

**Children's Mercy Occupational Health
Non-Employee Health Form for Vendors / Contractors (non-patient care)**

Please Print ALL Entries			
Name (Last)	(First)	(Middle Initial)	Gender
Address (Street, City, State, Zip Code)		Personal Phone	Date of Birth
Business Affiliation or Company Name	Specialty or Role	CM Sponsor or Contact	Employee ID No. (Infor)

REQUIRED Immunization History and/or Test Results

- You must **attach copies of your immunization records and/or lab results** AND complete the following:

Needed for Compliance:	Dates:		Lab Results:	Needs:
MMR- Measles/Mumps/Rubella (2 vaccines or titers that verify immunity)	MMR #1: ___/___/___ MMR #2: ___/___/___	Or	Rubeola Titer: ___/___/___ Result: _____ Mumps Titer: ___/___/___ Result: _____ Rubella Titer: ___/___/___ Result: _____	<input type="checkbox"/>
Varicella (Chicken Pox) (2 vaccines or titers that verify immunity)	Varicella #1: ___/___/___ Varicella #2: ___/___/___	Or	Varicella Titer: ___/___/___ Result: _____	<input type="checkbox"/>
Tdap Vaccine (Tetanus/diphtheria/pertussis)	Date: ___/___/___			<input type="checkbox"/>
Influenza Vaccine: (Required only during current flu season)	Date: ___/___/___			<input type="checkbox"/>
COVID-19 Vaccine: (Required: initial doses only)	Dose #1: ___/___/___ Dose #2: ___/___/___ Manufacturer: _____		Booster #1: ___/___/___ Manufacturer: _____ Booster #2: ___/___/___ Manufacturer: _____	<input type="checkbox"/>
Tuberculosis (TB) Screening If you have had a positive TB screening in the past, you must provide documentation of original positive result or documentation of treatment AND your most recent chest x-ray report	Provide copies of 2 TB skin tests within the last 12 months, with the most recent test no greater than 90 days prior to the first day of affiliation or an IGRA TB blood test (e.g. QFT or T-spot) within 90 days prior to affiliation.			<input type="checkbox"/>
	TST 1: ___/___/___ Result: _____ TST 2: ___/___/___ Result: _____	Or	TB blood assay: ___/___/___ Result: _____	
	Chest X-Ray following a previous positive result: ___/___/___ Result: _____			

I hereby declare that the information provided on this form is true and complete. I understand that false information or omissions could cause me to be subject to loss of affiliation privileges.

Non-employee Signature _____ Date _____

<input type="checkbox"/> Compliant with CM requirements per Occupational Health review <input type="checkbox"/> NON-COMPLIANT with CM requirements for reasons below: <hr/> <hr/>
Occupational Health Representative _____ Date _____
Please direct questions to: Children's Mercy Occupational Health 2401 Gillham Road Kansas City, MO 64108 P: (816) 234-3179 F: (816) 460-1077 occupationalhealth@cmh.edu