## VIRGINIA MASON MEDICAL CENTER CONTRACTOR/STUDENT FITNESS FOR DUTY COMPLIANCE CERTIFICATION

This Certification Form must be submitted to VMMC Workforce Relations <u>a minimum of 10 days prior</u> to the start of assignment. No Contractor Employee/Student is permitted to commence services or training until VMMC Workforce Relations confirms satisfactory completion of the Fitness for Duty process with the accountable VM Manager and a VM ID badge has been issued.

Contractor/School certifies that the Contractor Employee/Student identified below meets all VMMC Fitness for Duty requirements.

ent Nan	ne:						
ker Typ	e: (Circ	le one)					
mmunity	/ Provide	er / Consultant	/ Contractor /	/ Health C	Care Work	er / Student	
	Tempo	orary Agency Staf	f / Vendor / V	olunteer /	Observe	r	
Contractor Birthday (mm/dd):				Gender M/F:			
rt Date	(mm/dd	/yy):	Assignn	nent End	Date (mi	m/dd/yy):	
nt Scho	ool:						
ol Conta	ict Nam	e & Phone Nun	nber:				
Title/Ty	pe of S	tudent:					
VM Manager Contact Name:				VM Department:			
Certific	cation/	Criminal Background Check Date Completed	Disclosure Statement Attach to this form	General Services Administration Results and Date Check Completed		OIG Excluded Party Results and Date Check Completed	
POS: Date of Clear Chest date of			Varicella/Chickenpox History of Disease or date of Vaccination/Titer		Influenza Vaccine Mandatory during flu season as determined by VMMC. Date of vaccination.		
rds held ctor/Sch	by Contr	ractor/School. esentative:	VI Na	MMC Work ame:	force Rela		
	ker Typ mmunity day (mi rt Date ent Scho ol Conta fitle/Ty ntact Na  Requir Certific Expirat Date  est chest ent certify the	ker Type: (Circ mmunity Provide Tempo day (mm/dd): et Date (mm/dd. ent School: ol Contact Name fitle/Type of Sentact Name: Required Certification/ Expiration Date  MMR History date of Vaccina  certify that the a eds held by Contract ctor/School Repr	mmunity Provider / Consultant Temporary Agency Staff day (mm/dd): Tt Date (mm/dd/yy): Int School: Int Contact Name & Phone Num Title/Type of Student: Intact Name:  Required Certification/Expiration Date  MMR History of Disease or date of Vaccination/Titer	Temporary Agency Staff / Vendor / Vendo	mmunity Provider / Consultant / Contractor / Health Contended / Vendor / Volunteer / day (mm/dd):	Mare   Consultant   Contractor   Health Care Work   Temporary Agency Staff   Vendor   Volunteer   Observed   Observed	