KAISER PERMANENTE®

Healthcare Provider Attestation Form

HEALTH REQUIREMENTS FOR CONTINGENT WORKERS, STUDENTS, AND VOLUNTEERS
WHO WILL WORK IN A MEDICAL FACILITY

Name:

Kaiser Permanente Program:

☐ Intern ☐ Volunteer ☐ Student/Resident ☐ Shadow ☒Other: HPMG Career Shadowing

Anticipated Timeline: _____ to _____

Requested Shadowing Department(s): _____

These health requirements help reduce the spread of infectious disease to our members, patients, and staff. This also assures compliance with regional policies and regulatory agency requirements. Please reach out with any questions.

Approved career shadowers who have an infectious disease or do not feel well should not enter our facilities. Career Shadowers are to have their health care provider complete the below checklist, attesting that the career shadower meets the program requirements. Career shadowers are responsible for any expense incurred.

I certify that this person meets the following health requirements to participate in the above Kaiser Permanente Hawaii program (please check and list all that apply):

☐ (Required) Evidence of immunity by vaccinations or blood test:
- Mumps
- Rubeola
- Rubella

☐ (Required) Evidence of immunity by vaccinations or blood test:
- Varicella

☐ (If exposed to blood or bodily fluids) Evidence of immunity by vaccinations AND blood test:
- Hepatitis B

☐ (If reporting more than 10 hours a week) TB clearance for health care worker (within past 12 months), including risk assessment – **Date of TB Clearance**: _____

☐ (If reporting to an infant and pediatric population) Adult Tdap vaccination

☐ Current Season Influenza vaccination (shadowers must wear a surgical mask in patient care areas if not current)

☐ COVID-19 vaccinations – **All Vaccination Dates**: _____

Provider's Name:_____ Signature: _____

Company/Agency: _____ Phone Number: _____ Date: _____

Please return this form to your Kaiser Permanente Hawaii Program Coordinator