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

Medical Health Administration (MHA)
USF HEALTH Department of Quality and Safety

TO:	Residents and Fellows Entering the University of South Florida Morsani College of Medicine
FROM:	Medical Health Administration
SUBJECT:	**Communicable Disease Prevention Certification & Physical Examination Verification Forms**
DUE DATE:	May 1 of your start year

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.

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@usf.edu**

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 may be required during your entire program. This Screening will be provided at no cost to you through the Medical Health Administration (MHA) office after your first year.

2) INFLUENZA Vaccination will be required each year. This vaccine will be provided for you at no cost beginning in August or when the vaccine is received of each year through the USF Medical Clinic/Medical Health Administration (MHA) office.

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

Phone: **(813) 974-3163**
Email: **mha@usf.edu**

Medical Health Administration (MHA)
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Communicable Disease Prevention Certification: Residents/Fellows

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

PRINTED NAME:____DATE:_______________

STREET:___________________________________ CITY:_______________ STATE: ______ ZIP:_______________

PHONE NUMBER(S): ____________________________________ EMAIL: _____________________________________

DATE OF BIRTH: ___/_____/_____ Residency/Fellowship Program (Specialty)____________________________________

☐ **I completed a previous Residency or Medical School at USF HEALTH. Complete section D and complete page #4. We have your records if you completed a previous Residency or Medical School.**

COMPLETE ITEMS A-G

A. **TUBERCULOSIS (TB) Screening:** Attach provider documentation or lab results for the section(s) completed.

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 I am submitting NEGATIVE** Interferon Gamma Release Assay (IGRA) blood test results (QFT/T-Spot) in lieu of the "Two-Step" TST. Must be within 6 months of the start date. **Copy of the Lab report required**. Date of test:____________

3. **OR** Individuals with a history of a **POSITIVE TB skin test without a follow-up IGRA or a POSITIVE IGRA** must submit the following:
   a. Verification of a NEGATIVE Chest X-ray within 12 months of start date.
      Date of Chest X-ray_______________ Result_____________(Attach report)

B. MMR (Measles, Mumps, Rubella) *Choose one option*: Attach Vaccine Documentation

Option 1

MMR: 2 doses of vaccine after the first birthday Dose #1 ___/___/___ #2 ___/___/___

OR Option 2

Attach vaccine documentation or the lab report
(Serologic results can be historical)

Measles Dose #1 ___/___/___ #2 ___/___/___ OR Serologic Immunity (IgG, antibodies titer) Date__/__/_____Results__________

Mumps Dose #1 ___/___/___ #2 ___/___/___ OR Serologic Immunity (IgG, antibodies titer) Date__/__/_____Results__________

RUBELLA: 1 Dose ___/___/____ OR Serologic Immunity (IgG, antibodies titer) Date__/__/_____Results__________

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Name:

C. VARICELLA (Chicken Pox): 2 doses of vaccine or positive serology.
***** A history of chicken pox does NOT satisfy this requirement *****

Two Varicella immunizations #1___/___/___ #2___/___/___ Vaccine Documentation Copy

Or Varicella Titer (IgG Blood Test) Date___/___/___ Results____________ Lab Report Copy
(Serologic results can be historical)

D. Adacel™or BOOSTRIX® Vaccine Booster: One Tdap on or after June 2005**, if >8 years ago, an updated Tdap or Td.**

Tdap (Adacel™or BOOSTRIX®) vaccine **Date** ___/___/___ Vaccine Documentation If>8 years ago, also need: Updated Tdap **Date** ___/__/____ or TD __/__/____

E. HEPATITIS B Vaccination Series: *Documentation of a complete Hepatitis B vaccination series of 2 or 3 injections.*

Two Series Dates (Heplisave) **#1 __/__/____ #2 __/__/____ OR**

Three series Dates: **#1**___/___/___ **#2** ___/___/___ **#3** ___/___/___ Vaccine Documentation Copy

F. HEPATITIS B "POSITIVE" QUANTITATIVE SURFACE ANTIBODY TITER (Blood Test) *that verifies IMMUNITY to the Hepatitis B Virus. The results should be reported as "POSITIVE" or as a number. "REACTIVE" results will NOT be accepted unless the lab report states that reactive means immunity to Hepatitis B.*

Hepatitis B Surface Antibody Titer (IgG) (**Quantitative**) Date ___/___/___ Result________ Lab Report Copy
(Results can be historical)

(The Hepatitis B Quantitative Surface Antibody test can be performed by any lab that offers the service. For your convenience, if using **Quest Labs, the test number is 8475** or if using **Lab Corp, the test number is 006530**.)

If the antibody titer is Negative, you will need to have Hepatitis B vaccine dose #4 and then a titer 30 days later.

#4 Dose of Hepatitis B Vaccination Date __/__/______ Submit Vaccine Documentation

Quantitative Antibody Titer Date___/___/____ Results:______________ Lab Report Copy

If your titer is still negative, contact us. (813-974-3163)

ANNUAL TB Screening may be required during your entire program. This Screening will be provided at no cost to you through the Medical Health Administration (MHA) office after your first year.

INFLUENZA VACCINATION will be required each year. This vaccine will be provided for you at no cost through the Medical Health Administration (MHA) office.

USF HEALTH

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TUBERCULOSIS SCREENING QUESTIONNAIRE

Employee/Student Health and Wellness
Department of Clinical Affairs
USF Health Morsani College of Medicine
Phone: 813-974-3163 Fax: 813-974-3415

DATE: ____________________________

Last Name: __ __ __ __ __ __ __ __ __ __ **First Name**: __ __ __ __ __ __ __ __ __ __ __ __ Date of Birth____/____/____
Please Print Please Print

Email Address: ____________________________ **Phone:** ______________________

☐**USF Health STUDENT: College:**____________________________**Graduation Year:**___________________

☐**EMPLOYEE Department**: ______________________________**Other**_________________________________

Have you ever received BCG Vaccine? ☐No ☐ Yes → If YES, date of BCG: _______________

Have you ever had a Positive TB Skin Test ☐No ☐ Yes If YES, when_________________ and did you take any medication associated with the positive TB skin test? ☐No ☐Yes → Dates: _____________

What medication(s) did you take? _____________ Did you complete the course of Medication ☐No ☐ Yes

Please check (√) your response for any of the following **Unexplained Symptoms/Questions**

Unexplained fatigue	☐ Yes ☐ No	Night sweats (drenching)	☐ Yes ☐ No
Unexplained weight loss	☐ Yes ☐ No	Unexplained Persistent cough (>2 weeks)	☐ Yes ☐ No
Loss of appetite	☐ Yes ☐ No	Spitting/coughing up blood	☐ Yes ☐ No
Fever (usually at night)	☐ Yes ☐ No	Pain in chest	☐ Yes ☐ No

Have you had temporary or permanent residence (for ≥ 1 month) in a country with a high TB rate (i.e., any country **other than** Australia, Canada, New Zealand, the United States and those in western or northern Europe)?	☐ Yes ☐ No
Current or planned immunosuppression, including human immunodeficiency virus infection, receipt of an organ transplant, treatment with a TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone ≥ 15 mg/day for ≥ 1 month), or other immunosuppressive medication?	☐ Yes ☐ No
Close contact with someone who has had infectious TB disease since the last TB test?	☐ Yes ☐ No

Box: MHA, Forms, TB