Non-Employee Attestation Form and Signature Page

(Completion of this document is required before an ID badge will be issued)

Name: _____ DOB: _____ Date: _____

Primary Source Verification – IF APPLICABLE (*Not applicable for the Student Job Shadowing Program)* I attest that I hold a valid WV professional license, certification or registration as required for the services I will be performing if required by law or regulation. I further attest that a copy of primary source verification can be provided before I initially begin performing services at Cabell Huntington Hospital and primary Source Verification is available before my license, certification or registration expires.	_____ initial
FIT Test (*Not applicable for the Student Job Shadowing Program*) I understand that in order to go into a room where a patient is on airborne precautions I must wear a special N95 respirator mask. I attest that I will not enter that area unless I have been fit tested at Cabell Huntington Hospital.	_____ initial

ALL APPLICANTS MUST RESPOND TO THE NEXT TWO STATEMENTS

Orientation and Confidentiality Agreement I attest that I have read and understand orientation materials and that my duties and responsibilities to maintain confidentiality as set forth in the Cabell Huntington Hospital Confidentiality Agreement shall remain in effect even after my access to PHI ceases.	_____ initial
Physical and Functional Status I attest that I have no physical or mental disabilities that would prevent me from performing services at Cabell Huntington Hospital.	_____ Initial

ALL APPLICANTS (EXCEPT THOSE WHO ARE COVERED BY AN AFFILIATION AGREEMENT THAT INCLUDES ALL THE FOLLOWING) MUST ALSO RESPOND TO THE NEXT TWO STATEMENTS

Criminal Background Check (Not applicable for the Student Job Shadowing Program) I attest that I have completed a background check and provided proof of such to the Cabell Huntington Hospital HR dept.	
Drug Test (*Not applicable for the Student Job Shadowing Program*) I attest that I have taken and passed a 10-panel drug test and provided proof of such to the Cabell Huntington Hospital HR dept.	Initial

Initial

ALL APPLICANTS

By signing this form I acknowledge that I have a continuing obligation to screen on a daily basis and to self-quarantine if any of my answers to the screening questions is "YES" and to inform my clinical supervisor. I further acknowledge that this is for my health and safety as well as the health and safety of my patients and co-workers.

- Do you have any of these symptoms: fever, new cough, new shortness of breath, new body aches, new sore throat?
- Are you currently in quarantine or have a test pending for COVID-19?
- Have you had any close contact outside of clinicals with: A COVID-19 positive person or a person in quarantine or awaiting test results?
- Any travel: International or a cruise within the last 14 days?

Initial _____

ALL APPLICANTS (EXCEPT THOSE WHO ARE COVERED BY AN AFFILIATION AGREEMENT THAT INCLUDES ALL THE FOLLOWING) MUST ALSO PROVIDE EVIDENCE OF THE FOLLOWING:

• Influenza vaccination for the current flu season (October - March)
• Immunization records for the following:
  o Hepatitis B
  o MMR
  o Varicella
  o Tdap
These records will be reviewed by the CHH Occupational Health Department. I understand that I may be required to receive additional vaccinations and/or titers.
	initial

Release of Information & Attestation:

I authorize the use or disclosure of any health information listed on this page to Cabell Huntington Hospital. I understand that authorizing the use or disclosure of this health information is voluntary but may be a condition being able to perform services or otherwise conduct business with Cabell Huntington Hospital. Unless revoked, this authorization will be effective for no more than two years from the date signed.

I also attest that I have given correct information on this attestation form. I understand that if asked can provide verification of this information. I understand that providing false information will result in me no longer being able to perform services or otherwise conduct business with Cabell Huntington Hospital.

Written Name	Signature	Date

Revised May 2020