St. Tammany HEALTH SYSTEM℠

Exhibit B to Education Affiliation Agreement
Student/Instructor Attestation Sheet for Clinical Rotations

Please indicate the campus for the clinical rotation: ☐ Clinics ☐ Hospital

Name of School: _____ Name of Student: _____

Program Type: ☐ MA ☐ LPN ☐ BSN ☐ MSN/MN ☐ Medical Student ☐ NP Student ☐ Other: Allied Health _____

Inclusive Dates of Clinical Rotation: _____ Clinical Unit/Department: _____

Please complete the following grid. A check mark indicates compliance. This form must be submitted to the EDT department PRIOR TO beginning the clinical rotation. School will maintain documentation for ALL items listed, which are included in the current Affiliation Agreement between St. Tammany Health System and School. Per Agreement, this information must be available upon request.

Name of Student /Instructor	Proof of Negative TB test (within 12 months) or Health Screen Form	Positive Titer: Rubella	Positive Titer: Mumps	Positive Titer: Measles	Positive Titer: Chicken Pox	Hepatitis B Vaccine complete, or declination form signed	Current Influenza Vaccination (Must have received prior to Spring rotation)	LA License if out of state Nursing student
Example Student	YES	YES	YES	YES	YES	YES	YES	N/A

I acknowledge and attest that I/we own, and have in our possession, the above documentation and reports. I also acknowledge and agree to regular compliance audits by St. Tammany Health System to ensure documentation is available upon request. By the execution hereof, School hereby warrants and confirms to St. Tammany Health System the accuracy of the information provided above as of Date: _____

By: _____ Title: _____