WVU Medicine
BERKELEY MEDICAL CENTER

Job Shadowing Program Applicable Health Information

Participant: _____

Please read the following statements and check the box next to the statement, if you agree that the statement is accurate.

The following immunizations are up to date for me / my child:

- Purified Protein Derivative (PPD) within the last year (Tuberculosis skin test)
- Influenza Immunization (Required between October 1 and April 30)
- COVID-19 vaccination

I / my child will only participate in the Job Previewing Program if free from infectious disease on the day of the program.

_____
Participant's Printed Name

_____ _____
Participant's Signature Date

If under 18 years of age, notarized signature of parent or legal guardian is required.

_____
Parent/Legal Guardian's Printed Name

_____ _____
Parent/Legal Guardian's Signature Date

STATE OF _____ COUNTY OF _____

On this day, personally appeared before me _____,
to me known to be the person(s) described in and who executed the within and foregoing instrument and acknowledged that he/she signed the same as his/her voluntary act and deed, for the uses and purposes therein mentioned.

Witness my hand and official seal hereto affixed on this _____ day of _____, _____.

/ **Betsy J. Gambino, MSN, RN**

Director of Strategic Partnerships