



INITIAL ATTESTATION FORM STUDENT & FACULTY (CWR's) – GENERAL & ALLIED HEALTH

Student/Faculty Name: _____ Date: _____

Academic Affiliate: _____

Printed Name of Academic Affiliate Representative
OR Sponsoring AH Department Representative Name: _____

This Initial Attestation is required for all students. Attestation of the following requirements shall be provided prior to first assignment. Evidence of completion shall be immediately available by Academic Affiliate or Sponsoring AH Department, upon request.

Resume / Application / Interview Notes (if applicable) **Check if on file** _____

Skills Checklist/Competency tests (if applicable) **Check if on file** _____

I-9 / Work / VISA permit (if applicable) **Check if on file** _____

Primary Source Verification of Licensure / Registration / Certification (if applicable) **Expiration Date** _____

Criminal Background Check Report - Associated with enrollment in current academic program with no more than 4 months break in active enrollment, or hire date with school **Date Completed** _____

Contingent Worker (CWR) Student Orientation Packet* **Date Completed** _____

Proof of Negative 5 panel Drug Test - Associated with enrollment in current academic program with no more than 4 months break in active enrollment, or hire date with school **Date Completed** _____

Confirmation that Student/Faculty has answered "NO" to all 4 COVID-19 Questions **Date Completed** _____

"Employee/Student or Faculty Rotation Understanding" has been signed** **Date Completed** _____

Flu Vaccine for current flu year **Date Completed** _____

(Signed waiver if refused & CWR Staff must wear a mask during months of Oct, Nov, Dec, Jan, Feb & March)

CWR's WORKING IN PATIENT CARE AREAS OR WITH ITEMS THAT WILL BE USED BY PATIENTS OR IN THE PATIENT'S ENVIRONMENT MUST ALSO MEET THE FOLLOWING REQUIREMENT

Complete Hand Hygiene Attestation Form **Date Completed** _____

Complete Hand Hygiene Competency Validation Form **Date Completed** _____



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Student/Faculty Name: _____

CWR's WORKING IN PATIENT CARE AREAS MUST ALSO MEET THE FOLLOWING REQUIREMENTS

Proof of MMR Vaccination	Check if on file _____
Proof of Varicella (chicken pox) vaccination or immunity by titer or history	Check if on file _____
Hepatitis B (recommended - signed waiver if refused)	Check if on file _____
TB Requirement - Associated with enrollment in current academic program with no more than 4 months break in active enrollment, or hire date with school	Date Completed _____
Tetanus, Diphtheria, Pertussis (Tdap) (or signed waiver if refused)	Date Completed _____
Annual Respirator Mask Fit Testing (within last 12 months) (if applicable)	Date Completed _____

Signature of Academic Affiliate Representative
OR Sponsoring AH Department Representative

Date

*Forms provided by AdventHealth
** AdventHealth University Faculty exempt



COVID 19 QUESTIONS

Effective June 1, 2020, Students and Faculty are requested to attest to the below questions with the University Program Coordinator.

COVID-19 Questions

Please ask yourself the following questions:

1. Do you currently have a cough, fever, shortness of breath or difficulty breathing?
2. Have you had any international, cruise ship or domestic travel to a location with widespread community transmission within the past 14 days?
3. Have you had close contact with someone with known or suspected COVID-19 in the last 14 days?
4. Have you been tested for the COVID-19 within the past 14 days?

If you answered yes to any of the above questions or are experiencing any respiratory related symptoms, related to or un-related to COVID-19, you are **NOT** allowed to enter any AdventHealth facility until you are symptom free for **14 days**.

All students and faculty able to answer negative to the above will be asked to wear a facemask, and further tested upon entering the building to ensure they are fever free. While in the building you will be expected to follow all PPE requirements.

AdventHealth is placing the health and well-being of its patients and staff in the highest priority. Thus, these measures are **effective immediately** and until **FURTHER** notice.



EMPLOYEE/STUDENT or FACULTY ROTATION UNDERSTANDING

By signing below, I understand that if I am currently an employee of AdventHealth, or become an employee in the future, if I'm assigned to do a student or faculty rotation in the department where I work I will:

- 1. Only perform employee duties when clocked in as an employee**
- 2. Only perform student or faculty duties when on my educational rotation**

Student/Faculty Print name

Student/Faculty Signature

Date



Hand Hygiene Education Requirement Attestation

(Orientation or Annual)

To be completed by all healthcare workers who can potentially touch patients, items that will be used by patients, or the patient's environment on Initial Orientation and Annually.

I _____ confirm that I have read the "Hand Hygiene for Healthcare Workers" presentation or the Hand Hygiene section of the Contingent Work Force Manual and:

- Understand how hand hygiene helps prevent infections
- Know when to do hand hygiene
- Know how to do hand hygiene using alcohol-based sanitizer and soap and water
- Know when to use gloves
- Know minimum time that should be spent doing hand hygiene
- Understand how hand hygiene compliance will be monitored

CWR Signature

Date

To be completed by preceptor, instructor or other facility designee for all healthcare workers who can potentially touch patients, items that will be used by patients, or the patient's environment as part of **Initial** Hand Hygiene Education.

I _____ confirm that _____ has correctly demonstrated proper hand hygiene with soap and water and with alcohol-based hand sanitizer.

Signature

Date

Department

AdventHealth Hand Hygiene Competency Validation

Name: _____ OPID: _____ Date of Evaluation: ___/___/___

Job Title: _____ Facility: _____ Department: _____

Type of validation: Return Demonstration	<input type="checkbox"/> Orientation
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Competency Statement: The team member must complete the health care organization-required education during orientation.¹

HAND HYGIENE WITH SOAP & WATER	COMPETENT	
	YES	NO
1. Pushed long uniform sleeves above the wrists. Avoided wearing a watch or rings or removed during hand hygiene.		
2. Checks that sink areas are supplied with soap and paper towels.		
3. Turns on faucet and regulates water temperature.		
4. Wets hands and applies the recommended amount of soap according to manufacturer's instructions for use over. Keeps hands and uniform away from sink surface. If hands touch sink during hand washing, repeats hand washing.		
5. Vigorously rubs hands for at least 15 seconds or for the length of time stated by the manufacturer's IFU for the product use, including palms, back of hands, between fingers and thumbs, and wrists.		
6. Rinses thoroughly keeping fingertips pointed down.		
7. Dries hands and wrists thoroughly with paper towels or warm air dryer.		
8. Uses a paper towel to turn off faucet to prevent contamination to clean hands and discards paper towel in wastebasket.		
9. If uses lotion or barrier cream on hands, uses only organization-approved products.		
HAND HYGIENE WITH ALCOHOL BASED HAND RUB (ABHR) (60% - 95% alcohol content)	COMPETENT	
	YES	NO
1. Applies the recommended amount of product per the manufacturer's instructions for use into palm of one hand. Quantity sufficient to cover all surfaces of hands and fingers that requires at least 15 seconds to dry.		
2. Rubs hands including palms, back of hands, between fingers and thumbs, until all surfaces dry. Allows the hands to dry completely before donning gloves.		
3. Verbalized scenarios when an alcohol waterless antiseptic rub for hand hygiene should not be used: <ul style="list-style-type: none"> a. When hands are visibly soiled b. when <i>Clostridiodes difficile</i> or Norovirus is suspected or confirmed. 		
GENERAL OBSERVATIONS	COMPETENT	
	YES	NO
1. Direct care providers—no artificial nails, gel nail, or enhancements.		
2. Nails are clean, well-groomed, and less than ¼ inch long (CDC Recommendation) for members working in direct patient care areas.		
Comments/Notes:		

_____/_____/_____
Employee/Team Member Signature Validator Signature & Title Date