

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.

Any delays in the provision of this documentation, and failure to complete the steps outlined below, will delay your final service clearance.

Please follow the steps below:



Submit proof of Immunity to Measles (Rubeola), Mumps, and Rubella. 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 below.



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

WELCOME TO THE MGH TEAM!



FOUNDED BY BRIGHAM AND WOMEN'S HOSPITAL
AND MASSACHUSETTS GENERAL HOSPITAL

Occupational Health – Observer Attestation Form

In order to promote and maintain a safe environment for our employees and patients, all prospective observers must have this form completed by their health care provider and have the information verified by their sponsor.

All information will be handled in a confidential manner.

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 _____

II. TB Status: Answer the following questions. Any “yes” answers need to be consulted with Occupational Health Service

Do you have a cough that has lasted longer than 3 weeks?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you spit up or coughed up blood?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had an ongoing fever?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you lost weight without trying?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you sweat at night?	<input type="checkbox"/> Yes <input type="checkbox"/> 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.

Observer Signature: _____

Date: _____

Sponsor Signature: _____

Date: _____

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