Marshall University Joan C. Edwards School of Medicine/ University Physicians & Surgeons, Inc.

Division of Graduate Medical Education

Pre-Training Documentation & Physical

This form is to be completed and submitted to the Program Coordinator with supporting documentation.

Name _____**DOB:** _____ **Program** _____

Mandatory Online Training - To be completed and certificate provided to program coordinator verifying documentation.

Blood Borne Pathogens Training Date _____ Certificate on file _____

Hazard Communication Training Date _____ Certificate on file _____

Preventing Sexual Harassment Date _____ Certificate on file _____

ACLS/BLS/ATLS Training (Copy of Certificate(s) attached). If any not applicable, please put N/A.

ACLS Date _____ BLS Date _____ ATLS Date _____

Immunization Record	**Completion Date/Dose 1**	**Date – Dose 2**	**Date – Dose 3**	**Results**
Hepatitis B Vaccine Series				N/A
MMR Vaccine 2 doses			N/A	N/A
TDaP Booster after 2005		N/A	N/A	N/A
TB Skin Test within the past year (BCG is not a contraindication)		_____ Negative _____ Positive		
If positive TB Skin Test:		Prophylactic treatment given		
		Date medication started		
Had chickenpox or received Varicella Vaccine	____ Yes ____ No	Date:		
The below section will be completed at the time of your physical except for your signature. Please bring any medications you are taking to your pre-employment physical.				
N95 Respirator/mask fit-tested		_____ Mask Number/Size		
Physical Completed	_____Date	Drug Screen Completed	_____Date	

Verified by_____ _____Date

Printed name_____ _____

Department of Family Medicine, Occupational Health Resident/Fellow Signature