

## Communicable Disease Screening Questionnaire

### Visitors, Volunteers & Observers

Anticipated Dates of Visit: From:        /        /        To:        /        /

***If “Yes”, you must show documentation of a “current” Tetanus/Diphtheria (Td) booster  
(received within the past 10 years)***



College of Medicine  
Medical Health Administration  
University of South Florida

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## Medical Health Administration

### Division of Infectious Diseases and International Medicine

**DATE:** May 22, 2013

**TO:** Visitors/Volunteers/Observers for the University of South Florida Medical Clinics,  
Clinical Affiliates and/or Research Laboratories

**FROM:** Linda R. Lenneth, RN, MSN Assoc. Director, Medical Health Administration

**SUBJECT:** **Communicable Disease Prevention Certification**

Completion of the Communicable Disease Prevention Certificate is required if you responded “**Yes**” to **question #1** on the screening Questionnaire i.e. you will have direct patient contact. Prior to your visit to a **Clinical Area** at the University of South Florida Clinics, and/or its affiliated institutions, you must complete and return the attached form and supportive documentation 30 days prior to your arrival.

**\*\*You will not be permitted in patient care areas until the form and documentation are complete\*\***

If you have a history of a Positive TB skin test in the past, you must submit a completed copy of a **Screening Questionnaire** along with a Negative **Chest X-ray** report completed within 12 months of your start date at USF. A Questionnaire can be found and downloaded from the USF Medical Health Administration website at: <http://hsc.usf.edu/medicine/internalmedicine/infectious/medicalhealthadmin/forms.html>

If, in the normal course of your job, you will have the potential to come in contact with Human blood, body fluids, tissue or sharps such as needles, you must show documentation that you have either completed the Hepatitis B vaccine series and have a “Positive” Hepatitis B surface antibody titer (Quantitative) or have declined the vaccine. You will also need to complete the OSHA Bloodborne Pathogen Training prior to your visit.

If you will be working with animals in a research lab setting, you must show documentation of a “current” Tetanus/Diphtheria (Td) booster (received within the past 10 years).

If you will have direct contact with **Infants from 0-12 months**, you will need to show evidence of **Pertussis** immunization. A combination tetanus toxoid, reduced diphtheria toxoid and acellular pertussis (Tdap) **Adacel™** vaccine was licensed in June, 2005 for use in persons aged 11-64 years and (Tdap) **BOOSTRIX®** vaccine was licensed in December, 2008 for use in persons aged 10-64 years as a single dose booster vaccination (ie. to be given in place of **one** tetanus diphtheria (Td) booster for adolescents and adults). Please note that the Advisory Committee on Immunization Practices (ACIP) recommends at least a **2 year interval** between the last tetanus/diphtheria (Td) booster and Tdap to reduce the risk of reactions following vaccination. If you have received a Td booster within the last 2 years, Tdap should be postponed at this time and you will need to provide documentation of the date you received the Tetanus/diphtheria (Td) booster.

The completed Communicable Disease Prevention Certification form along with the required, supportive documentation specified should be mailed or faxed to:

**Linda Lenneth, RN, MSN, Medical/Health Administration, USF College of Medicine, MDC Box 19  
12901 Bruce B. Downs Blvd. Tampa, FL 33612-4799 Fax: 813-974-3415**

**The University Of South Florida Morsani College Of Medicine is unable to provide the vaccines and laboratory titers required. These immunizations and/or laboratory tests must be completed prior to your visit. If you are not able to receive certain immunizations i.e. they are contraindicated; please contact us directly to discuss your situation. All required vaccines are readily available through your local Health Department.**

If you have any questions regarding the communicable disease prevention certification process, please contact us by email, phone or fax:

Phone: **(813) 974-3163**  
Email: [llennert@health.usf.edu](mailto:llennert@health.usf.edu) or [kperry@health.usf.edu](mailto:kperry@health.usf.edu)  
Fax: **(813) 974-3415**

## Communicable Disease Prevention Certification: Visitors, Volunteers, Observers

Prior to your visit to a **Clinical Area** at the University of South Florida, its affiliated institutions and/or selected Research Laboratories (**See Memo**), this form **must** be completed and submitted with **all required documentation attached 30 days prior to your arrival**. You will not be permitted in patient care areas until the form and documentation are complete.

**All documentation must be in English.**

PRINTED NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

STREET: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE NUMBER(S): \_\_\_\_\_ EMAIL: \_\_\_\_\_

### COMPLETE ITEMS A - H

**A. TUBERCULOSIS:** Documentation of an initial "2-Step" Tuberculin Skin Test (TST/ PPD) within **6 months** of visit to USF. There must at least 1 to 3 weeks between Step 1 and Step 2.

TST Step 1	Date	Result	TST Step 2	Date	Result
		____mm induration			____mm induration

If 2<sup>nd</sup> step of 2 step Tuberculin Skin Test not within 6 months of start date at USF, please complete the following:

TST	Date	Result
		____mm induration

Individuals with a history of a positive TST/PPD skin test must submit documentation of a negative chest x-ray within **12 months** of visit to USF and a current Screening Questionnaire for signs/symptoms of TB (see memo)\*

CXR (if required)	Date:	Result (ATTACHED):
* Current Screening Questionnaire (if required) History of INH for treatment of Latent TB Infection: From ____/____/____ To ____/____/____ Received BCG vaccine Yes <input type="checkbox"/> No <input type="checkbox"/>		Date Required Documentation Completed Questionnaire Copy

**B. RUBELLA (German Measles):** Serologic documentation of a positive Rubella immune titer **OR** immunization with at least **one dose of live Rubella or MMR vaccine after 12 months of age**.

Rubella Titer (IgG Blood Test)	Pos <input type="checkbox"/> Neg <input type="checkbox"/>	Result <u>    </u> Date <u>    </u>	<b>Required Documentation</b>
<b>Or One</b> live Rubella or MMR vaccine after <b>1/1/80</b>			Lab Report Copy Vaccine Documentation Copy

**C. RUBEOLA: (10 Day Measles):** Serologic documentation of a positive Rubeola immune titer **OR** immunization with **two doses of live Rubeola or MMR vaccine administered after 12 months of age and separated by 28 days or more**.

Rubeola Titer (IgG Blood Test)	Pos <input type="checkbox"/> Neg <input type="checkbox"/>	Result <u>    </u> Date <u>    </u>	<b>Required Documentation</b>
<b>Or Two</b> live Rubeola or <b>Two</b> MMR vaccines after <b>1/1/80</b>			Lab Report Copy Vaccine Documentation Copy

**D. MUMPS:** Serologic documentation of a positive Mumps immune titer **OR** immunization with at least **two doses of live Mumps or MMR vaccine after 12 month of age**.

Mumps Titer (IgG Blood Test)	Pos <input type="checkbox"/> Neg <input type="checkbox"/>	Result <u>    </u> Date <u>    </u>	<b>Required Documentation</b>
<b>Or Two</b> live Mumps or <b>Two</b> MMR vaccines after <b>1/1/80</b>			Lab Report Copy Vaccine Documentation Copy

**E. VARICELLA (Chicken Pox):** Serologic documentation of a positive Varicella titer **OR** two Varicella immunizations (given 4 to 8 weeks apart). This requirement is satisfied only by a positive titer or the vaccine series.

**\*\* A history of chicken pox does NOT satisfy this requirement \*\***

Varicella Titer (IgG Blood Test)	Pos <input type="checkbox"/> Neg <input type="checkbox"/>	Result <u>    </u> Date <u>    </u>	<b>Required Documentation</b>
<b>Or</b> Varicella vaccine series		#1 <u>    </u> / <u>    </u> / <u>    </u> #2 <u>    </u> / <u>    </u> / <u>    </u>	Lab Report Copy Vaccine Documentation Copy

## Communicable Disease Prevention Certification: Visitors, Volunteers, Observers (page 2)

**F. TETANUS/DIPHTHERIA/PERTUSSIS (Tdap):** Documentation of a Tetanus/diphtheria/acellular pertussis booster only if you will have contact with **Infants 0-12 months of age**. Tdap (Adacel™) vaccine was licensed in June, 2005 for use in persons aged 11-64 years and Tdap (BOOSTRIX®) vaccine was licensed in December, 2008 for use in persons aged 10-64 years as a single dose booster vaccination (ie. to be given in place of **one** tetanus diphtheria (Td) booster for adolescents and adults).

**Note:** a 2 year interval between Td (tetanus/diphtheria booster) and Tdap is suggested to reduce the risk of reactions following vaccination. If you have received a Td booster within the past 2 years, provide documentation of the Td Booster at this time and at the end of the 2 year period, you will need to obtain a Tdap booster and provide documentation upon completion.

<b>Tdap (Adacel™ or BOOSTRIX®) vaccine</b>	<u>Date</u> ____/____/____	<u>Required Documentation</u> Vaccine Documentation Copy
<b>Or</b> Ineligible for Tdap vaccine as Tetanus/diphtheria (Td) vaccine was received <b>within last 2 years</b>	____/____/____	Vaccine Documentation Copy

**G. HEPATITIS B:** (Required only if you will have a risk of exposure to blood and/or body fluids)  
Serologic documentation of a Positive **(Quantitative) Hepatitis B surface antibody titer** following completion of the Hepatitis B vaccination series of 3 injections. You must provide documentation of the Vaccine series **AND** the Positive Antibody Titer to meet this requirement.

	<u>Result</u>	<u>Date</u>	<u>Required Documentation</u>
Hepatitis B Surface Antibody Titer (IgG) (Quantitative) Pos <input type="checkbox"/> Neg <input type="checkbox"/>		____/____/____	Lab Report Copy
<b>AND</b> Hepatitis B vaccine series #1 ____/____/____ #2 ____/____/____ #3 ____/____/____			Vaccine Documentation Copy

**H. Laboratory Personnel ONLY: TETANUS/DIPHTHERIA (Td):** Documentation of a Tetanus/diphtheria (Td) **OR** Tetanus/diphtheria/acellular pertussis (Tdap) booster within the **past 10 Years** if you will have contact with animals in a research laboratory.

	<u>Date</u>	<u>Required Documentation</u>
Td or Tdap vaccine (Booster within the past 10 years)	____/____/____	Vaccine Documentation Copy

**Please return completed form and supportive documents to:**

Linda R. Lenneth, RN, MSN, Assoc. Director **OR** Kathy Perry, LPN, Administrative Assistant  
Medical Health Administration - Employee/Student Health & Wellness  
USF College of Medicine, MDC 19  
12901 Bruce B. Downs Blvd.  
Tampa, FL 33612-4799

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