Morsani College of Medicine
Medical Health Administration (MHA)
University of South Florida
mha@health.usf.edu

12901 Bruce B. Downs Blvd., MDC 19
Tampa, FL 33612-4799
Phone: (813) 974-3163
Fax: (813) 974-3415

Medical Health Administration (MHA)

USF HEALTH Department of Quality, Safety & Risk (QSR)

TO:	Residents and Fellows Entering the University of South Florida Morsani College of Medicine, **Academic Year 2017/2018**
FROM:	Diana Doughty, RN, MBA, CIC, FAPIC, CPHQ, LHRM, Assoc. Director, Medical Health Administration
SUBJECT:	**Communicable Disease Prevention Certification Form**
DUE DATE:	**May 1, 2017**

Prior to beginning training at the University of South Florida and its affiliated institutions, you must:

1) Complete and return the attached **Communicable Disease Prevention Certification Form** to the **MHA Office**
2) Submit all Required Documentation as specified in each of the blocks on the Certification Form
3) All documentation must be in **ENGLISH.**

You are urged to obtain the documentation from your Medical School or current Residency Program.
You will not be permitted to begin your program until the form and documentation are complete.

N-95 Respirator Fit Testing:

- Verification of fit-testing using a Tecnol N-95 or a 3M N-95 mask is required within 6 months of your start date.
- The Manufacturer's name and mask size must be included on the report of the testing

Submit the completed Communicable Disease Prevention Certification form along with the required, supportive documentation specified in **one** of the following ways:

1) Upload the documents to New Innovations
2) Scan and email to **mha@health.usf.edu**
3) Fax to (813) 974-3415 (Please call to confirm receipt)
4) Mail to the following address:

Medical Health Administration
13330 USF Laurel Drive, MDC 33
Tampa, FL 33612

The University of South Florida Morsani College of Medicine is unable to provide the TB screening, vaccines and/or laboratory titers required for starting your program. These Immunizations and/or laboratory tests must be completed prior to beginning your program. If you are not able to receive certain immunizations e.g. they are contraindicated, please contact us directly to discuss your situation.

Annual Requirements:

1) TB Screening will be required during your entire program. This Screening will be provided at no cost to you through the Medical Health Administration (MHA) office or from our clinical affiliates.

2) INFLUENZA Vaccination will be required each year. This vaccine will be provided for you at no cost beginning in October of each year through the USF Medical Clinic/Medical Health Administration (MHA) office or from our clinical affiliates.

If you have any questions regarding the communicable disease prevention certification process, please contact us directly:

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Communicable Disease Prevention Certification: Residents / Fellows

Prior to beginning training at the University of South Florida and its affiliated institutions, this form ***must*** be completed and submitted with ***all required documentation attached by May 1, 2017***
All documentation must be in English.

PRINTED NAME:_____ DATE:_____

STREET:_____ CITY:_____ STATE: _____ ZIP:_____

PHONE NUMBER(S): _____ EMAIL: _____

DATE OF BIRTH: _____/_____/_____ **Residency / Fellowship Program (SPECIALTY):**_____

COMPLETE ITEMS A-I

A. **TUBERCULOSIS (TB) Screening:** To meet the USF requirement, you must submit documentation of **ONE** of the following:

1. Results of NEGATIVE **"Two-Step" TB Skin Testing (TST/PPD). This screening requires 2 separate TB skin tests** administered at least one week apart but within 12 months of each other. The last TST must be within 6 months of your start date. **Attach provider documentation.**

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

2. **OR** Lab Copy showing a "NEGATIVE" Interferon Gamma Release Assay (IGRA) blood test **(QFT or T-Spot)** within 6 months of start date (accepted in lieu of the "Two-Step" TST).

OR
I am submitting NEGATIVE Interferon Gamma Release Assay (IGRA) blood test results (QFT/T-Spot) in lieu of the "Two-Step" TST. **Copy of the Lab report required**. Date of test:_____

3. **OR** Individuals with a history of a POSITIVE TB skin test or IGRA must submit both of the following:
   Verification of a NEGATIVE Chest X-ray within 12 months of start date to the USF COM **and**
   a. A current NEGATIVE Screening Questionnaire. A Questionnaire can be found and downloaded from the USF Medical Health Administration website at:
   http://hsc.usf.edu/medicine/internalmedicine/infectious/medicalhealthadmin/Forms.htm

OR
Individuals with a history of a **POSITIVE TB skin test or IGRA blood test** must submit the following:

CXR	Date of Chest X-ray:	Result (ATTACH REPORT):
ATTACH the COMPLETED Screening Questionnaire: Date:		

B. MEASLES (RUBEOLA): Two doses 1 year after birthdate.

	Result	Date	Required Documentation
Rubeola Titer (IgG Blood Test)	Pos ☐ Neg ☐	___/___/___	Lab Report Copy
Or **Two** live Rubeola or **Two** MMR vaccines after **1/1/80** #1 ___/___/___ #2 ___/___/___			Vaccine Documentation Copy

C. MUMPS: Two doses 1 year after birthdate.

	Result	Date	Required Documentation
Mumps Titer (IgG Blood Test)	Pos ☐ Neg ☐	___/___/___	Lab Report Copy
Or **Two** live Mumps or **Two** MMR vaccines after **1/1/80** #1 ___/___/___ #2 ___/___/___			Vaccine Documentation Copy

D. RUBELLA (German Measles): One dose 1 year after birthdate.

	Result	Date	Required Documentation
Rubella Titer (IgG Blood Test)	Pos ☐ Neg ☐	___/___/___	Lab Report Copy
Or **One** live Rubella or MMR vaccine after **1/1/80**		___/___/___	Vaccine Documentation Copy

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Communicable Disease Prevention Certification: Residents / Fellows (Page 2)

E. VARICELLA (Chicken Pox): *Serologic documentation of a positive Varicella titer **OR** two Varicella immunizations (given at least 4 to 8 weeks apart).* ***** A history of chicken pox does NOT satisfy this requirement *****

	Result	Date	Required Documentation
Varicella Titer (IgG Blood Test)	Pos ☐ Neg ☐	___/___/___	Lab Report Copy
Or Varicella vaccine series	#1___/___/___ #2___/___/___		Vaccine Documentation Copy

F. Adacel™or BOOSTRIX® Vaccine Booster: *Documentation of an Adult* **TETANUS/diphtheria/acellular pertussis (Tdap)** vaccine booster is required. Tdap was licensed in June, 2005 for use as a single dose booster vaccination *(ie. not for subsequent booster doses).* The current CDC recommendation states "Healthcare personnel, regardless of age, should receive a single dose of Tdap as soon as feasible if they have not previously received Tdap and regardless of the time since last Td dose".

	Date	Required Documentation
Tdap (Adacel™or BOOSTRIX®) vaccine	___/___/___	Vaccine Documentation Copy

G. HEPATITIS B Vaccination Series: *Documentation of a complete Hepatitis B vaccination series of 3 injections.*

	Vaccination Dates	Required Documentation
Complete Hepatitis B vaccine series:	**#1**___/___/___ **#2** ___/___/___ **#3** ___/___/___	Vaccine Documentation Copy

H. HEPATITIS B "POSITIVE" QUANTITATIVE SURFACE ANTIBODY TITER (Blood Test): *Serologic documentation of a Positive **(QUANTITATIVE) Hepatitis B surface antibody titer** that verifies IMMUNITY to the Hepatitis B Virus. The TITER is required in addition to completion of the vaccination series. The results should be reported as "POSITIVE" or as a number. "REACTIVE" results will NOT be accepted.*

	Result	Date	Required Documentation
Hepatitis B Surface Antibody Titer (IgG) (**Quantitative**)	Pos ☐ Neg ☐	___/___/___	Lab Report Copy

If the antibody titer is Negative, you will need to have dose #4 and then a titer 30 days after the #4 vaccine dose.
#4_____ Quantitative Antibody Titer Pos ☐ Neg ☐ ___/___/___ Submit Documentation and Lab Report.
If your titer is still negative, contact us.

I. N-95 RESPIRATOR FIT TESTING: *Documentation of fit testing using the Technol N-95 or a 3M N-95 mask completed within **6 months** of start date at USF. **A Copy of the Fit Test Record must be submitted**. If your facility does not offer fit-testing, indicate below and you will be scheduled for a fit-test upon arrival at USF.*

Date:	Manufacturer / MODEL Number:	Size:
___/___/___	Kimberly-Clark (Tecnol):_____	_____
	3M Mask:_____	_____

☐ **I am unable to arrange fit-testing at my current facility.**

***Note:* Several affiliated hospitals require drug and alcohol screening with and without advanced notice.**

Please Return Completed Form and Supportive Documents in ONE of the following ways:

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