QUEENSBOROUGH COMMUNITY COLLEGE | CUNY

Office of Health Services
Medical Arts Building, Room, MC-02
222-05 56th Avenue, Bayside, New York 11364-1497
Telephone (718) 631-6375 • Fax (718) 631-6330

Medical Requirements for Massage Therapy

Please submit **Two** copies and original of all material to Health Services. Health Services will **Not** make copies for you. Whiteout renders forms null and void.

– To be completed by Student –

Student Information (Please print):

CUNYFIRST ID No.: _____ Last four digits of S.S. No.: _____

Gender: Male _____ Female _____ Trans. (specify) _____ Other (specify) _____

Last Name: _____ First Name: _____ Birth Date: _____ /_____ /_____

Address: _____ City _____ State _____ Zip _____

E-mail: _____

Home Phone No.: _____-_____–_____ Cell No.: _____-_____–_____

– Below to be completed by Health Practitioner (MD, DO, NP, or PA) –

1. History and physical examination
2. Urinalysis
   - Routine and microscopy *(lab report required)* or chemical dipstick *(Health Practitioner note required)*
3. QuantiFERON-TB Gold *(lab report required)*
   - Chest x-ray report required only for **positive** QuantiFERON-TB Gold
4. Tdap (tetanus, diptheria, acellular pertussis) vaccination: Date _____ /_____ /_____
5. Influenza vaccination (for current season) Date: _____ /_____ /_____ Lot #: _____ Exp. Date: _____ /_____ /_____
6. Hepatitus B vaccination Date 1 : _____ /_____ /_____ Date 2 : _____ /_____ /_____ Date 3 : _____ /_____ /_____
7. Hepatitus B surface antibody (HBsAb) titer *(lab report required)*
8. Hepatitus B surface antigen (HBsAg) titer *(lab report required)*
9. Complete blood count (CBC) with differential *(lab report required)*
10. MMR (measles, mumps, rubella) vaccine Date 1 : _____ /_____ /_____ Date 2 : _____ /_____ /_____
11. Rubeola (measles) IgG titer *(lab report required)*
12. Mumps IgG titer *(lab report required)*
13. Rubella (German measles) IgG titer *(lab report required)*
14. Varicella IgG titer *(lab report required)*
15. Varicella vaccine Date 1 : _____ /_____ /_____ Date 2 : _____ /_____ /_____

Health Practitioner Signature _____

Health Practitioner Stamp Required (MD, DO, NP, or PA)

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