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

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
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@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 after your first year.

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.

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**
Fax: **(813) 974-3415**

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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, 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):**_____

COMPLETE ITEMS A-I

A. **TUBERCULOSIS (TB) Screening:**

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 both of the following:
   a. Verification of a NEGATIVE Chest X-ray within 12 months of start date.
      Date of Chest X-ray_____ Result_____(Attach report)
      and
   b. A current Screening Questionnaire. A Questionnaire can be obtained by emailing mha@health.usf.edu and requesting the Screening Questionnaire form.
      Date form completed_____

B. MEASLES (RUBEOLA): Positive Titer or 2 vaccines

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

C. MUMPS: Positive Titer or 2 vaccines

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

D. RUBELLA (German Measles): Positive Titer or 1 vaccine

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

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Communicable Disease Prevention Certification: (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 Two Varicella immunizations	#1___/___/___	#2___/___/___	Vaccine Documentation Copy

F. Adacel™or BOOSTRIX® Vaccine Booster: Tdap on or after June 2005

	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) *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.*

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

(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 Pos ☐ Neg ☐ ___/___/___ Lab Report Copy

If your titer is still negative, contact us.

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 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.