Decatur County
Memorial Hospital
The Quality Care You Want. Close By.

LIP Health Records Verification Form

Name:_____

Date Requested:_____

Organization:_____

Date of Birth:_____

Contact Information Phone:_____

Email:_____
(Indicates requirement for all non-employees unless Individual was born before 01/01/1957.)*

By signing below you verify completion of the following immunizations and the records may be obtained per our request.*

- MMR-(Positive Titer or 2 vaccines)*
- Varicella-Positive Titer or 2 vaccines)*
- Influenza-(Vaccination within past 12 months)
- Tdap
- Tuberculin Skin Test or Equivalent-(within past 12 months)

Location of Records:

Company name:_____

Contact Name:_____

Contact Number:_____

Email:_____

*If any of the above mentioned immunizations have not been administered and/or are not attainable, please explain.

_____

_____

Please fax or email this form to the attention of:

Kaysie Jolliff
Credentialing Specialist
Decatur County Memorial Hospital
Fax: (812) 663-1299
Kaysie.jolliff@dcmh.net

_____ _____

Signature Date

HEALTH CHECKLIST

Please place a check beside the communicable disease/immunization you have experienced. If possible, please provide the year as well. Thank you.

Disease	Have Had Disease	Have Had Immunization	Year
Mumps	_____	_____	_____
Measles	_____	_____	_____
Varicella (Chickenpox)	_____	_____	_____
Rubella	_____	_____	_____
Tetanus	_____	_____	_____
Diphtheria	_____	_____	_____
Smallpox	_____	_____	_____
Pneumonia	_____	_____	_____

Name:_____ Date:_____