

EXHIBIT C ATTESTATION FORM

This document serves as an attestation from _____ (School) to Whittier Hospital Medical Center (Hospital) that the required elements listed below are completed and up to date for each of the students who will be utilizing Hospital for their clinical rotation as listed below. Enter the date of completion in the appropriate column.

STUDENT/ INSTRUCTOR NAME	DATE OF BIRTH	PHYSICAL	BACKGROUND SCREEN	DRUG SCREEN	TUBERCULOSIS 2 STEP <small>(list the two negative result dates)</small>	ANNUAL TUBERCULOSIS <small>(list the last two negative result dates)</small>	NEG CXR <small>(include symptom check form)</small>	MUMPS MEASLES RUBELLA			TDAP	VARICELLA			HEPATITIS B <small>LAST DATE ENTERED SIGNIFIES COMPLETION OF 3 VACCINATIONS OR IMMUNE BY POSITIVE TITER</small>	FLU <small>INFLUENZA VACCINATION OR DECLINATION</small>	COVID-19	
								1ST DOSE	2ND DOSE	IMMUNE BY POSITIVE TITER		1ST DOSE	2ND DOSE	IMMUNE BY POSITIVE TITER			MANUFACTURER1ST DOSE	2ND DOSE <small>(IF APPLICABLE)</small>

_____ (School) will provide copies of documentation indicated above upon request by Whittier Hospital Medical Center for the purposes of compliance with regulatory agency requirements.

ACKNOWLEDGED BY _____ Date _____
 (School Representative)