Brookwood Baptist Health

EXHIBIT C

HEALTH, BACKGROUND SCREENING AND DRUG SCREENING ATTESTATION

THIS FORM VERIFIES THAT ALL STUDENTS LISTED ARE IN GOOD STANDING

HEALTH OF PROGRAM PARTICIPANTS. School affirms the Program Participant(s) listed below have completed the following health screenings or documented health status as follows:

1. Tuberculin skin test within the past 12 months or documentation as a previous positive reactor or a chest x-ray taken within the past 12 months; and
2. Proof of Rubella and Rubeola immunity by positive antibody titers or 2 doses of MMR; mumps
3. Varicella immunity, by positive history of chickenpox or proof of Varicella immunization; and
4. Proof of Hepatitis B immunization or completion of a certification of declination of vaccine, if patient contact is anticipated.
5. Proof of the most current immunization against influenza strain(s) as recommended by the Centers for Disease Control or physician verification that the immunization(s) are contraindicated for the Program Participant.

BACKGROUND CHECKS. School has conducted a retrospective background check on all students assigned to the program and members of staff/faculty responsible for supervision and/or instruction prior to their participation in clinical activities. Unless Hospital is notified in writing, all background checks are negative.

The background check included the following:

1. Social Security number verification.
2. Criminal Search (7 years)
3. Violent Sexual Offender & Predator registry
4. HHS/OIG/GSA

BASIC LIFE SUPPORT (CPR). School affirms that the Program Participant(s) is current on their CPR certification.

DRUG SCREENS. School affirms that all Program Participant(s) are not under the influence of illegal drugs or alcohol. Such evidence shall include without limitation results of testing, prior to start of Program, for amphetamines, barbiturates, benzodiazepines, cocaine, marijuana, methadone, methaqualone, opiates, phencyclidines, and propoxyphene.

STAFF (who will be in clinical area or visiting students):

1. _____Orientation Completion Date:_____
2. _____Orientation Completion Date:_____

School acknowledges this information will be available to all Tenet affiliates as reasonably necessary.

SCHOOL INFO:

Name of School_____

Signature (School representative): _____

Title: _____ Date_____

Brookwood Baptist Health

EXHIBIT C ATTACHMENT
(Please type or print clearly)

School:_____

BBH FACILITY:_____

Discipline: _____

Dates of clinical rotation: _____

Attending Students with school email address.

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