HEALTH CERTIFICATION FOR DIVISION OF EDUCATION PROGRAMS

NAME:_____________________________________
Social Security Number _________________
Department or Program ____________________

☐ Resident
☐ Medical Student
☐ PA Student
☐ Nursing Student
☐ Other _______________________

Welcome to Lehigh Valley Hospital & Health Network. We are dedicated to protecting you and our patients from infectious diseases. To meet the requirements set forth by LVHHN Policies and OSHA, you will need documentation for the following immunizations and tests before beginning your experience at LVHHN. <u>The Documentation that follows must be provided by a healthcare professional capable of certifying that the following requirements have been met.</u>

DISEASES		**IMMUNIZATION DATES***			**DOCUMENTED HISTORY OF DISEASE***	**TITERS***	
						Date	**Result**
Hepatitis B (for those with potential blood/body fluid contact)		(1)	(2)	(3)			(+) (-)
Varicella (chickenpox)		(1)	(2)				(+) (-)
MMR		(1)	(2)				(+) (-)
Measles (rubeola) (Only 1 dose required if born before 1957)		(1)	(2)				(+) (-)
Mumps		(1)					(+) (-)
Rubella		(1)					(+) (-)
Diphtheria/Tetanus Not required but please document last dose and update if necessary							
Other Vaccines not required but please document date if applicable	BCG						

Must have documentation of appropriate number of immunizations,* *<u>or</u>*** *documented history of disease* ***<u>or</u>*** *positive titer.*

Tuberculosis: Two TB skin tests within 12 months prior to your start date at LVHHN, and one of which is within 3 months of the start date:

Date #1:____/____/____ Result ☐ (+) ☐ (-)
Date #2:____/____/____ Result ☐ (+) ☐ (-)

Or if applicable
Date of first positive TB skin test: ____/____/____ ☐ INH Therapy ☐ Yes ☐ No
Chest x-ray within the past 6 months: ____/____/____ Result ☐ nl ☐ abnl

I hereby certify that___________________________________ is free from communicable diseases in the communicable state. This individual does not possess any health handicap or other physical limitation which would interfere with his or her ability to satisfactorily perform the duties to which assigned within the scope of duties normally performed in the role identified above. I also certify that the immunization/immunity/testing requirements, as listed above, have been fulfilled.

Health Care Provider's Signature_____________________________

Health Care Provider's Name (print)_________________________

Phone number__________________________________

Date:____

Visiting Residents must return this form to: Kimberly Cornwell, P.O. Box 7017, Suite 601 Allentown, PA 18105-7017

Medical Student must return this form to: Sherri White, P.O. Box 7107, Suite 601, Allentown, PA 18105-7017

Nursing Student must return form to: Donna Stout, P.O. Box 7017, Suite 601, Allentown, PA 18105-7017