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:	Incoming USF Health Students
FROM:	Medical Health Administration
SUBJECT:	**Communicable Disease Prevention Certification & Physical Examination Verification Forms**
DUE DATE:	PA Students - April 1 of Incoming Year College of Pharmacy Students - Deadline Determined by Admissions Medical Students – July 1 of Incoming Year DPT Students – July 1 of Incoming 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.**
4) **I**f you are relying on your provider to complete and fax the form, it is your responsibility to follow-up with your provider to ensure the forms have been sent to us.

Healthcare requirements differ from general public requirements. 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.

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** (PREFERRED)
2) Fax to (813) 974-3415 (Please call to confirm receipt)
3) Deliver in person to Morsani (MDH Building) Room 6108
4) Mail to the following address:
   Medical Health Administration
   Morsani Room 6108
   12901Bruce B. Downs Blvd., MDC 33
   Tampa, FL 33612

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:

Prior to beginning training at the University of South Florida this form ***must*** be completed and submitted with ***all required documentation attached.*** **All documentation must be in English.**

PRINTED NAME:_____DATE:_____

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

PHONE NUMBER(S): _____ EMAIL: _____

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

College/Graduation Year:
College of Medicine/_____ Due by July 1 **College of DPT/_____ Due by July 1**
College of Pharmacy/_____ Deadline Determine by Admissions
PA Program/_____ Due by April 1

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.

I. MENINGOCOCCAL Vaccination: *The signed Declination, **below**, or documentation of immunization with **one dose** of Meningococcal vaccine after 16th birthday.*

Signed Declination: I 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

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

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PHYSICAL EXAMINATION VERIFICATION

To be completed by Student *(please print)*

_____ _____ _____
LAST NAME FIRST NAME MIDDLE NAME

_____/____/_____
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 Provider

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: _____

_____

_____
Provider Signature **Printed Name** Date

_____
Facility Name *(please print)* office phone number

_____
Address

_____

Please return completed form to:

Medical Health Administration
FAX: 813-974-3415
Email: mha@health.usf.edu (PREFERRED)