Supplemental B

Health Status. ***Please answer each of the following questions in full. DO NOT ANSWER THESE QUESTIONS if you are seeking to be employed by the credentialing entity.***

1. Do you currently have any physical or mental condition(s) that may affect your ability to practice or exercise the clinical privileges or responsibilities typically associated with the specialty and position for which you are submitting this Application? *If the answer to this question is "YES", please give full explanation of the specific details on an Explanation Form and attach to the Application.*

   ☐ Yes ☐ No

   (*Note: Physical or mental condition(s) include, but are not limited to, current alcohol or drug dependency, current treatment or monitoring programs for alcohol or drug dependency, medical limitation of activity, workload, etc., and prescribed medications that may affect your clinical judgment or motor skills.)*

2. Are you currently in a treatment or monitoring program(s) for a physical or mental condition that may affect your ability to practice or exercise the clinical privileges or responsibilities typically associated with the specialty and position for which you are submitting this application?
   If the answer to this question is "YES", please give a full explanation of the specific details, including dates of treatment or monitoring, on an Explanation Form and attach to the Application.

   ☐ Yes ☐ No

   (*Note: Physical or mental condition(s) include, but are not limited to, current alcohol or drug dependency, current treatment or monitoring programs for alcohol or drug dependency, medical limitation of activity, workload, etc., and prescribed medications that may affect your clinical judgment or motor skills.)*

3. Are you able to perform all the essential functions of the position for which you are applying, safely and according to accepted standards of performance, with or without reasonable accommodation? *If reasonable accommodation is required, please specify such on an attached Explanation Form.*

   ☐ Yes ☐ No

4. Please document your current TB status by checking the applicable boxes below:

   ☐ I have had a TB test within the last 12 months and the test was negative. Documentation attached. I have not experienced new risk factors for TB nor am I experiencing symptoms of active TB since my last TB test.

   ☐ I have had a history of previous infection with Mycobacterium Tuberculosis or a positive TB test but I since have had a chest x-ray which was read as normal. Documentation attached. I currently have no symptoms of active disease and have not experienced new risk factors for TB in the past year.

   ☐ I currently have active TB disease which is being adequately treated. Applicable documentation is attached.

   ☐ Other _____

5. The Colorado Board of Health requires licensed health care facilities to annually report their health care worker influenza vaccination rate and achieve a vaccination rate of at least 90%. To facilitate compliance with this rule, some health care facilities may require annual influenza vaccination of employees and staff.

☐ If this facility must comply with the Colorado Board of Health requirements, I agree to provide proof of influenza vaccination or a medical exemption before practicing at this facility.

Please print your name: _____

_____ _____

Signature Date

REMEMBER TO SAVE THE COMPLETED APPLICATION