**AHS ATTESTATION REGARDING KNOWN EXPOSURE TO COVID-19**

Name: ­

Current Address:

Permanent Address:

Phone Number:

Dates of Rotation:

Medical School:

|  |  |
| --- | --- |
| Initials |  |
|  | I hereby attest that I have NOT had any known exposure to any person (patient, family member, other personal contact) who have been diagnosed with COVID-19 in the 2 weeks prior to starting this current clinical rotation at Highland Hospital.\* |
|  | I have received the Safety Agreement with Regard to COVID-19 as part of my Expectations packet at the start of my rotation. |
|  | I will wear a mask at all times when in clinical spaces on the hospital premises. |
|  | I will do my best to maintain social distancing of 6’ as much as possible in my interactions with others while on the premises of the hospital. |
|  | I realize that I can speak to any medicine attending, resident, intern, my preceptor(s) or clerkship director if I have any questions regarding safety or if I feel uncomfortable or concerned for my safety with regard to any patient I am asked to see, even if the patient is not believed to have COVID.  |
|  | I realize that as a part of the safety agreement between AHS and my medical school, I will **NOT be permitted** to see formal PUI or COVID-confirmed patient or any patient who requires the use of PPE (e.g. MDRO, CRE, TB). |

*\* Note that if you have had known contact to any person with diagnosis of COVID-19 (whether they were symptomatic or asymptomatic) in the 2 weeks prior to starting your rotation at Highland, you will be required to self-isolate for 14 days and thereby delay the start of your rotation.*

I hereby certify that the above is true and accurate to the best of my knowledge.

Signature: Date: