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: _____ School ID #: _____

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.

05/15 OH approval format change 12/15)