PROMEDICA | Your health. Our mission.

HEALTH REQUIREMENTS FORM

It is the policy of ProMedica facilities to ensure learners meet the appropriate health requirements determined by Employee Health prior to placement in a ProMedica Facility. Please review and submit the information below in conjunction with your health care provider or learning institution.

TO BE COMPLETED BY LEARNER

Name: ____________________ Email: ____________________

Phone #: ____________ Name / # of Emergency Contact: ____________________

Sponsoring Institution/University/School: ____________________

Learner's Program of Study (i.e. Medical Student, Nursing, Pharmacy): ____________________

DOCUMENTED PROOF OF

Liability Coverage ($1M/$3) **Yes** ___ **No** | **Current CPR:** **Exp. Date:** ____________

REQUIRED PROOF OF IMMUNITY

VACCINE (series of 2 after the age of 1; at least 4 weeks apart, or proof of positive titer)

	Dates of Immunizations		Positive Immune Titer Date
Rubella	________	________	________
Rubeola	________	________	________
Mumps	________	________	________
Varicella	________	________	________

VACCINE (series of 3) Hepatitis B #1 ________ #2 ________ #3 ________

or, I declined to receive Hepatitis B Vaccination Series Initial Here: ________

ANNUAL INFLUENZA VACCINE

ProMedica requires influenza vaccination for individuals employed or accessing facilities for learning experiences. If you have a medical or religious reason for declining the influenza vaccine, please be aware that you will be required to submit decliniation forms and follow ProMedica's guidelines for masking during influenza season

Influenza, administered September - March Date of Most Recent Vaccine: ________

REQUIRED TB DOCUMENTATION:

TB Skin Test or T-Spot are required for all learners

Initial 2-Step PPD:

Date 1: ____________ Result: ______ mm Date 2: ____________ Result: ______ mm

TB Test is required annually for learners in a long term care environment

PLUS *documented proof of most recent annual PPD if initial 2-Step date is older than 12 months.*

Most Recent PPD (must be within the previous 12 months) Date: ____________ Result: ______ mm

TB skin reaction test greater than 10 mm; or positive blood test for TB, attached documentation confirming completion of treatment by physician with appropriate therapy for 6-12 months

OR

T-Spot / Quantiferon: Date: ____________ Result: ____________

FITNESS FOR DUTY

"The above named individual is fit for duty and free from communicable disease" Exam Date: ____________

ATTESTATION BY LICENSED HEALTH PROFESSIONAL (MD, DO, NP, PA) OR AUTHORIZED DESIGNEE FROM THE SPONSORING INSTITUTION

Attestation: I certify that the individual named above, meets the criteria established above for learning experiences at ProMedica

____________________ ____________________ ________

Printed/Name & Title Signature Date

PROCESSING INSTRUCTIONS:

Submit to your ProMedica affiliation coordinator.