

17-9509 Job Shadow Observation Health Screening Questionnaire

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JOB SHADOW/OBSERVATION HEALTH SCREENING QUESTIONNAIRE

Name: _____ Phone: _____

Job Role to be observed: _____

Requested Date of Job Shadow Experience: _____

Please complete the following questions and submit with your application to job shadow/observe. This will assist Charleston Area Medical Center, Inc. in minimizing any risk to you or our patients during your job shadow/observation experience.

PERSONAL HEALTH HISTORY:

1. Have you traveled anywhere within the last 8 weeks? If so, where: _____

2. List any chronic health problems or immune disorders: _____

3. List any allergies: _____

4. Describe any chronic skin conditions or open wounds: _____
_____5. Have you ever had any exposure with active tuberculosis? Yes No6. Have you had a positive TB skin test? Yes No7. Current PPD date _____ (Must be current \leq 1 year) Please submit result of PPD.
*** Must provide results from physician's office ***8. Have you ever had chicken pox? Yes No
*** Must provide proof of immunity, titer, or 2 vaccinations *****DATE:**
Required**TIME:**
Required**SIGNATURE:**
Required

IMMUNIZATIONS: All immunizations are required before approval of application. Please list immunizations for the following diseases and attach a copy of immunization records:

	Date Received	Date Received	Date Received
Measles, Mumps, Rubella (MMR)			(You must list 2 dates)
Varivax (chicken pox)			
Hepatitis B			
Polio			
Adult tDap			
Seasonal Flu Vaccine			

Observers should avoid being in patient care areas if they have relevant contagious respiratory, gastrointestinal or skin diseases.

I certify that the foregoing statements are true and complete.

Signature

Date

In addition, if applicant is < 18 years of age, please include parental or legal guardian signature below. We cannot accept electronic signatures.

I certify that the foregoing statements are true and complete.

Signature

Date

OFFICE USE ONLY – DO NOT WRITE BELOW THIS LINE

Health history
reviewed by: _____

Date _____