



**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



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. **A. INTERNATIONAL Residents/Fellows:** 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

1. **B. US Residents/Fellows:** (Have resided in the US for the past year) Results of Negative TB Skin testing (TST/PPD) within 6 months of 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 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 _____



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	<input type="checkbox"/> Yes <input type="checkbox"/> No	Night sweats (drenching)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Unexplained weight loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Unexplained Persistent cough (>2 weeks)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Loss of appetite	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spitting/coughing up blood	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fever (usually at night)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in chest	<input type="checkbox"/> Yes <input type="checkbox"/> 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