Intermountain Health

November 2, 2023

Annual Worker Verification
for Non-Intermountain Clinical Worker

Employer / Worker Information

Please PRINT

- Worker's Full Name: _____
- Job Function / Role: _____
- Employer: _____
- Affiliated physician/dentist if different from Employer: _____
- Employer Phone: _____
- Intermountain Manager if known: _____

Verification of Worker Requirements

The following must be verified annually by Worker in order to continue temporary work assignment. Unless otherwise indicated (and approved), Worker must answer **YES** to all fields.

1) Licensure/Certification/Accreditation/Registration ☐ Yes ☐ No, Clarify: _____

2) Healthcare Provider or Professional Rescuer BLS ☐ Yes, Expiration Date: _____
Must be Intermountain approved certification

3) Insurance Coverage provided by Employer ☐ Yes ☐ No
General, Professional, and Workers Comp.

4) Annual / Current Flu vaccination ☐ Yes ☐ No *(approved medical exemption)*
Vaccination Date: _____

5) OPTIONAL: COVID Booster (most recent) ☐ Yes ☐ Choose not to disclose
Vaccination Date: _____ ☐ Unknown
Vaccine Manufacturer: _____ ☐ Unknown

6) Required Orientation / Education completed (attached):
- Contingent Workforce Packet ☐ Yes ☐ No
- Clinical Role Specific Packet or Skills Assessment ☐ Yes ☐ No ☐ N/A *(not required)*

Worker understands that they must immediately notify Intermountain of any changes in Worker's employment status, ability to perform services, or any items noted on this form.

Signatures

_____ _____
Worker Date

_____ _____
Intermountain Health Representative Date