Office of the Registrar
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# Communicable Disease Prevention Certification – Visiting Students

**Prior to entering** any of the affiliated institutions of the University of South Florida clinical training programs, this form **must** be completed with **all required documentation attached**. **All** deficiencies must be remedied before your application for a course will be processed. Patient contact will not be permitted until the form and documentation are complete. You are urged to obtain the following documentation from your current program. Perceived contraindications to the administration of any vaccine must be communicated in writing and attached to this form.

**REQUIREMENTS ARE SUBJECT TO CHANGE WITHOUT PRIOR NOTICE BASED UPON RECOMMENDATIONS FROM THE CDC.**

**COMPLETE ITEMS A-K**

PRINTED NAME:______________________________________________ DATE OF BIRTH:__________________

**REQUIRED IMMUNIZATIONS** (To be completed by Health Care Provider)

**A. TUBERCULOSIS:** *Documentation of a Tuberculin Skin Test (TST/ PPD) within* ***6 months*** *of visit to USF. Individuals with a history of a positive TST/PPD skin test must submit documentation of a negative chest x-ray within* ***12 Months*** *of visit to USF* ***and*** *a current screening questionnaire for signs/symptoms of TB (see memo).*

| | Result | Date | Required Documentation |
|---|---|---|---|
| TST/PPD (within past 6 months) | Pos ☐ Neg ☐ | ___/___/___ | Skin Test Documentation Copy |
| If **positive** TST/PPD, CXR (within past 12 months) | | ___/___/___ | Radiology Report Copy |
| ***And*** Current Screening Questionnaire | | ___/___/___ | Completed Questionnaire Copy |
| History of INH for treatment of Latent TB Infection: | | From___/___/___ To ___/___/___ | |
| Received BCG vaccine | Yes ☐ No ☐ | ___/___/___ | |

**B. 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 |

**C. 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** | | ___/___/___ ___/___/___ | Vaccine Documentation Copy |

**D. 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** | | ___/___/___ ___/___/___ | Vaccine Documentation Copy |

**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 | | ___/___/___ ___/___/___ | Vaccine Documentation Copy |

**F. HEPATITIS B:** *Serologic documentation of a Positive* ***(Quantitative) Hepatitis B surface antibody titer*** *following completion of the Hepatitis B vaccination series of 3 injections. You must provide documentation of the Vaccine series* ***AND*** *the Positive Antibody Titer to meet this requirement.*

| | Result | Date | Required Documentation |
|---|---|---|---|
| Surface Antibody Titer (IgG)(quantitative) | Pos ☐ Neg ☐ | ___/___/___ | Lab Report Copy |
| ***And*** Hepatitis B vaccine series | ___/___/___ | ___/___/___ ___/___/___ | Vaccine Documentation Copy |

***Continued on next page***

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**STUDENT NAME:** ______________________________________________

**G. TETANUS/DIPHTHERIA/PERTUSSIS (Tdap):** *Documentation of a Tetanus/diphtheria/acellular pertussis booster.* **Tdap (Adacel™)** vaccine was licensed in June, 2005 for use in persons aged 11-64 years as a single dose booster vaccination *(ie. not for subsequent booster doses).*
***Note**: a 2 year interval between Td (tetanus/diphtheria booster) and Tdap is suggested to reduce the risk of reactions following vaccination. If you have received a Td booster within the past 2 years, provide documentation of the Td Booster at this time and at the end of the 2 year period, you will need to obtain a Tdap booster and provide documentation upon completion.*

| | Date | Required Documentation |
|---|---|---|
| **Tdap (Adacel™) vaccine** | ___/___/___ | Vaccine Documentation Copy |
| *Or* Ineligible for Tdap vaccine *as* tetanus/diphtheria (Td) vaccine was received **within last 2 years** | ___/___/___ | Vaccine Documentation Copy |

**H. N-95 RESPIRATOR FIT TESTING**: *Documentation of fit testing completed within* ***6 months*** *of visit to USF. A Copy of the Fit Test Record must be submitted.*

| Date: | Manufacturer / MODEL Number: | Size: |
|---|---|---|
| ___/___/___ | Kimberly-Clark (Technol):________________<br>3M Mask:________________<br>Other:___________________ | ________________ |

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

| | Date | Required Documentation |
|---|---|---|
| Influenza Virus Vaccine | ___/___/___ | Vaccine Documentation Copy |

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

**J. HEALTH CARE PROVIDER CERTIFICATION AND ADDRESS:**
I certify that the information noted in items A - I is true and accurate to the best of my knowledge.

SIGNATURE: ______________________________________ DATE: ____________________

Please print/type Heath Care Provider's name, stamp address, and business phone.

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

**K. STANDARD/UNIVERSAL PRECAUTIONS:** Personal assurance that you are thoroughly familiar with Standard/Universal Precautions in the management of patients.

I certify that I am aware of and intend to practice "Standard/Universal Precautions" in the management of patients throughout my training program with USF and its affiliated institutions.

Information on this form is true and accurate to the best of my knowledge. Students who knowingly provide false information on this form are subject to dismissal.

STUDENT SIGNATURE: ________________________________ DATE: ____________________

***APPENDIX B***

# TUBERCULOSIS SCREENING
## History of Positive TB Skin Test

**Employee/Student Health and Wellness**
**Division of Infectious Disease and International Medicine**
**College of Medicine**
**813-974-3163**

## Please complete the following information if you have a History of a Positive TB skin test:

**EMPLOYEE / STUDENT / FACULTY INFORMATION:** **DATE:**

**Last Name**: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ **First Name**: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

*Please print!* *Please print!*

**College/School:** ☐ Medicine ☐ Public Health ☐ Medical Clinics ☐ Nursing ☐ Physical Therapy ☐ Other:_____________

**Department/Unit/Zone**: ________________________

**Cell Phone:**________________ **Home Phone:**________________

**Work Phone:** ____________________________ **Mail Code**: ________________ **Fax**: __________________

**Email Address**:____________________

**Position:** ☐ MD ☐ DO ☐ ARNP ☐ PA ☐ Resident / Fellow: PGY____

☐RN ☐ LPN ☐MA ☐ Student ☐ Other:____________________

Have you ever received BCG? ☐No ☐ Yes → If YES, date of BCG: ______________________

Date of last PPD skin test: ______________________

Did you take any medication associated with the positive TB skin test? ☐No ☐Yes → Dates: ___________
What medication(s) did you take?

Please check (√) your response for any of the following **unexplained symptoms**:

1. Unexplained fatigue ☐ Yes ☐ No
2. Unexplained weight loss ☐ Yes ☐ No
3. Loss of appetite ☐ Yes ☐ No
4. Fever (usually at night) ☐ Yes ☐ No
5. Night sweats (drenching) ☐ Yes ☐ No
6. Persistent cough (>2 weeks) ☐ Yes ☐ No
7. Spitting/coughing up blood ☐ Yes ☐ No
8. Pain in chest ☐ Yes ☐ No

Date of last chest x-ray: ________________ Results:______________________