AdventHealth

Orlando
Deland
Waterman
Palm Coast
Fish Memorial
Daytona Beach
New Smyrna Beach

INITIAL ATTESTATION FORM
STUDENT & FACULTY (CWR's) – GENERAL & ALLIED HEALTH

Student/Faculty Name: _____ Date: _____
MM/DD/YYYY

Academic Affiliate: _____

Printed Name of Academic Affiliate Representative
OR Sponsoring AH Department Representative Name: _____

This Initial Attestation is required for all students. Attestation of the following requirements shall be provided prior to first assignment. Evidence of completion shall be immediately available by Academic Affiliate or Sponsoring AH Department, upon request.

Resume / Application / Interview Notes (Required for Faculty only) **Check if on file** _____

Skills Checklist/Competency tests (Required for Faculty only) **Check if on file** _____

I-9 / Work / VISA permit (Required for Faculty only) **Check if on file** _____

Primary Source** Verification of Licensure (if applicable) **Expiration Date** _____ MM/DD/YYYY

Primary Source** Verification of Registration / Certification **Expiration Date** _____ MM/DD/YYYY
(BLS is Required for Nursing, EMT, PCT and CNA Students & Faculty)

Criminal Background Check Report - Associated with enrollment in current academic program with no more than 4 months break in active enrollment, or hire date with school **Date Completed** _____ MM/DD/YYYY

Contingent Worker (CWR) Staff Orientation Packet* **Date Completed** _____ MM/DD/YYYY

Proof of Negative 5 panel Drug Test - Associated with enrollment in current academic program with no more than 4 months break in active enrollment, or hire date with school **Date Completed** _____ MM/DD/YYYY

"Employee/Student or Faculty Rotation Understanding" has been signed **Date Completed** _____ MM/DD/YYYY

Flu shot for current flu year (or signed waiver if refused) ◯ **Declined or** ◯ **Date Completed** _____ MM/DD/YYYY
(If refused, CWR Staff must wear a mask during months of Oct, Nov, Dec, Jan, Feb & March)

COVID 19 Vaccine ◯ **Declined or** ◯ **Date Completed** _____ MM/DD/YYYY
(signed waiver if declined for approved Religious or Medical exemption)

CWR's WORKING IN PATIENT CARE AREAS OR WITH ITEMS THAT WILL BE USED BY PATIENTS OR IN THE PATIENT'S ENVIRONMENT MUST ALSO MEET THE FOLLOWING REQUIREMENT

Complete Hand Hygiene Attestation Form **Date Completed** _____ MM/DD/YYYY

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CWR's WORKING IN PATIENT CARE AREAS MUST ALSO MEET THE FOLLOWING REQUIREMENTS

Proof of MMR Vaccination — **Check if on file** _____

Proof Varicella (chicken pox) vaccination or immunity by titer or history — **Check if on file** _____

Hepatitis B (or signed waiver if refused) — **Check if on file** _____

TB Requirement - Associated with enrollment in current academic program with no more than 4 months break in active enrollment, or hire date with school — **Date Completed** _____ MM/DD/YYYY

Tetanus, Diphtheria, Pertussis (Tdap) (or signed waiver if refused) — ◯ **Declined or** ◯ **Date Completed** _____ MM/DD/YYYY

Annual Respirator Mask Fit Testing (within last 12 months) — **Date Completed** _____ MM/DD/YYYY

_____ _____

Signature of Academic Affiliate Representative OR Sponsoring AH Department Representative

Date MM/DD/YYYY

*Forms provided by AdventHealth Orlando, Deland, Waterman, Palm Coast, Fish Memorial, Daytona Beach, New Smyrna Beach

**Primary Source – Direct written correspondence with the issuing source

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EMPLOYEE/STUDENT or FACULTY ROTATION UNDERSTANDING

By signing below, I understand that if I am currently an employee of AdventHealth, or become an employee in the future, if I'm assigned to do a student or faculty rotation in the department where I work I will:

1. **Only perform employee duties when clocked in as an employee**
2. **Only perform student or faculty duties when on my educational rotation**

_____ _____
Student/Faculty Print name Employee OPID

_____ _____
Student/Faculty Signature Date

Hand Hygiene Education Requirement Attestation

To be completed by all healthcare workers who can potentially touch patients, items that will be used by patients, or the patient's environment on Initial Orientation and Annually.

I _____ confirm that I have read the "Hand Hygiene for Healthcare Workers" presentation or the Hand Hygiene section of the Contingent Work Force Manual and:

- □ Understand how hand hygiene helps prevent infections
- □ Know when to do hand hygiene
- □ Know how to do hand hygiene using alcohol-based sanitizer and soap and water
- □ Know when to use gloves
- □ Know minimum time that should be spent doing hand hygiene
- □ Understand how hand hygiene compliance will be monitored

_____ _____
CWR Signature Date

To be completed by preceptor, instructor or other facility designee for all healthcare workers who can potentially touch patients, items that will be used by patients, or the patient's environment as part of **Initial** Hand Hygiene Education.

I _____ confirm that _____ has correctly demonstrated proper hand hygiene with soap and water and with alcohol-based hand sanitizer.

_____ _____
Validator Signature & Title Date

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Hand Hygiene Competency Validation

Student/Faculty Name:_____ Date of Evaluation:__/_____/_____
MM/DD/YYYY

HAND HYGIENE WITH SOAP & WATER	COMPETENT	
	YES	NO
1. Pushed long uniform sleeves above the wrists. Avoided wearing a watch or rings or removed during hand hygiene.	○	○
2. Checks that sink areas are supplied with soap and paper towels.	○	○
3. Turns on faucet and regulates water temperature.	○	○
4. Wets hands and applies the recommended amount of soap according to manufacturer's instructions for use over. Keeps hands and uniform away from sink surface. If hands touch sink during hand washing, repeats hand washing.	○	○
5. Vigorously rubs hands for at least 15 seconds or for the length of time stated by the manufacturer's IFU for the product use, including palms, back of hands, between fingers and thumbs, and wrists.	○	○
6. Rinses thoroughly keeping fingertips pointed down.	○	○
7. Dries hands and wrists thoroughly with paper towels or warm air dryer.	○	○
8. Uses a dry, clean paper towel to turn off faucet to prevent contamination to clean hands and discards paper towel in wastebasket.	○	○
9. Applies only organization-approved lotion or barrier cream to hands.	○	○
HAND HYGIENE WITH ALCOHOL BASED HAND RUB (ABHR) (60% - 95% alcohol content)	**COMPETENT**	
	YES	NO
10. Applies the recommended amount of product per the manufacturer's instructions for use into palm of one hand.	○	○
11. Rubs hands including palms, back of hands, between fingers and thumbs, until all surfaces dry. Allows the hands to dry completely before donning gloves.	○	○
12. Verbalized scenarios when an alcohol waterless antiseptic rub for hand hygiene should not be used: a. When hands are visibly soiled b. when Clostridiodes difficile or Norovirus is suspected or confirmed.	○	○
GENERAL OBSERVATIONS	**COMPETENT**	
	YES	NO
13. Direct care providers—no artificial nails, gel nail, or enhancements.	○	○
14. Nails are clean, well-groomed and less than ¼ inch long (CDC Recommendation) for members working in direct patient care areas.	○	○
Comments/Notes:		

_____ _____
Validator Signature & Title Date