**Clinical Clearance Form**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name | TB Annual | TB CXRAs applicable | Tdap | Varicella | MMRDate (+/-) | HBV (Hep B) | Flu Vaccine/ Declination  | Mask Fit(Completed by THOP) |
| Date | Results | Date | Results | Questionnaire.y/n |  | Titer | +/- | Titer |  | Titer | +/- |  |  |
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I attest that the information provided is accurate based on official vaccination and immunization records.

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Signature Date