) you are working with.

**Name:** _____ **Date of Birth:** _____

**Address:** _____

_____

**Telephone: (  ) _____ Email:** _____

***This form is required on an annual basis, one year from the date signed, every year that you are employed with RCIL/AHIC/LDA. There is no need to have a physical by a medical professional while completing this document. Please note, you are only required to complete this form and not a medical professional. However, depending on your current health status you might require medical clearance from a provider.***

**Date of last physical examination by medical professional? _____***

** Please be advised, there is no need to have a physical with this assessment.*

**Have there been any changes in your health since the date of your last physical or annual self -health assessment that would prohibit you from performing the essential functions of your job? Yes_____ No _____**
*If yes, list the active disease, or condition and describe your symptoms below. Please remember that the intent of the annual health assessment is to offer accommodations that will ensure your safety as well as the safety of the consumers we serve.*

_____

_____

**Is there anything in your current Health status that puts you or the consumer at risk? Yes_____ No _____**
*If yes, please explain:* _____

_____

**Are you addicted to or habitually uses depressants, stimulants, narcotics, alcohol, hallucinogenic or other drugs? Yes_____ No _____**
*If yes, please explain:* _____

_____

**I hereby certify that the above statements are true and answered to the best of my knowledge and ability.**
**I hereby certify that I am capable of performing my job duties.**

**Employee Signature** **Date**

**This form is valid for one year from the date signed above. Failure to submit this assessment annually will result in suspension from employment.**

**Please return this form to:** **rev:09/16**
**The Resource Center for Independent Living (RCIL)**
**Attention: HR Medical**
**PO Box 210; Utica, NY 13503-0210**
**Phone: 315-797-4642**
**Confidential Fax: 1(888) 959-4260**
**Email: hrmedical@rcil.com**

**Reviewed by RCIL/AHIC RN:** _____ **Date:** _____