**Department of Medical Education**

**Screening Attestation for Rotating Residents and Fellows**

Dear Rotating Resident/ Fellow

Please complete the questions below, sign, date, and return this attestation form to Ms Samantha Salman ([Samantha.Salman@Nicklaushealth.org](mailto:Samantha.Salman@Nicklaushealth.org)) along with the rest of the required paperwork **PRIOR** to the start of your rotation at Nicklaus Children’s Hospital

|  |  |
| --- | --- |
| 1. During my rotation at Nicklaus Children’s Hospital, I will be providing some additional clinical duties at my home institution (back and forth) in addition to NCH (i.e. ER coverage, call, continuity clinic) | YES  NO |
| 1. In the past 14 days prior to the start of my rotation at Nicklaus Children’s Hospital, I travelled to an international destination (If NO; go to Question 4) | YES  NO |
| 1. If YES to Question #2; in the past 14 days prior to the start of my rotation at Nicklaus Children’s Hospital, I travelled internationally to one of the following Countries (UK, South Africa, Brazil, India) | YES  NO |
| 1. Currently I am experiencing URI symptoms, and/or cough, and/or low grade fever and/or loss of smell/taste sensations | YES  NO |
| 1. In the past 14 days I have had exposure to a documented COVID-19 positive individual | YES  NO |
| 1. In the past 14 days I had a reason to be tested for COVID-19 | YES  NO |

(For any **YES** answer to any of the above questions – **\*\*** **STOP \*\***  - *Requires further investigation prior to starting the rotation*)

* By the time I start my rotation at Nicklaus Children’s Hospital, I would be over 14 days from completing a COVID-19 vaccination course (either 2 doses of Pfizer or Moderna or 1 dose of the Johnson & Johnson vaccine) -  YES  NO

By signing this form, I attest that the above information is accurate to the best of my knowledge and I attest that I will abide with Nicklaus Children’s Hospital measures of:

1. Daily temperature screening of all staff and visitors at entrances stations
2. Wearing the mask provided at the temperature check station at all times during clinical care, rounds, and in common areas of the hospital

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Training Program/ Institution

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

(Return completed and signed form to Dept of Medical Education; Ms Samantha Salman by email ([Samantha.Salman@Nicklaushealth.org](mailto:Samantha.Salman@Nicklaushealth.org)) or fax (305-669-6531) prior to start of rotation)