ECRI Institute
The Discipline of Science. The Integrity of Independence.

Health Attestation Form

adapt Integrated Health Care

Clinician Name: _____

Please explain any "yes" answers in the space provided on this form or by attaching a separate sheet. This form is confidential and will be kept in the clinician's credentials file.

Do you presently have any physical or mental condition that may affect your ability to perform clinical or professional duties? If yes, please explain: _____	☐ Yes ☐ No
Within the past five years, have you been treated in an inpatient or outpatient facility or have you missed work due to any physical or mental condition that may affect your ability to perform clinical or professional duties? If yes, please explain: _____	☐ Yes ☐ No
Do you presently suffer from an addiction to drugs, alcohol, or other chemical substances that may affect your ability to perform clinical or professional duties? If yes, please explain: _____	☐ Yes ☐ No
Within the past five years, have you been treated in an inpatient or outpatient facility or have you missed work due to an addiction to drugs, alcohol, or other chemical substances? If yes, please explain: _____	☐ Yes ☐ No
Are you currently taking any medications that may affect your ability to perform clinical or professional duties? If yes, please explain: _____	☐ Yes ☐ No
Do you have any communicable diseases? If yes, please explain: _____	☐ Yes ☐ No
Please provide the date of your most recent physical exam: _____ Performed by_____	
Please provide dates for the following vaccinations, diagnostic screening, and/or treatment Hepatitis B: _____ _____ _____ or TwinRix series _____ _____ _____	

TB Screening History:

PPD_____(Result_____) or IGRA_____(Result_____)

Chest X-ray_____(Result)_____

Treatment completed for latent infection _____or active disease_____

BCG _____ and IGRA_____(Result_____)

If you declined any vaccinations or screening, please explain:

_____

_____

Please list any other physical or mental conditions that you think Adapt/SouthRiver Community Health Center should be aware of:

_____

_____

I (please print full name) _____ can attest that I am in good health and have no physical or mental conditions that may affect my ability to perform clinical or professional duties. I can also attest that I have no current addictions to drugs, alcohol, or any other recreational chemical substances. I understand that I may not hold Adapt/SouthRiver Community Health Center responsible for any physical or mental conditions or addictions that I have or have not disclosed.

Clinicain Signature: _____ Date: _____

Program Director or Medical Director Signature: _____

Date: _____