Communicable Disease Prevention Certification:
USF Health Clinical Providers

PRINTED NAME (Include maiden name)_____ DATE:_____

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

DATE OF BIRTH: ____/____/___ PHONE NUMBER: _____ EMAIL: _____

DEPARTMENT: _____DIVISION: _____SUPERVISOR:_____

☐ **I completed a previous** Clinical Rotation at USF HEALTH as a Student and/or Resident Physician

As a new USF Health Clinical Provider, you <u>may</u> be required to meet Communicable Disease screening requirements depending upon your job classification and/or job responsibilities:

- Verification of immunity to common vaccine preventable communicable diseases, including: Rubeola, Mumps, Rubella, and Varicella.
- Documentation of Negative Tuberculosis Screening within the past 6 months.
- Documentation of an Adult Tdap (Tetanus, diphtheria, acellular pertussis) Booster
- Verification of Immunity to the Hepatitis B Virus.
- Fit Testing to wear a N-95 Respirator
- Education in Bloodborne Pathogen Exposure prevention and management (within 10 days of employment).

Please Answer the Following Questions to determine if you will need to meet Screening Requirements:

1) Will you have direct patient contact?
   ☐ Yes ☐ No
2) Will you have the potential to come in contact with human blood, body fluids, tissue or sharps?
   ☐ Yes ☐ No
3) Will you practice in a USF Clinical Affiliate Hospital?
   ☐ Yes ☐ No If "YES" Please specify Site(s): _____
4) Will you be working in a Research lab setting?
   ☐ Yes ☐ No If "YES", when was your last Tetanus Booster?_____

If you answered "YES" to Question 1, 2 and/or 3 above, you will need to complete the Communicable Disease Prevention Certification Form and return to the MHA Office along with documentation of any immunizations, and/or laboratory titer results that you may have already received in the past.

Please send the information in advance of your arrival to USF, if possible, to expedite your in-processing:

1) Scan and email to <u>mha@health.usf.edu</u>
2) Fax to **(813) 974-3415**

If you do not have documentation, we will provide the appropriate lab testing, TB Screening, N-95 Respirator Fit-testing and any required vaccinations during your orientation to USF Health.

If you will have a risk of exposure to blood or body fluids in the normal course of your job duties, you will need to complete the "on-line" Bloodborne Pathogen education program "Safety-Back to Basics" available on the **"USF LEARN" website: https://learn.health.usf.edu/login/index.php**

Morsani College of Medicine
Medical Health Administration
University of South Florida
March 1, 2016

12901 Bruce B. Downs Blvd., MDC 19
Tampa, FL 33612-4799
Phone: (813) 974-3163
Fax: (813) 974-3415

Communicable Disease Prevention Certification:
USF Health Clinical Providers

Prior to beginning employment in a ***Clinical Area*** at the University of South Florida or any Clinical Affiliate, this form ***must*** be completed with ***all required documentation attached*** and returned to the office of Medical Health Administration**.** If you do not have the required documentation, lab testing will be ordered during your orientation. Patient contact will not be permitted until the form and documentation are complete.

COMPLETE ITEMS A-H

A. **TUBERCULOSIS (TB) Screening:** To meet the USF requirement, you must submit documentation of **ONE** of the following:

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.
2. Lab Copy showing a "NEGATIVE" Interferon Gamma Release Assay (IGRA) blood test **(QFT or T-Spot)** within 6 months of start date (accepted in lieu of the "Two-Step" TST).
3. Individuals with a history of a POSITIVE TB skin test or IGRA blood test must submit both of the following:
   a. Verification of a NEGATIVE Chest X-ray within 12 months of start date to the USF COM **and**
   b. A current NEGATIVE Screening Questionnaire. A Questionnaire can be found and downloaded from the USF Medical Health Administration website at: http://hsc.usf.edu/medicine/internalmedicine/infectious/medicalhealthadmin/Forms.htm

TST Step 1	Date Placed	Date Read	Result	TST Step 2	Date Placed	Date Read	Result
			____mm induration				____mm induration
OR **I am submitting NEGATIVE** Interferon Gamma Release Assay (IGRA) blood test results (QFT/T-Spot) in lieu of the "Two-Step" TST. **Copy of the Lab report required**. Date of test:_____							
OR Individuals with a history of a **POSITIVE TB skin test or IGRA Blood test** must submit the following:							
CXR	Date of Chest X-ray:		Result (ATTACH REPORT):				
ATTACH the COMPLETED Screening Questionnaire: Date:							

B. RUBEOLA: (10 Day Measles): *Serologic documentation of a positive Rubeola immune titer **OR** immunization with **two doses of live** Rubeola or MMR vaccine administered after 12 months of age and separated by 28 days or more.*

		Result	Date	Required Documentation
	Rubeola Titer (IgG Blood Test)	Pos ☐ Neg ☐	___/___/___	Lab Report Copy
Or	Two live Rubeola or two MMR vaccines after 1/1/80	**(#1)** ___/___/___	**(#2)** ___/___/___	Vaccine Documentation Copy

C. MUMPS: *Serologic documentation of a positive Mumps immune titer **OR** immunization with **two doses of live** Mumps or MMR vaccine after 12 month of age.*

		Result	Date	Required Documentation
	Mumps Titer (IgG Blood Test)	Pos ☐ Neg ☐	___/___/___	Lab Report Copy
Or	Two live Mumps or two MMR vaccines after 1/1/80	**(#1)** ___/___/___	**(#2)** ___/___/___	Vaccine Documentation Copy

D. RUBELLA (German Measles): *Serologic documentation of a positive Rubella immune titer **OR** immunization with at least **one dose of live** Rubella or MMR vaccine after 12 months of age.*

		Result	Date	Required Documentation
	Rubella Titer (IgG Blood Test)	Pos ☐ Neg ☐	___/___/___	Lab Report Copy
Or	One live Rubella or MMR vaccine after 1/1/80		___/___/___	Vaccine Documentation Copy

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E. VARICELLA (Chicken Pox): *Serologic documentation of a positive Varicella titer **OR** two Varicella immunizations (given 4 to 8 weeks apart). This requirement is satisfied only by a positive titer or the vaccine series.*

***** 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 Varicella vaccine series		**(#1)** ___/___/___ **(#2)** ___/___/___	Vaccine Documentation Copy

F. Adacel™or BOOSTRIX® Vaccine Booster: *Documentation of an Adult* **TETANUS/diphtheria/acellular pertussis (Tdap)** vaccine booster is required. The current CDC recommendation states "Healthcare personnel, regardless of age, should receive a single dose of Tdap as soon as feasible if they have not previously received Tdap and regardless of the time since last Td dose". After receiving Tdap, personnel should receive routine booster shots against tetanus and diphtheria by existing guidelines (every 10 years)".

	Date	Required Documentation
Tdap (Adacel™or BOOSTRIX®) vaccine	___/___/___	Vaccine Documentation Copy

G. HEPATITIS B: *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: *Serologic documentation of a Positive **(QUANTITATIVE) Hepatitis B surface antibody titer**.*

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

**** Annual TB Screening may be required during your employment and will be offered at no cost through the USF Medical Health Administration office.**

**** Annual Influenza Vaccination is highly encouraged and may be required by certain affiliated clinical facilities. This vaccine will be provided for you at no cost beginning in October of each year through the USF Medical Health Administration office.**

Please complete entire form, attach any documentation you have and return to the MHA Office.
If you have any questions or need additional information or clarification about the USF Health Communicable Disease Screening requirements, please contact us directly at (813) 974-3163

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MHA Office Location:
USF Health Morsani Center (MDH)
13330 USF Laurel Drive
6th Floor – Room 6108

USF UNIVERSITY OF SOUTH FLORIDA

Student Health Services

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Name of Patient/Previous Name(s) _____

Date of Birth _____ Student ID Number _____ Phone Number _____

I REQUEST AND AUTHORIZE:	RELEASE HEALTH INFORMATION TO:
_____	USF COM- Medical Health Administration
Name of Health Care Provider/Plan/Other	Name of Health Care Provider/Plan/Other
_____	12901 Bruce B. Downs Blvd., MDC 19
Street Address	Street Address
_____	Tampa, FL 33612-4799
City, State, Zip	City, State, Zip
_____	(813)974-3163
Telephone #	Telephone #
_____	(813)974-3415
Fax #	Fax #

INFORMATION TO BE RELEASED:

☐ Entire Record ☐ Discharge Summary ☐ GYN Records including PAP Smear ☐ Progress Notes
☐ X-ray Reports ☐ Allergy Records ☐ Laboratory Reports ☐ TB Skin Test Results
☐ Sexually Transmitted Diseases ☐ Immunizations
☐ Other (Specify): _____

DISCLOSURES REQUIRING SPECIAL CONSENT: If requesting information relating to: (1) Acquired immunodeficiency syndrome ("AIDS") or human immunodeficiency virus ("HIV") infection; (2) treatment for drug or alcohol abuse; (3) mental or behavioral health or psychiatric care, excluding psychotherapy notes or (4) genetic testing, specific authorization on this form or a court order is required since this information is privileged. A separate authorization is required for psychotherapy session notes. Psychotherapy session notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date. 45 CFR 164.501. I am authorizing that the following information also be disclosed. **Initial all that apply.**

_____ HIV/AIDS _____ Sexual Assault/Victimization _____ Mental Health Condition _____ Alcohol/Drug Abuse/Treatment

For the following date(s): From: _____ to _____

Disclosure may be in the form of photocopies, verbal or fax.

PURPOSE FOR DISCLOSURE: **medical clearance for new employment**

I may revoke this authorization form at any time by notifying the above-referenced records custodian at the location listed above, of my intent to revoke this authorization. Returning this form, signed, dated and with the words "authorization revoked" is sufficient notice. However, I understand that such revocation will not have any effect on any information already used or disclosed by the University of South Florida before the University received my written notice of revocation. ***This authorization expires 90 days from date signed.***

I may inspect and receive a copy of the information to be used and disclosed pursuant to this Authorization form. I understand that I am not required to sign this Authorization form in exchange for the patient receiving treatment from the University of South Florida or _____ _____. I also understand that payment, enrollment in a health plan and/or eligibility for benefits will not be conditioned upon my signing this form. I understand that I may refuse to sign this form. There is a potential that the PHI may be re-disclosed by the recipient and no longer protected by federal or state privacy laws.

Note: First requests for the patient are at no charge. The charge thereafter will be $1.00 per page for the first 25 pages and $0.25 per page thereafter. The information released may be subject to re-disclosure by the receiving entity. I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of Patient _____ (If signed by person other than patient, state relationship and authority to do so.) Date _____

Patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased
Legal Authority: ☐ Custodial Parent ☐ Legal Guardian ☐ Executor or Estate of Deceased
☐ Power of Attorney for Health Care ☐ Authorized Legal Representative

Action Taken: ☐ Pick up ☐ Mail ☐ Fax
Date _____ Staff Initials _____
Approval: Date _____ Staff Initials _____

SHS Policy Committee Approval 01.13.10