

## Annual Self-Health Assessment Form

In order to comply with New York State Department of Health Regulation 766.11 “an **annual**, or more frequent if necessary, health status assessment 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: (     ) \_\_\_\_\_

Date of last physical examination by medical professional? \_\_\_\_\_

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 self-health assessment is to offer accommodations that will ensure your safety as well as the safety of the consumers you serve.

\_\_\_\_\_

Is there anything in your current health status that puts you or the consumer at risk?   **Yes** \_\_\_\_\_   **No** \_\_\_\_\_

If you checked Yes – please explain:

\_\_\_\_\_

Are you addicted to, or habitually use, depressants, stimulants, narcotics, alcohol, or other drugs or substances that could alter your behavior?

**Yes** \_\_\_\_\_   **No** \_\_\_\_\_

If you checked 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

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

Revised 9/16/11