



Student/Faculty Name: _____ Date: _____

Academic Affiliate: _____

Printed Name of Academic Affiliate Representative
OR Sponsoring AH Department Representative Name: _____

This Initial Attestation is required for all students. Attestation of the following requirements shall be provided prior to first assignment. Evidence of completion shall be immediately available by Academic Affiliate or Sponsoring AH Department, upon request.

Resume / Application / Interview Notes (if applicable) **Check if on file** _____

Skills Checklist/Competency tests (if applicable) **Check if on file** _____

I-9 / Work / VISA permit (if applicable) **Check if on file** _____

Primary Source Verification of Licensure / Registration / Certification (if applicable) **Expiration Date** _____

Criminal Background Check Report - Associated with enrollment in current academic program with no more than 4 months break in active enrollment, or hire date with school **Date Completed** _____

Contingent Worker (CWR) Staff Orientation Packet* **Date Completed** _____

Proof of Negative 5 panel Drug Test - Associated with enrollment in current academic program with no more than 4 months break in active enrollment, or hire date with school **Date Completed** _____

"Employee/Student or Faculty Rotation Understanding" has been signed **Date Completed** _____

Flu shot for current flu year (or signed waiver if refused) **Declined or Date Completed** _____
(If refused, CWR Staff must wear a mask during months of Oct, Nov, Dec, Jan, Feb & March)

COVID 19 shot (signed waiver if declined for approved Religious or Medical exemption) **Declined or Date Completed** _____

CWR's WORKING IN PATIENT CARE AREAS OR WITH ITEMS THAT WILL BE USED BY PATIENTS OR IN THE PATIENT'S ENVIRONMENT MUST ALSO MEET THE FOLLOWING REQUIREMENT

Complete Hand Hygiene Attestation Form **Date Completed** _____



Student/Faculty Name: _____

CWR's WORKING IN PATIENT CARE AREAS MUST ALSO MEET THE FOLLOWING REQUIREMENTS

Proof of MMR Vaccination **Check if on file** _____

Proof Varicella (chicken pox) vaccination or immunity by titer or history **Check if on file** _____

Hepatitis B (or signed waiver if refused) **Check if on file** _____

TB Requirement - Associated with enrollment in current academic program
with no more than 4 months break in active enrollment, or hire date with school **Date Completed** _____

Tetanus, Diphtheria, Pertussis (Tdap) (or signed waiver if refused) **Declined or Date Completed** _____

Annual Respirator Mask Fit Testing (within last 12 months) **Date Completed** _____

Signature of Academic Affiliate Representative
OR Sponsoring AH Department Representative

Date

*Forms provided by AdventHealth