Medical Requirement Record Form- This form will not be accepted without the Healthcare Provider Attestation portion completed and official provider stamp.

Name: _____ DOB: _____

Test	Dates Completed	Dates Completed
TB-QuantiFERON or T-Spot blood draw (within the last 12 months) **-OR-** **PPD Skin Test (must be placed twice and read twice)** **Chest X-Ray** (only required if TB blood test is positive)	**QuantiFERON or T-Spot:** Date Drawn: _____ Result: POS _____ NEG _____ PPD Placement 1 Date: _____ PPD Placement 1 Read Date: _____ PPD Placement 1 Result: _____ PPD Placement 2 Date: _____ PPD Placement 2 Read Date: _____ PPD Placement 2 Result: _____ **Chest X-Ray Completion Date:** Date Taken: _____ Result: POS _____ NEG _____	***Blank Area***
Hepatitis B Titer (positive titer is required, if titer is negative, vaccine series and titer are required; if currently receiving vaccine series, a titer is required upon completion)	**Titer:** Date Drawn: _____ Result: POS _____ NEG_____ **Dates Received:** Dose #1: _____ Dose #2: _____ Dose #3: _____	***Blank Area***

MMR Vaccine Series or Titer (2 dose series or positive titer for each individual component; if received the 2 dose MMR series, no further testing is required; if negative titer then repeat series required; no repeat titer needed after repeat series	**Titer:** Date Drawn: _____ Result: POS _____ NEG _____	**Date Received:** Dose #1: _____ Dose #2: _____
Varicella Vaccine Series or Titer (2 dose series or positive titer; if received the 2 dose Varicella series, no further testing is required; if negative titer then repeat series required; no repeat titer needed after repeat vaccine series)	**Titer:** Date Drawn: _____ Result: POS_____ NEG _____	**Date Received:** Dose #1: _____ Dose #2: _____
Flu Vaccine *(August-May of current flu season)*	**Date Received:** _____	
Tdap Vaccine	**Date Received:** _____	

Luminis Health

Name: _____ DOB: _____

Name: _____ DOB: _____

HEALTHCARE PROVIDER ATTESTATION

This form will not be accepted if not signed by a healthcare provider.

The information presented on this form is true and accurate to the best of my knowledge.

Provider Signature: _____Date: _____

Provider Name: _____

Address: _____

Phone: _____ Provider Type: ☐ MD ☐ DO ☐ PA ☐ APRN

HEALTHCARE PROVIDER STAMP