Medical Health Administration (MHA)

Prior to beginning training at the University of South Florida and its affiliated institutions, you must complete and return the attached form and supportive documentation **30 days prior to your arrival.**

Patient contact will not be permitted until the form and documentation are complete. You are urged to obtain the following documentation from your medical school or current residency program. All documentation must be in **ENGLISH**.

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

TB Screening: USF Health utilizes the tuberculin skin test (TST) to determine if a healthcare worker is infected with M. tuberculosis. All new healthcare employees and students must submit documentation of an initial TST
To meet the USF requirement, you must submit:

- Documentation of a current "Negative" TST **within 6 months** of training start date is required OR
- Documentation of a current "Negative" IGRA blood test (QFT / T-Spot) within 6 months of start date will be accepted in lieu of the TST.
- If you have a history of a Positive TB screening in the past (TST / QFT / T-Spot), you must submit a copy of a Negative Chest X-ray report.
- Tuberculosis Screening Questionnaire must be completed by everyone.

Documentation of influenza vaccination is required for visiting rotations scheduled from September through March.

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

Medical/Health Administration, Fax: 813-974-3415 or email to mha@usf.edu

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

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

Communicable Disease Prevention Certification: VISITING Residents

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 30 Days prior to beginning your rotation.*** Patient contact will not be permitted until the form and documentation are complete.
All documentation must be in English.

PRINTED NAME:_____ DATE:_____

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

PHONE NUMBER(S): _____Residency Program Specialty: _____

DATE OF BIRTH: _____/_____/_____ Visiting Dates from _____ To _____ __

COMPLETE ITEMS A-I

A. **TUBERCULOSIS (TB) Screening: Everyone who has TB screening must complete page #4.**

1. Results of NEGATIVE TB Skin Testing (TST/PPD). The last TST must be within 6 months of your start date. **Attach provider documentation.**

TST	Date Placed	Date Read	Result
			_____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
      Date of Chest X-ray_____ Result_____(Attach report)

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

Communicable Disease Prevention Certification:

Name_____

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, if more than 10 years ago, an updated Tdap or Td is required.

	Date	Circle one	Date	Required Documentation
Tdap (Adacel™or BOOSTRIX®) vaccine	___/___/___	If > 10 years Tdap or Td	____/____/____	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

I. INFLUENZA: *Documentation of Influenza vaccination **is required for visiting rotations scheduled from September through March**.*

	Date	Required Documentation
Influenza vaccine (**Required if rotation scheduled September through March.)	___/___/___	Vaccine Documentation Copy

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

Please return completed form and supportive documents to:

Medical Health Administration, Morsani Room 6108
Phone: 813-974-3163
FAX: 813-974-3415
Email : mha@ usf.edu (PREFERRED)

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**: _____

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_____

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
Have you had close contact with someone who has had infectious TB disease since the last TB test?	☐ Yes ☐ No