UNIVERSITY OF MARYLAND MEDICAL CENTER

OBSERVER CLEARANCE FORM

Observer/Volunteer Name: _____ Social Security Number: _____

Department: _____ Date: _____

Section 1: Medical History

By signing this statement, I am certifying that to the best of my knowledge, I have 1) no long-term medical or psychological condition, or 2) any other reason that might prevent me from safely working as an observer/volunteer.

Observer/Volunteer Signature: _____

OR

I am under a doctor's or therapist care for a long-term medical or psychological condition, and have a letter form him/her that I can safely and reliably work as an observer/volunteer.

Observer/Volunteer Signature: _____

Section 2: Vaccine and Screening required for ALL observers/volunteers. Please be sure to attach medical documentation for each and check off below:

1. **Measles, Mumps and Rubella**:
   ____ Documentation of 2-shot vaccine series, or titer results for Measles, Mumps & Rubella showing immunity

2. **Varicella (chickenpox):**
   ____ Documentation of 2-shot vaccine series or Titer results for Varicella showing immunity or Physician documentation of disease

3. **Tdap, Adult Dose (Tetanus, Diptheria and Pertussis) applicable only if working in high risk area: Mother Baby Unit, OBGyn Clinic, General Peds, PICU, NICU, Pediatric ED**
   _____ Show evidence of Tdap vaccination or Signed Tdap Declination form

4. **Tuberculosis:**
   ____ Previous **positive** TB skin test in past, requires both:
   - Completion of TB Screening Questionnaire (reviewed by EHS)
   - Report of negative chest x-ray in past 12 months (Radiology report or physician's letter)

   ____ Evidence of **negative TB testing dated within 3 months of your observation start date** (Step 1). If you are here longer than 3 weeks, you may need to get a second test during your observation.

5. **Hepatitis B:**
   ____ Documentation of 3-shot vaccine series in past or documented immunity or physician statement or
   ____ Referred to private physician to consider vaccination or Signed Hepatitis B Declination form

6. **Influenza:**
   ____ Documentation of seasonal influenza vaccination

********** **Form reviewed by:**

_____ _____

Signature/Name **Date**