***Genesis Healthcare Associates, LLC***

***Carla Neal-Haley, MD · Crystal Johnson, FNP-BC · Christine Wasilewski, FNP-BC***

***3200 Highlands Parkway · Suite 250 ·Smyrna, Ga 30082***

***770-434-1904 Office 770-434-1304 fax***

**Student Clerkship Disease Immunity record**

For your health and wellbeing Genesis Healthcare Associates requires proof of Immunity for the following before you begin your student clerkship:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Disease** | **Date or DS\*** | **Vaccination**  **Date #1** | **Vaccination**  **Date # 2**  **(if required)** | **Titer Date (attach lab verification)** |
| Varicella |  |  |  |  |
| Mumps |  |  |  |  |
| Measles |  |  |  |  |
| Rubella |  |  |  |  |
| Hepatitis A |  |  |  |  |
| Hepatitis B |  |  |  |  |
|  |  |  |  |  |

\* State or local medical documentation required

I certify that the above information is medically documented and correct.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Healthcare Provider signature (If titers and / or records not available)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone