Marshall Health Network
Non-Employee Attestation Form and Signature Page

(Completion of this document is required before an ID badge will be issued)

Name: _____

Primary Source Verification – IF APPLICABLE (Not applicable for the Student Job Shadowing Program) I attest that I hold a valid WV professional license, certification or registration as required for the services I will be performing if required by law or regulation. I further attest that a copy of primary source verification can be provided before I initially begin performing services within Marshall Health Network and primary Source Verification is available before my license, certification or registration expires.	_____ initial
FIT Test (*Not applicable for the Student Job Shadowing Program*) I understand that to go into a room where a patient is on airborne precautions I must wear a special N95 respirator mask. I attest that I will not enter that area unless I have been fit tested at my designated hospital.	initial

ALL APPLICANTS MUST RESPOND TO THE NEXT TWO STATEMENTS

Orientation and Confidentiality Agreement I attest that I have read and understand orientation materials and that my duties and responsibilities to maintain confidentiality as set forth in the MHN Confidentiality Agreement shall remain in effect even after my access to PHI ceases.	_____ Initial
Physical and Functional Status I attest that I have no physical or mental disabilities that would prevent me from performing services within MHN.	_____ Initial

ALL APPLICANTS (EXCEPT THOSE WHO ARE COVERED BY AN AFFILIATION AGREEMENT THAT INCLUDES ALL THE FOLLOWING) MUST ALSO RESPOND TO THE NEXT TWO STATEMENTS

Criminal Background Check (Not applicable for the Student Job Shadowing Program) I attest that I have completed a background check and provided proof of such to the applicable hospitals' Human Resources department.	_____ Initial
Drug Test (*Not applicable for the Student Job Shadowing Program*) I attest that I have taken and passed a 10-panel drug test and provided proof of such to the applicable parties within MHN.	_____ Initial
Immunizations o Hepatitis B o MMR o Varicella o Tdap o Influenza (October – March) o COVID Vaccine (If applicable) o TB Skin Test within the last 12 months These records will be reviewed by the applicable recipient within MHN (CHH Occupational Health, SMMC Employee Health, RH Employee Health, and/or MHN School Placement Coordinator).	_____ Initial

Release of Information and Attestation:

I authorize the use or disclosure of any health information listed on this page to the applicable party within Marshall Health Network. I understand that authorizing the use or disclosure of this health information is voluntary but may be a condition being able to perform services or otherwise conduct business within Marshall Health Network. Unless revoked, this authorization will be effective for no more than two years from the date signed. I also attest that I have given correct information on this attestation form. I understand that if asked can provide verification of this information. I understand that providing false information will result in me no longer being able to perform services or otherwise conduct business with Marshall Health Network

_____ _____

Legal Name (First, M.I., Last) **Signature**

_____

Date

Adpt: 05/2020, Rsvd: 10/2024