SHC Non-Hospital Employee MEDICAL CLEARANCE FORM FOR MEDICAL CENTER ACCESS (MDs, Visitors, Students)

Name (Print) Last	First	Middle
Preferred Phone Contact	Preferred e-mail Contact	DOB
Sponsoring Department	Sponsor Contact Name	Sponsor Phone Number
Period of time present at SHC	Start Date	End Date

IMMUNIZATIONS HISTORY

☐ **Visiting Faculty USA Hospital credentialed:** ☐ ***Yes*** letter of compliance adequate.

☐ **Visiting MD Foreign and all other visitors:**

Official medical records required. Reported history is not adequate.

1. Varicella (Chickenpox) ☐ Pos. Titer or ☐ Evidence of 2 Varicella vaccines
2. Measles ☐ Pos. Titer or ☐ Evidence of 2 MMR vaccines
3. Mumps ☐ Pos. Titer or ☐ Evidence of 2 MMR vaccines
4. Rubella ☐ Pos. Titer or ☐ Evidence of 2 MMR vaccines
5. Flu Vaccine Nov 1 – March31 ☐ Yes date
6. Tuberculosis Screening Questionnaire ☐ Yes date:
   and **one** of the following within 1 year of visit
   a. Tuberculin Skin Test (TST) ☐ Yes date:
   b. Quantiferon Test (QFT) ☐ Yes date: or
   c. Chest x-ray for history of + TST or +QFT ☐ Yes date:

SPONSORING DEPARTMENT or OHS ATESTATION CERTIFICATION

☐ **Cleared for badge access. I certify that I have reviewed the records for _____ and attest that this person is in compliance to Title 22, and the CDC recommendations for Health Care Personnel. The information I have provided is true and complete.**		
Signature of Medical /Clinical Examiner	**Telephone**	**Department**
Medical/ Clinician Examiner Name	☐**MD** ☐**PA** ☐**NP** ☐ **RN**	
Medical /Clinician Provider License or Certification No.	**Date of Review: ___ / ___ / ___**	