

CERTIFICATE OF HEALTH

Shadowing and Short Term Observational Educational Experience

Date: _____

I, _____, certify that I do not have any health problems that may pose a risk to hospital patients or staff. I am free from contagious or infectious disease, do not have any symptoms of illness, and am feeling well.

The shadowing or short term educational experience will take place with _____ in the department of _____.

Signature: _____

Print Name: _____

Parent Signature (if student is a minor): _____

Company/School: _____