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

13330 USF Laurel Drive, MDC 33
Tampa, FL 33612-
Phone: (813) 974-3163
Fax: (813) 974-3415

Medical Health Administration (MHA)

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

TO:	Medical Students Entering the University of South Florida Morsani College of Medicine Program, **Academic Year 2017/2018 (Class of 2021)**
FROM:	Diana Doughty, RN, MBA, CIC, FAPIC, CPHQ, LHRM, Assoc. Director, Medical Health Administration
SUBJECT:	**Communicable Disease Prevention Certification & Physical Examination Verification Forms**
DUE DATE:	**July 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) Submit the Physical Examination Verification Form **AFTER** it is completed and signed by your Healthcare Provider
4) All documentation must be in **ENGLISH.**

A Hepatitis B ***Positive Quantitative*** antibody titer is required. Healthcare requirements differ from general public requirements. Read more info at: http://www.immunize.org/catg.d/p2109.pdf or www.cdc.gov/mmwr/pdf/rr/rr6210.pdf

USF Meningococcal Vaccination Requirement:
In order to register for classes, USF requires all incoming students to either submit evidence of Meningitis immunization **or** a signed declination form. The immunization is required **ONLY** if you will be living in student housing. **If you do not submit this documentation, you will be blocked from registering for classes.**

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

1) Scan and email to **mha@health.usf.edu**
2) Fax to (813) 974-3415 (Please call to confirm receipt)
3) Mail to the following address:
   Medical Health Administration
   13330 USF Laurel Drive, MDC 33
   Tampa, FL 33612
4) Deliver in person to Morsani Room 6108

We are 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. All vaccines are readily available through your Primary Care provider, Walk-in Clinics, select Pharmacies or your local Health Department.

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

Phone: **(813) 974-3163**
Email: **mha@health.usf.edu**
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Vaccine and health requirements are subject to change based on CDC recommendations.

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Communicable Disease Prevention Certification: Medical Students

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 July 1, 2017***
All documentation must be in English.

PRINTED NAME:_____DATE:_____ Class of:_____

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

PHONE NUMBER(S): _____ EMAIL: _____

DATE OF BIRTH: ___/_____/_____ USF STUDENT NUMBER: _____ (ex. UXXXXXXXX)

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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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: Tdap was licensed in June, 2005 for use as a single dose booster vaccination. 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. MENINGOCOCCAL Vaccination: *Documentation of immunization with **one dose** of Meningococcal vaccine after 16th birthday **OR** a completed and signed USF Student Health Services Immunization Health History Form*

	Date:	Required Documentation
Meningococcal vaccine (**Required if living in USF Housing)	___/___/___	Vaccine Documentation Copy

OR Signed Declination

I have read the information (http://www.cdc.gov/vaccines/hcp/vis/vis-statements/mening.html) about Menactra/Meningococcal Meningitis and decline receipt of this vaccine **and** will **NOT** be living on a USF campus.

_____ _____ _____ _____

Signature of Student | Date | AND | Signature of parent/guardian Relationship if student under 18 | Date

**** ANNUAL 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 at the start of your 2nd and 3rd years.**

**** 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.**

***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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2) Fax to (813) 974-3415 (Please call to confirm receipt)
3) Mail to the following address:
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PHYSICAL EXAMINATION VERIFICATION

To be completed by Student *(please print)*

LAST NAME _____ FIRST NAME _____ MIDDLE NAME _____

USF STUDENT NUMBER (UXXXXXXXX) _____ BIRTHDATE (mm/dd/year) _____

Do you have any health problems or concerns of which USF Student Health Services should be aware?

☐ Yes ☐ No

If you wish to receive care for the above problems or concerns at USF Student Health services, it is your responsibility to make a follow-up appointment and to provide copies of pertinent medical records as necessary.

Student Signature _____ Date _____

To be completed by Physician

A thorough history and physical examination were completed on the above named individual, with the following results:

☐ All findings were within normal limits
☐ The individual is free from TB in a communicable form, and apparent signs and symptoms of other communicable diseases.
☐ Follow-up care is required; Patient was advised

Comments: _____

_____

Physician Signature **Printed Name** Date

Facility Name *(please print)* office phone number

Address

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