Health Requirements for WOC Clinical Experience

Student Name: ___________________________________________ Date of Exam: ________________

Is the applicant:

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Free from communicable/infectious disease?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Able to handle and lift patients?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have manual and finger dexterity?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have eye/hand coordination within normal limits?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Able to stand/walk for extensive periods of time?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Able to lift/carry items weighing up to 50 pounds?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Able to hear and have vision corrected to normal range?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Immunization Record (must have been administered within last 10 years or a titer is required; if available):

Hepatitis B Immunity:
- Documented positive/negative immunity status from positive titer on: (date) ________________ or,
- Declination of Hepatitis B Vaccine form signed and attached. or,
- Hepatitis Vaccination: Date of 1st vaccination ________________
  Date of 2nd vaccination ________________
  Date of 3rd vaccination ________________

Last Tetanus Diphtheria booster date: ________________ (strongly recommended if greater than 7 years)

Measles, Mumps, Rubella (MMR) Immunity:
- Laboratory evidence of immunity or positive titer on ________________ (date) (attach lab copy) or,
- Documentation of two (2) doses of live measles and mumps vaccine given at least 28 days apart and one (1) dose of live rubella vaccine. Please indicate if combined vaccination of MMR.
  Date of 1st measles & mumps vaccination ________________
  Date of 2nd measles & mumps vaccination ________________
  Date of live rubella vaccination ________________

Varicella (Chicken Pox) Immunity:
- Laboratory evidence of immunity or disease ________________ (date) (attach lab copy) or,
- History of varicella or herpes zoster based on physician diagnosis ________________ (date) or,
- Documentation of two (2) doses of varicella vaccine given at least 28 days apart.
  Date of 1st vaccination ________________
  Date of 2nd vaccination ________________

Tuberculosis (TB) (must be current within past 12 months):
- TB Skin Test Date: ________________ Result: ________________
- TB Gamma Interferon (blood draw) or,
- Quantiferon-B Gold- Tube Assay (QTF) or,
- History of positive PPD: CXR date ________________ (within one year).

Flu Vaccine (for clinical experiences during flu season months of October through March):
_______________________________________________________________________________________________

I hereby certify __________________________ is in a state of physical and mental health to participate in the didactic courses and that would allow safe clinical practice. The above information is true and correct. I willingly submit to all tests necessary to complete this examination. I authorize the release of information to the appropriate school personnel.

Medical Examiner Name (print): _________________________________________________
Medical Examiner Signature: ____________________________________________________
Medical Examiner Title: __________________________________________ Date: ______________
Student Signature: __________________________________________ Date: ______________