Penn Medicine
Princeton Health

Hospital Time Clearance Form

To be completed by your personal primary care physician.

Penn Medicine Princeton Health is not responsible for any insurance or doctor fees.

Name of Patient:_____ DOB_____

A. To my medical knowledge, this applicant is capable of performing hospital time for EMT students:

__ **Yes** __ **NO**

__ **With no restrictions**

__ **With restrictions** (medically, physically, or behaviorally) and/or precautions to be observed (including diagnosed allergies that may affect service):

_____

_____

B. **Immunity Information** (Titers Bloodwork OR 2 Immunization Dates)

**(Having the disease does not preclude you from requirements below)*

Disease	Titers w/ Dates		2 Immunization Dates (2 required)	
	Pos.	Neg.		
Measles				
Mumps				
Rubella				
Varicella *(chicken pox)*				

C. **Immunization Dates**

Vaccine	tdap	FLU Seasonal
Dates		

D. **Tuberculosis (TB) Results**

1) **TB Skin Test**

Date	Result

2) **Chest X-Ray** (if you test positive for TB)

Date Administered (within 1 yr)	Date Read	Result

Name of Physician:_____

Address:_____

Phone: _____ Fax: _____

_____ _____

Physician Signature Date

SEND TO: Barbara Vaning at barbara.vaning@pennmedicine.upenn.edu