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

Please Print ALL Entries

Name (Last)	**(First)**	**(Middle Initial)**	**Gender**	**Today's Date**

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: _____	☐
Varicella (Chicken Pox) *(2 vaccines or titers that verify immunity)*	Varicella #1: ____/____/____ Varicella #2: ____/____/____	Or	Varicella Titer: ____/____/____ Result: _____	☐
Tdap Vaccine (Tetanus/diphtheria/pertussis)	Date: _____/_____/_____			☐
Influenza Vaccine *(Required only during current flu season)*	Date: _____/_____/_____			☐
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. TST 1: ___/___/___ Result: _____ TST 2: ___/___/___ Result: _____ Chest X-Ray following a previous positive result: ___/___/___ Result: _____	Or	TB blood assay: ___/___/___ Result: _____	☐
COVID-19 Vaccine *(Not required; recommended)*	Dose #1: ____/____/____ Dose #2: ____/____/____ Manufacturer: _____		Additional Doses: ____/____/____ Manufacturer: _____ ____/____/____ Manufacturer: _____ ____/____/____ Manufacturer: _____	☐

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

☐ Compliant with CM requirements per Occupational Health review

☐ NON-COMPLIANT with CM requirements for reasons stated:_____

_____

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