Affiliating Health Record

☐ **Shadow (0005)** ☐ **Intern (0005)** ☐ **Student (0005)** ☐ **Other**

Start Date: _____ **End Date:** _____

School/College: _____

Centra Site/Campus: _____

Centra Preceptor: _____

Name: _____

Email Address: _____

Date of Birth: _____

Social Security Number: _____
(Required-Used for record keeping and compliance tracking purposes only)

Address: _____
(Street) (City) (State) (Zip)

Phone: _____
(Home or Cell)

Signature: _____

HEALTHWORKS OFFICE USE ONLY-PLEASE ATTACH IMMUNIZATION RECORDS

MMR Vaccination & Booster	**#1**		**#2**			Titer Pending:	☐
Varicella (Chicken Pox) Vaccine	**#1**		**#2**			Titer Pending:	☐
Hepatitis B Vac:	**# 1**		**# 2**		**# 3**	CAT III ☐ Titer Pending:	☐
Influenza Vac:			**Tetanus/Diptheria/Pertussis Vaccine:**				
Last TST Date:		**Result Date:**					
Healthworks Nurse Signature						Date:	