

Job Shadowing/Observation Health Requirement Form
Medical Provider Certification Form

I, _____ certify that _____
Healthcare Provider (PRINT NAME) *Student Name (PRINT NAME)*

has completed the following immunization/test requirements for observation:

For observation in clinical and non- clinical areas

- Completed 2 dose series of MMR Vaccine
- OR** positive measles, mumps, rubella titer
- Completed 2 dose series Varicella Vaccine
- OR** positive varicella titer
- 2-step TB skin test within the past 12 months
- OR** Negative Chest-x-ray, Tspot blood test, or QuantiFERON Gold blood test
- Completed 3 dose series of Hepatitis B vaccine if working in exposure prone area-received or declined as per OSHA 29 CFR 1910.1030.
- Current flu vaccination (required between September and March)
- Complete Covid-19 vaccine series
 - o Name of Manufacturer _____ (Pfizer, Moderna, J&J)

Note: You will need to provide a copy of your COVID vaccination card.

Date: _____

Medical Provider Name (printed): _____

Medical Provider Signature: _____

Office Phone Number: _____

Medical Provider Office Name and Address:

PROVIDER STAMP HERE: