DOCTORS HOSPITAL OBSERVATION
MEDICAL CLEARANCE FORM

This is to certify that _____
has met/does not meet the immunization, screening, and physical criteria of Doctors Hospital listed below for observation of care :

____Two Tuberculin skin tests within the past 12 months or documentation of a chest x-ray for previous positive reactors; and

____ Proof of Rubella, Rubeola and mumps immunity by positive antibody titers or 2 doses of MMR; and

____ Varicella immunity, by proof of Varicella immunization or positive antibody titer; and

____ Proof of Hepatitis B immunization or declination of vaccine, if patient contact is anticipated; and

____ Proof of Seasonal Influenza Vaccine; and

____ Current Immunization Certificate for appropriate adult immunizations or proof of; and

____ Urine Drug Screen

By signing this document you are attesting that the above listed items have been satisfactorily completed and records are available if requested. Doctors Hospital may you to submit proof of the above to ensure compliance of this agreement.

_____ _____
Healthcare Provider Signature *Date of review by MSO*

_____ _____
Printed Name

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_____
Area where shadowing is taking place

Please fax back to the Medical Staff Office at 706-651-6774