AdventHealth

Central Florida and East Florida Divisions

INITIAL ATTESTATION FORM (Students & Instructors)

Legal Name: _____ OPID: _____ Date: _____ (mm/dd/yyyy)

Academic Affiliate Name: _____ Program of Study: _____

Academic Representative / Sponsoring AH Department Representative Name: _____

This Initial Attestation is required for all students and instructors. All elements are required unless in a non-patient facing rotation. Attestation of the following requirements shall be provided prior to the first assignment. Evidence of completion shall be immediately available by Academic Affiliate or Sponsoring AH Department, upon request.

The following requirements are associated with enrollment in current academic program with no more than 4 months break in active enrollment or on boarding with AdventHealth unless otherwise noted. All dates must be formatted as mm/dd/yyyy. AdventHealth audits school partners throughout the year. ***Your integrity in this process is required.***

Criminal Background Check Report — **Date Completed** _____
(Must report to AH any background check that comes back with a violation)

Proof of Negative 10-panel Drug Test — **Date Completed** _____

Flu Vaccine — **Date Completed** _____
- *Flu Season is October-March, Outside of Flu Season:* ☐
*(*Signed waiver if declined)* or
Date Declined* _____

TB Requirement — **Date Completed** _____
(within the last 12 months)

Respirator Mask Fit Testing — **Date Completed** _____
(within the last 12 months) ***or Non-Patient Facing*** ☐

Contingent Worker Orientation Manual — **Date Completed** _____
(within the last 12 months)

Primary Source Verification of Registration / Certification — **Expiration Date** _____
(*BLS/CPR is REQUIRED in all clinical care areas*)

Currently Holds a Professional License Yes ☐ No ☐ — **Expiration Date** _____

By checking the box, you are attesting these requirements are on file and current.

		Non-Patient Facing
COVID-19 Vaccination *(Signed waiver if declined)*	☐	
MMR Vaccination	☐	☐
Hepatitis B Vaccination	☐	☐
Tetanus, Diphtheria, Pertussis (Tdap) *(Signed waiver if declined)*	☐	☐
Proof of Varicella Vaccination *(or immunity by titer)*	☐	☐
Hand Hygiene Competency	☐	
Student & Instructor Rotation Understanding	☐	

_____ _____

Academic Representative / Sponsoring AH Department Representative Signature **Date**

Revised 11/11/2024