KAISER PERMANENTE®

Health and Safety Verification Form for Medical Learners

The following requirements are to support the onboarding processes for medical learners and help reduce the spread of infectious disease to our members, patients, staff, and learners. This process also assures compliance with regional education policies and regulatory agency requirements.

By submitting the Health and Safety Verification Form for Medical Learners, the Clinical Coordinator/Designee attests a) to the accuracy and validity of the information submitted, b) that a Criminal Record Search was completed for the learner within 90 days from the start of the Program and any abnormalities were disclosed to the Academic Liaison, and c) that an 11-Panel Drug Test was completed for the learner within 90 days from the start of the Program and positive results were disclosed to the Academic Liaison (11-Panel Drug Test: amphetamines, barbiturates, benzodiazepines, benzoylecgonine [cocaine], marijuana, meperidine [Demerol], methadone, opiates, oxycodone, phencyclidine [angel dust], and propoxyphene).

In the event of any changes to the below information, the responsible Academic Liaison must be notified in writing. Please note, the information contained within this document is subject to random audits. Supporting documents must be submitted to the Academic Liaison/designee within four hours of the request. Inaccurate, incomplete, and late submissions will result in an escalation process, up to and including termination of the affiliation agreement with the Kaiser Permanente Hawaii Market.

Name of University/ School	
Name of Program	
Name of Clinical Coordinator/ Designee *(completing the form and attesting to information)*	
Date of Attestation	
Rotation Dates/ Academic Year	

Learner Information

First Name: ______________________ Middle Initial(s): _____ Last Name: ___________________________

Phone Number: (_____) ____________________ Email Address: __________________________________

Professional License Number *(if applicable)*: ____

Emergency Contact Information

Last Name	
Frist Name	
Relationship	
Contact Number	

Insurance Information

Current Personal Health Insurance	
Health Insurance Company	
Health Insurance Contact Phone Number	
Current Auto Insurance Policy *(required if driving to/ from clinical)*	

KAISER PERMANENTE®

Fit Test Information

Date of Annual Fit Test *(within 1 year)*	
N95s Cleared to Use	

American Heart Association Basic Life Support

Date of BLS Provider Expiration	

Tuberculosis Screening

1. Date of Annual TB Screening Questionnaire with No Symptoms *(within 1 year)*		
2. Also required is one of the below:		
a. Date of Negative IGRA *(within 1 year)*		
b. Dates of 12- and 24-month Negative TST (PPD)		
c. Dates of 2-step Negative TST (PPD)		
d. Date of Positive TST/IGRA and Date of Negative Chest X-Ray *(within 1 year from start of program)*		

Evidence of Immunity by Vaccine or Lab Test

Measles, Mumps, & Rubella *(1 of the below)*	
a. Dates of 2 MMR vaccines	
b. Date of positive titer	
c. Date of lab confirmation of disease	

Varicella *(1 of the below)*	
a. Dates of 2 Varicella vaccines	
b. Date of positive titer	
c. Date of lab confirmation of disease	

Hepatitis B *(1 of the below)*	
a. Date of positive Hep B antibody after complete series	
b. Proof of past infection	
c. Date began Hep B series with Hep B antibody testing	

COVID-19 Vaccine	
1. Name of COVID-19 Vaccine Manufacturer	
2. Date of First Dose	
3. Date of Second Dose	
4. Manufacturer and Date of Third Dose/ Booster	

Date of Current Seasonal Flu Vaccine	
Date of Tetanus (Tdap) Vaccine *(within the past 10 years)*	