



STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
NEW HAMPSHIRE HOSPITAL
36 CLINTON STREET, CONCORD, NH 03301

Prior to employing, assigning, or referring clinical staff, Agencies shall review the below to verify that the Agency has determined the clinical staff to be employed, assigned, or referred to New Hampshire Hospital (NHH) by the Agency and are able to perform any and all duties within the full scope of practice for which they are required, prior to entering into a contract. Please attest to the following components below.

ATTESTATION IS DUE ONE (1) WEEK PRIOR TO START.

I, the undersigned with responsibility for (Agency Name: _____) attest that (name of clinical staff employed by Agency: _____) has met the following pre-hire employment requirements as mandated by NHH:

- ☐ Health Screening with physical capacity exam Date: _____
- ☐ Fit Testing Date: _____ Mask Type: ☐ 3M 1870+ Aura, or
(select 1) ☐ Halyard Duckbill Reg & Small
- ☐ Negative Urine Drug Screening Date: _____ Result: _____
- ☐ TB Screening (QuantIFERON Gold) Date: _____ Result: _____
- ☐ MMR ☐ Vaccine #1 and Vaccine #2 or ☐ Titer Date #1/2: _____ / _____ Titer Result: _____
- ☐ Varicella ☐ Vaccine #1 and Vaccine #2 Date #1: _____ Date #2: _____
- Or ☐ Varicella Titer Date: _____ Titer Result: _____
- ☐ Hepatitis B ☐ Vaccine #1, Vaccine #2 and Vaccine #3 Series End Date: _____
- Or Hepatitis B Titer ☐ Date: _____ Result: _____ Or Declination Date: _____
- ☐ Tetanus, Diphtheria & Pertussis (T-Dap) Most recent date received: _____
- ☐ COVID Vaccination within the current season (or documented refusal) Completion Date: _____
- Or Declination Date: _____
- ☐ Influenza Vaccination within the current season (or documented refusal) Completion Date: _____
- Or Declination Date: _____
- ☐ Basic Life Support Training – Copy of card attached. (including child, infant and AED) Expiration Date: _____
- ☐ Compact State RN License or ☐ NH RN License. License # _____ Expiration Date: _____
- ☐ Criminal and BEAS Background Checks: Are there any active or inactive findings? ☐ No ☐ Yes. If yes, attach copy to this Attestation. Completion Date: _____
- ☐ DCYF Background Check: Completed form mailed to NHH, Helen Symonds Submission Date: _____
- ☐ Contract Dates: _____ to _____

The Agency verifies that all supporting documentation is on file with the Agency.

New Hampshire Hospital has the right to request that the clinical staff and/or the referring Agency provide copies of any required documentation to meet New Hampshire Hospital requirements.

Signature: _____ Date: _____