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

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

# Medical Health Administration (MHA)

## USF HEALTH Department of Clinical Affairs

| | |
|---|---|
| **DATE**: | January 22, 2015 |
| **TO:** | Medical Students Entering the University of South Florida Morsani College of Medicine Program, **Academic Year 2015/2016 (Class of 2019)** |
| **FROM:** | Linda R. Lennerth, RN, MSN Assoc. Director, Medical Health Administration (MHA) |
| **SUBJECT:** | **Communicable Disease Prevention Certification & Physical Examination Verification Forms** |
| **DUE DATE:** | **July 1, 2015** |

### 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) Submit the Physical Examination Verification Form **AFTER** it is completed and signed by your Healthcare Provider
4) All documentation must be in **ENGLISH.**

**Do NOT wait until the last minute to complete these requirements. It may take time to locate your past immunization records, obtain required vaccinations and schedule a physical exam appointment with your Primary Care Provider.**

**USF Meningococcal Vaccination Requirement:**
In order to register for classes, USF requires all incoming students to either submit evidence of Meningitis immunization **or** a signed declination form. The immunization is required **ONLY** if you will be living in student housing. If you decide to decline the vaccination, you must print off a copy of the USF Student Health Immunization form. The form is available for download at http://www.usf.edu/student-affairs/student-health-services/documents/mandatory-imm-form-122014.pdf. Check the declination box in Block 3, sign the form (#4), then attach it to the Communicable Disease Prevention Certification Form.
**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**
2) Fax to (813) 974-3415 (Please call to confirm receipt)
3) Mail to the following address:

**Medical Health Administration**
**USF Morsani College of Medicine - MDC Box 19**
**12901 Bruce B. Downs Blvd. Tampa, FL 33612-4799**

**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. All vaccines are readily available through your Primary Care provider, Walk-in Clinics or your local Health Department.**

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

Linda R. Lennerth, RN, MSN, Associate Director, MHA
Kathy Perry, LPN
Phone: **(813) 974-3163**
Email: **mha@health.usf.edu**
Fax: **(813) 974-3415**

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# Communicable Disease Prevention Certification: Medical Students

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 July 1, 2015***.
**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)

## COMPLETE ITEMS A-I

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 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** 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** must submit the following: | | | | | | | |
| CXR | Date of Chest X-ray: | | Result (ATTACH REPORT): | | | | |
| ATTACH the COMPLETED Screening Questionnaire: Date: | | | | | | | |

**B. MEASLES (RUBEOLA):** *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 at least **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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# Communicable Disease Prevention Certification: Medical Students (page 2)

**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. Tdap was licensed in June, 2005 for use as a single dose booster vaccination *(ie. not for subsequent booster doses).* 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".

| | 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):** *Serologic documentation of a Positive **(QUANTITATIVE) Hepatitis B surface antibody titer** that verifies IMMUNITY to the Hepatitis B Virus. The TITER is required in addition to completion of the vaccination series. The results should be reported as "POSITIVE" or as a number. "REACTIVE" results will NOT be accepted.*

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

**I. MENINGOCOCCAL Vaccination:** *Documentation of immunization with **one dose** of Meningococcal vaccine after 16th birthday **OR** a completed and signed USF Student Health Services Immunization Health History Form (Block 3, checkbox, signature) declining receipt of the Meningitis vaccine. The form is available at:* http://www.usf.edu/student-affairs/student-health-services/documents/mandatory-imm-form-122014.pdf.

| | | Date: | Required Documentation |
|---|---|---|---|
| | Meningococcal vaccine (**Required if living in USF Housing) | ___/___/___ | Vaccine Documentation Copy |
| ***Or*** | **Completed and signed** USF SHS Immunization Health History Form (Block 3, checkbox and signature) | ___/___/___ | USF SHS Immunization Health History Form |

**** 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 at the start of your 2nd, 3rd, and 4th years.**

**** 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.**

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

**Please Return Completed Form and Supportive Documents in ONE of the following ways:**

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2) Fax to (813) 974-3415 (Please call to confirm receipt)
3) Mail to the following address:

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# PHYSICAL EXAMINATION VERIFICATION

**To be completed by Student** *(please print)*

LAST NAME _____ FIRST NAME _____ MIDDLE NAME _____

USF STUDENT NUMBER (UXXXXXXXX) _____ 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 Physician**

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: _____

_____

**Physician Signature** **Printed Name** Date

Facility Name *(please print)* office phone number

Address

**Please return completed form to:**

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