Jefferson Occupational Health Network
33 S. 9th Street, Suite 205
Philadelphia, PA 19107
T: 215-955-6835 F: 215-923-5778

June, 2021

Dear Visiting Student:

Thank you for your interest in participating in an elective at Sidney Kimmel Medical School/Jefferson University Hospital. As a health care facility, we have requirements as follows that must be completed and approved prior to the scheduling of the rotation.

1. **Complete immunization form. See attachment.**
   Please review the requirements and submit with legible writing, copies of lab results if warranted. Incomplete or inaccurate information will delay your clearance and may jeopardize your ability to do the rotation.
2. **10 panel drug test within 30 days of submission of the immunization records**
   This test would be completed at your home institution. A copy of the result must be forwarded along with the immunization forms.

Beginning 8/1/2021 ALL students visiting Jefferson MUST have proof of receiving the COVID vaccine to come on campus.

To submit the information, please do one of the following:

Mail to: 33 S. 9th Street, Suite 205, Philadelphia, PA 19107; OR,

Email to jeffuhs@jefferson.edu

DO NOT FAX THIS DOCUMENTATION

Questions may be addressed by calling (215) 955-6835 or emailing jeffuhs@jefferson.edu

Once we have reviewed and approved the information, we will forward your clearance to the Registrar's Office to schedule.

Sincerely,

Kenneth M. Lankin, MD, MBA, MPH

Kenneth M. Lankin, MD, MBA, MPH
Enterprise Medical Director, Jefferson Occupational Health Network

Revised 01/2019
Revised 6/2021

Jefferson Health
HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

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VISITING STUDENT HEALTH DOCUMENTATION

NAME:____ GENDER: ☐ MALE ☐ FEMALE ☐ OTHER

DATE OF BIRTH: _____/_____/_____ TIME PERIOD OF YOUR VISIT: ____

ADDRESS: ____ CELL PHONE: ______________________________

____EMAIL:___________________________________

THE FOLLOWING INFORMATION IS REQUIRED. INCOMPLETE FORMS WILL DELAY YOUR START DATE.

PHYSICIAN/CRNP/EMPLOYEE HEALTH RN MUST COMPLETE AND SIGN BELOW.

A. Chicken Pox/Varicella: Proof of immunity will mean two doses of varicella or serologic evidence of immunity.

Immunization dates: #1 ________________ # 2 _________________

Titer date: ________________ Result (copy must be attached): ☐ Immune ☐ Not Immune

B. Rubella: Proof of immunity to German Measles will mean one dose of the rubella vaccine or serologic evidence of the disease.

Immunization date: ________________

Titer date: ________________ Result (copy must be attached): ☐ Immune ☐ Not Immune

C. Rubeola: Proof of immunity to measles means two doses of live vaccine (after 1968) administered on or after the first birthday, separated by at least one month, or serologic evidence of immunity.

Immunization dates: #1 ________________ # 2 _________________

Titer date: ________________ Result (copy must be attached): ☐ Immune ☐ Not Immune

D. Mumps: Proof of mumps immunity means two doses of mumps vaccine administered on or after the 1st birthday or serologic evidence of immunity.

Immunization dates: #1 ________________ #2 _________________

Titer date: ________________ Result (copy must be attached): ☐ Immune ☐ Not Immune

E. Tuberculosis Screen: IGRA (Interferon-Gamma Release Assays) blood test is required.

Date:____/____/____(must be within 3 months) **Result (copy must be attached):** ☐ Positive ☐ Negative ☐ Indeterminate

If IGRA is positive, a chest x-ray is required. Date:____/____/____(must be within 6 months; **attach a copy of the report)**

F. Influenza Vaccination from current or most recent season (PRIOR TO ARRIVAL):
Date of administration: ______________ **Lot #**_________________ **Manufacturer:** ________________________ **Exp** ___________

G. Pertussis: Proof of immunity will mean documentation of the Tdap vaccine (tetanus, diphtheria, pertussis or ADACEL).
Immunization date: ____________________________ (must be within the past 10 years)

H. Hepatitis B: Immunization dates: #1____/____/____ #2____/____/____ #3____/____/____ **AND** HBsAb titer date:____/____/____
(Required only if providing direct patient care)

☐ Immune ☐ Not Immune **(must attach titer results)**

COVID-19 Vaccine: Immunization dates: #1 _____/_____/_____ #2 _____/_____/_____/ **Brand:** __________________________

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☐ **I attest that I have examined this individual and he/she is free of communicable diseases.**

(REQUIREMENT FOR ALL VISITING STUDENTS.)

☐ **ATTACH COPY OF NEGATIVE 10 PANEL FORENSIC DRUG TEST**
MUST BE PERFORMED WITHIN 30 DAYS OF START

MD/CRNP: ___________________________________**(Print) Signature:** _______________________________ **Date:** _____________

Address: ____ **Phone**:_____________

Frequently Asked Questions

Regarding the Immunization/TB screening Requirements

1. **Can I document a history of disease for varicella?**
   No. History of disease is not accepted. The requirement is EITHER a reactive titer OR documentation of two doses of Varivax. No exceptions.
2. **Can I use estimated dates of vaccinations?**
   Approximate dates are not acceptable. If an individual has no reliable vaccine documentation for measles, mumps, or rubella, blood tests (titers) with reactive results must be submitted to document immunity.
3. **Can I document a TB skin test for my TB screen?**
   The requirement is an interferon gamma release assay (IGRA) and a copy of the lab result must be submitted. Those who have a history of latent tuberculosis with treatment must submit a copy of a chest x-ray done within 6 months of start.
4. **If I had BCG, what TB screen should I submit?**
   The interferon gamma release assay is the appropriate test to submit.
5. **I have had Td vaccine. Is that adequate?**
   The required vaccine is Tdap (tetanus, diphtheria, pertussis) and it must be within the previous 10 years.
6. **What should I do if I have not had the Tdap vaccine?**
   Tdap vaccination within the past 10 years is required and must be documented to complete the requirements.
7. **I have no dates of vaccinations for my hepatitis B vaccine and would like to know what to do?**
   The hepatitis B surface antibody must be documented as proof of immunity. Past reactive antibodies may be submitted, regardless of date.
8. **What if my hepatitis B surface antibody is non-reactive?**
   Additional vaccinations must be received. Contact Jefferson Occupational Health Network for more information.
9. **Is the hepatitis B vaccine required for all contracted employees?**
   This vaccine is required for anyone who is involved in direct patient care or works in patient care areas where there is potential exposure to blood or body fluids.
10. **What is a forensic 10 panel drug test? A medical review officer must sign off on the drug test result.**

Revised 01/2019
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