ADVOCATE HEALTH CARE MEDICAL EDUCATION
STUDENT/RESIDENT MEDICAL & IMMUNIZATION CLEARANCE FORM

This form must be completed in its ENTIRETY and on file 4 weeks before the rotation start date.

Name: _____ SSN:(last 5 digits) _____

Address: _____
Street City, State Zip Code

Phone: _____ DOB ___/___/___ College/Univ./Sponsor Hosp.: _____

AHC Hospital/Rotation: _____ Rotation Dates: _____

REQUIRMENTS

TB Surveillance:

a.) Skin Testing: Last TB skin test **OR** Quantiferon (QFT) test must be done **WITHIN ONE CALENDAR YEAR OF THE ROTATION END DATE.** Skin test result MUST be read in mm of induration.

b.) If TB skin test **OR** QFT is/was POSITIVE, the student MUST attach a copy of a negative CXR report. In addition, if a student/resident has had a positive TB screening in the past he/she MUST attach a copy of the Advocate annual screening questionnaire completed within one year of the rotation start date.

DATE of last TB skin test: _____ RESULT in mm: _____

DATE of last QFT: _____ RESULT: _____

TB Mask Fit Testing: Required prior to rotation start date; must be specific for the mask listed
Required Brand: Halyard Tecnol Fluid Shield PFR95 N95 Particulate Filter Respirator
TB Mask Fit Test Date: ____/____/____ Size (circle one): Regular/Model #46767 or Small/Model #46867

Immunization Record:

Circle Results

Rubella Immunity Status
Rubella Titer: Date____/____/____ Result: Immune / Non Immune - or
Proof of Vaccination: Date # 1 ____/____/____ # 2 ____/____/____

Rubeola Immunity Status
Rubeola Titer: Date ____/____/____ Result: Immune / Non Immune - or
Proof of Vaccination: Date # 1 ____/____/____ # 2 ____/____/____

Mumps Immunity Status
Mumps Titer: Date ____/____/____ Result: Immune / Non Immune - or
Proof of Vaccination: Date # 1 ____/____/____ # 2 ____/____/____

Varicella Immunity Status
Varicella Titer: Date ____/____/____ Result: Immune / Non Immune - or
Proof of Vaccination: Date # 1 ____/____/____ # 2 ____/____/____

Hepatitis B Immunity Status
Hepatitis B AB Titer: Date ____/____/____ Result: Positive / Negative
Hepatitis B Vaccination: Date #1____/____/____ # 2 ____/____/____ # 3 ____/____/____

Tetanus/Diphtheria/Pertussis (Tdap): Date vaccinated ____/____/____

Flu Vaccine: Current flu season vaccine required prior to rotations occurring between 10/1 and 4/30. Date vaccinated ____/____/____

The information provided on this questionnaire is accurate to the best of my knowledge. I understand and agree that any misrepresentation or omissions may be justification for denial of student/resident privileges. I authorize Advocate Heath Care to verify any information contained in this health history.

Signature_____ Date_____

Please return this form to the appropriate personnel of the Hospital Department/Program where you will be rotating.

Effective 7/2015