Nicklaus Children's Hospital

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) 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
2. 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
3. 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
4. Currently I am experiencing URI symptoms, and/or cough, and/or low grade fever and/or loss of smell/taste sensations	☐ YES ☐ NO
5. In the past 14 days I have had exposure to a documented COVID-19 positive individual	☐ YES ☐ NO
6. 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) or fax (305-669-6531) prior to start of rotation)