HEALTH CERTIFICATION

Please email the completed form to Occupational Health at **OccHealth@TrinityHealthOfNE.org**, **at least two weeks in advance of your start date.** Occupational Health requires a two-week lead time. Please do not follow up or request expedited review, as our Occupational Health team is processing requests as quickly as possible. Additional emails slow the review process.

For questions related to Health Clearance or Onboarding status, please contact: **Learners@TrinityHealthOfNE.org**

Student/School Information

Student Name: _____

School: _____

Course / Program: _____

TH Of NE Department contact: _____

Rotation Dates: _____ through _____

Organization Supervisor/Preceptor Information

Supervisor/Preceptor Name: _____

Title: _____

School: _____

*License #: _____

*License Expiration Date: _____

Project:_____

Rotation Dates: _____ through _____

Immunization Status Insert Date of Each Immunization, Date and Result of Titer, or Exemption/Declination	**TB Evaluation**	**Mumps**	**Rubella**	**Rubeola**	**Varicella Zoster**	**Hepatitis B**	**Influenza Vaccine**	**COVID-19 Vaccine**
Student Name:	Date completed:	Titer Date and Result: **OR** Vaccination 1 Date: **AND** Vaccination 2 Date:	Titer Date and Result: **OR** Vaccination 1 Date: **AND** Vaccination 2 Date:	Titer Date and Result: **OR** Vaccination 1 Date: **AND** Vaccination 2 Date:				
***School Supervisor/Preceptor Name:**								

*School Supervisor/Preceptor information is necessary only if school supervisor/preceptor will be onsite during educational experience.

If an exemption was granted for medical or religious reasons for the Influenza vaccine and/or COVID-19 vaccine, please indicate "Exemption" and the date it was granted.

This form must be signed by an authorized School official. Students cannot sign their own form.

I reviewed the vaccination information required for the Student and Supervisor/Preceptor noted above and affirm that the required vaccination documentation was presented to the School or the School has granted a medical or religious exemption for a vaccination. I also confirm Patient Rights was reviewed. I confirm I am authorized to sign this document on behalf of School.

_____

Name of Authorized School Official

_____ _____

Signature of Authorized School Official Date