CLINICAL SHADOW EXPERIENCE CLINICAL ATTESTATIONS

INFLUENZA ATTESTATION:

_____I certify that I have received the flu shot and have provided such records to the Employee Health Nurse.

Name (printed): _____

Signature of Individual: _____

Date Shot Received: _____

_____

_____I certify that I have NOT received the flu shot and agree to wear a mask while in patient care areas.

Name (printed): _____

Signature of Individual: _____

Tuberculosis Attestation: PROOF REQUIRED

_____ I certify that I have had a current Tuberculosis (TB) screening with appropriate documentation provided to the facility's employee health nurse.

Screening is defined as: TB skin testing and results, or documentation supporting positive testing with Chest X-Ray report.

Name (printed): _____

Signature of Individual: _____

Date of Screening: _____

Results: _____Negative _____ Positive / Chest X-Ray

Comments:

_____

_____

OHS Employee Health Nurse acknowledgement of receipt of the TB screening information:

_____ _____

Date of receipt Employee Health Nurse signature