



Morsani College of Medicine  
Medical Health Administration (MHA)  
University of South Florida  
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12901 Bruce B. Downs Blvd., MDC 19  
Tampa, FL 33612-4799  
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**Medical Health Administration (MHA)**  
**USF HEALTH Department of Quality, Safety and Risk**

<b>DATE:</b>	February 25, 2016
<b>TO:</b>	Physician Assistant (PA) Students Entering the University of South Florida Morsani College of Medicine Program, <b>Academic Year 2017/2018 (Class of 2019)</b>
<b>FROM:</b>	Linda R. Lennerth, RN, MSN Assoc. Director, Medical Health Administration (MHA)
<b>SUBJECT:</b>	<b>Communicable Disease Prevention Certification &amp; Physical Examination Verification Forms</b>
<b>DUE DATE:</b>	<b>April 1, 2017</b>

**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](mailto: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, Select Pharmacies 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](mailto:mha@health.usf.edu)  
Fax: **(813) 974-3415**



## Communicable Disease Prevention Certification: Physician Assistant (PA) 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 April 1, 2017**.  
**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 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
<b>OR</b>							
I am submitting <b>NEGATIVE</b> Interferon Gamma Release Assay (IGRA) blood test results (QFT/T-Spot) in lieu of the "Two-Step" TST. <b>Copy of the Lab report required.</b> Date of test: _____							
<b>OR</b>							
Individuals with a history of a <b>POSITIVE TB skin test or IGRA Blood test</b> 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.**

Rubeola Titer (IgG Blood Test)	<b>Result</b> Pos <input type="checkbox"/> Neg <input type="checkbox"/>	<b>Date</b> ___/___/___	<b>Required Documentation</b> Lab Report Copy
<b>Or Two</b> live Rubeola or <b>Two</b> MMR vaccines after <b>1/1/80</b> #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.**

Mumps Titer (IgG Blood Test)	<b>Result</b> Pos <input type="checkbox"/> Neg <input type="checkbox"/>	<b>Date</b> ___/___/___	<b>Required Documentation</b> Lab Report Copy
<b>Or Two</b> live Mumps or <b>Two</b> MMR vaccines after <b>1/1/80</b> #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.**

Rubella Titer (IgG Blood Test)	<b>Result</b> Pos <input type="checkbox"/> Neg <input type="checkbox"/>	<b>Date</b> ___/___/___	<b>Required Documentation</b> Lab Report Copy
<b>Or One</b> live Rubella or <b>MMR vaccine after 1/1/80</b>			Vaccine Documentation Copy



**Communicable Disease Prevention Certification:  
 Physician Assistant (PA) 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 \*\***

	<u>Result</u>	<u>Date</u>	<u>Required Documentation</u>
Varicella Titer (IgG Blood Test)	Pos <input type="checkbox"/> Neg <input type="checkbox"/>	___/___/___	Lab Report Copy
<b>Or</b> 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".

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

**G. HEPATITIS B Vaccination Series:** Documentation of a complete Hepatitis B vaccination series of 3 injections.

	<u>Vaccination Dates</u>	<u>Required Documentation</u>
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.

	<u>Result</u>	<u>Date</u>	<u>Required Documentation</u>
Hepatitis B Surface Antibody Titer (IgG) ( <b>Quantitative</b> )	Pos <input type="checkbox"/> Neg <input type="checkbox"/>	___/___/___	Lab Report Copy

**I. MENINGOCOCCAL Vaccination:** Documentation of immunization with **one dose** of Meningococcal vaccine after 16<sup>th</sup> 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>.

	<u>Date:</u>	<u>Required Documentation</u>
Meningococcal vaccine (**Required if living in USF Housing)	___/___/___	Vaccine Documentation Copy
<b>Or</b> 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.**

**\*\* 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:**

- 1) Scan and email to [mha@health.usf.edu](mailto:mha@health.usf.edu)
- 2) Fax to (813) 974-3415 (Please call to confirm receipt)
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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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