Center for Workforce Development – Allied Health Division
Ozarks Technical Community College
1001 East Chestnut Expressway, Springfield, MO 65802
(O) 417-447-8888 (F) 417-447-8893

Applicant's Name ______________________________________ **Date of Birth** __________________

Student ID number (to be completed by CWD staff upon return to office) __________________________________

Please present OFFICAL documentation from a physician or health official (Signed and Dated) for the following:

______Current MMR immunity/immunization (***REQUIRED***) **DATE GIVEN:** _____________________________

______ Current Tdap immunity/immunization (***REQUIRED***) **DATE GIVEN:** _____________________________

______ Flu vaccine date: ____________ (***REQUIRED when clinical falls between September - March***) ***Due 1 month before clinical begins**

_____ Varicella titer **DATE BOOSTER GIVEN**: ________________ **IMMUNITY** ____ Yes _____ No

______TB Skin Test :(***REQUIRED***) Pos ______Neg ______ OR **Chest X-Ray**: Pos ______ Neg ______
(A chest x-ray is required with a positive skin or a history of a positive skin test)

______Hepatitis B - series of 3 (***HIGHLY RECOMMENDED***)

1st: Date_______________ **2nd**: Date______________ **3rd**: Date______________

Provider, please initial one of the two choices below. The student may return this document, or it can be faxed directly to us at the number above. Thank you for your time and we appreciate your assistance in providing a safe clinical environment for our students.

_______***I have examined the above named individual and found him/her to be free of contagious chronic illness and in good health.***

_______***I have examined the above student and found restrictions to be followed during the clinical component of the program. Please see documentation on clinical letterhead with further instructions.***

____ ___________________
Signature of Physician or Health Official ***Date***

____
Name of Physician or Health Official (Please print)

____
Clinic Address ***City*** ***State*** ***Zip***

____________________________________ ________________________________
Phone Number ***Fax Number***

OFFICE STAFF ONLY BEYOND THIS POINT

When form is returned, a copy should be given to the program director or the lead instructor. The original will be filed in the student record and locked in the allied health cabinet. Please initial when this is completed _______. If form is not fully completed or any part is missing by student, please notify the student by email and phone and initial here when complete._______ (email) _______ (phone).