Occupational Health - Observer Attestation Form

Please read this form carefully and obtain the information requested from your primary care provider, student health service or any other source that can provide documentation of your childhood or current immunizations.

This information should be provided to the MGH Non-Employee coordinator as soon as possible. Any delays in the provision of this documentation will delay your final service clearance to observer.

Please follow the steps below:

Bring the attached sheet to your Student Health Service or your primary care physician. Ask them to complete the information requested by filling out the form, signing the form with name and licensure, and dating the form OR by providing you with any form their service uses that contains all of the information requested (this could even be a computer printout). Immunity is defined as 2 MMR vaccines or blood work (titers) that indicate you are immune to these viruses.

Complete the TB symptom analysis and Flu vaccine attestation form below.

Present the completed form and proof of immunity to Measles, Mumps, and Rubella to your sponsor. Both of you will sign the form together attesting that the information is accurate and complete.

Dear Healthcare Provider,

Shortly, your patient _____, will begin service at the Massachusetts General Hospital, (MGH). In order to promote and maintain a safe environment for our employees and patients, the following information is needed prior to start of service. Please complete the information below to facilitate this process for your patient. If you have this information on a lab report, medical record, or database, a copy of the original documentation can be provided in place of this form.

Please fax or mail this form directly to the MGH Non- Employee coordinator: Fax number: (617) 724-6056.
Address: 165 Charles River Plaza, Suite 200, Boston, MA 02114. All information will be handled in a confidential manner. If you have any questions regarding the information below, please call the Occupational Health Service at (617) 726-2217.

Information Required:

I. *Vaccination Status:*

Dates of MMR vaccination: Date #1: _____ Date #2: _____

OR

Rubella Titer: Date_____ Results_____
Rubeola Titer: Date_____ Results_____
Mumps Titer: Date_____ Results_____

Date of last Td vaccination: Date _____ **OR** Date of last Tdap vaccination: Date_____
Dates of Hepatitis B vaccination (if provided): Date #1: _____ Date #2: _____
Date #3: _____
Additional doses and dates (if any): _____

OR

Hepatitis B Antibody Titer: Date_____ Results_____
Date of varicella vaccine (if any): Date #1:_____Date #2: _____

OR

Varicella Titer: Date_____ Results_____

II. *TB Status:*

TB skin test (Mantoux) #1: Date_____ Results_____
TB skin test (Mantoux) #2: Date_____ Results_____

Do you have a cough that has lasted longer than 3 weeks?	Yes	No
Have you spit up or coughed up blood?	Yes	No
Have you had an ongoing fever?	Yes	No
Have you lost weight without trying?	Yes	No
Do you sweat at night?	Yes	No

III. *Flu Vaccine*: **I attest that I have received the Flu Vaccine on_____. If I have not been vaccinated, I agree to wear a surgical mask when within 3 feet of a patient in a clinical area.**

If there is a history of a positive PPD skin test, please provide a chest x-ray report within the past year.

Observer Signature for Information Release: _____ Date_____

Provider Signature for Information Verification: _____ Date_____