

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	
	Pos.	Neg.	(2 required)	
Measles				
Mumps				
Rubella				
Varicella <i>(chicken pox)</i>				

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