Children's National

Health Attestation Form

The District of Columbia Department of Health and Children's Hospital require each Rotating Resident to submit a Statement of Physical and Mental Competency to be certified by another licensed independent practitioner at a minimum of every two years.

Name: _____

Section I: Certification of Competency

I certify that the above-named practitioner has been examined by me and found to be competent to perform duties associated with the residency program at Children's Hospital.

Date of the Physical Exam: _____(*within last 24 months*)

Signature: _____ Date: _____

Print Name:_____

Address: _____

Section II: Tuberculin Status

Each practitioner is required to have a PPD skin or QFT Gold test every 24 months unless the practitioner has a history of previous positive skin test reaction.

PPD administered by _____ Date _____
(*Self-administering is not allowed)* *(Must be within past 24months)*

PPD read by _____ Date _____
(*Self-reading is not allowed)* *(Must be read within 72 hours)*

Interpretation ❑ Negative ❑ Positive

QFT Gold results _____ Interpretation_____

❑ Practitioners with a history of previous positive skin test reaction:

Most recent chest x-ray: _____(date) Interpretation ❑ Negative ❑ Positive

Does practitioner currently have any of the following signs or symptoms?

1. Unexplained fever for more than one week	❑ No	❑ Yes
2. Night Sweats	❑ No	❑ Yes
3. Chronic cough with mucus	❑ No	❑ Yes
4. Unexplained weight loss	❑ No	❑ Yes
5. Unexplained chest pain with breathing	❑ No	❑ Yes

Section III: Immunization Status

This practitioner has immunity to measles, mumps and rubella by vaccine or serologic testing.

□ MMR □ Serologic Testing

Section IV: Influenza Vaccine (mandatory Nov - April) Date: _____

Section V: Mask - Fit Testing Type: _____ Size: _____ Date: _____

If you have not been fit-tested within the past 12 months or need a influenza vaccine, please report to occupational health at Children's National for fit testing before starting your rotation.

Applicant's Signature: _____ Date: _____

(Upload into MedHub)