

Medical Student Medical Clearance Instructions Utilizing the AAMC Standardized Immunization Form

The [AAMC Standardized Immunization form](#) must be completed and signed by your health care provider or institutional representative. The provider or institutional representative must put their title and stamp on form. Please review the Northwell Health Visiting Student Application Service (VSAS) Medical Clearance requirements listed below to ensure that the [AAMC Standardized Immunization form](#) is completed in the appropriate sections.

Northwell Health Visiting Student Application Service (VSAS) Medical Student Clearance Requirements

Attestation of Physical Exam

- Submit the Northwell Health **VSAS Attestation of Physical Examination** form. Physical Examination must be completed within the past 12 months.
- This form must be completed, signed and stamped by the examining provider, a healthcare provider or school designee.

Tuberculosis Screening Proof of immunity

- **Tuberculosis Screening within the past 12 months.**
- **Proof of immunity to Measles, Mumps, Rubella, Varicella** (If submitting proof of immunity via lab titers - official lab report must be submitted)
- **Hepatitis B Surface Antibody** (2 vaccination series or positive titer proof)
- **Hepatitis B Surface Antigen** (titers only required if Hep B antibody is negative).
- *These requirements must be met and submitted by using the AAMC Standardized Immunization Form.*

Vaccination Proof: Tetanus/Diphtheria/Pertussis Seasonal Influenza

- **Proof of Tdap vaccination given as an adult dose & Proof of Influenza vaccination during the current flu season.**
- *These requirements must be met and submitted by using the AAMC Standardized Immunization Form.*

Instructions for Submission:

- Once you have uploaded the [AAMC Standardized Immunization Form](#) and the Northwell Health VSAS Physical Examination Form in VSAS, **YOU MUST** send an email to qualityrn@northwell.edu with notification of the upload. No documents will be accepted via email or fax.
- Be sure to include: VSAS, your name and your rotation date in the subject line. Example: VSAS, Jane Doe, 7/1/80.
- You must send us an email **every time** you upload new documentation.
- Please Note: If supplemental information is requested, then all documentation must be uploaded again.

No documents will be accepted via email or fax.

Failure to complete the required forms and submit them at least 30 working days prior to the date of the rotation may delay the commencement of your start date.

VSAS Attestation of Physical Examination Form
To be used in conjunction with the AAMC Standardized Immunization Form

Completed by the Student

Today's Date: ___/___/___

Last Name: _____ First Name: _____ M.I. : _____

DOB: ___/___/___ Current Hospital/School: _____

Northwell Health Rotation Location: _____ Department: _____

Rotation Start: ___/___/___ Rotation End: ___/___/___

Healthcare provider/school designee must complete the section below

The above individual has been evaluated in the past 12 months. The results of the evaluation is of sufficient scope to ensure the above named person is free from health impairment which is of potential risk to the patient or which might interfere with the performance of his/her duties, including habituation or addiction to depressants, stimulants, narcotics, alcohol, other drugs or substances which may alter the individual behavior. ***The office that is completing this form will be responsible for maintaining updated medical records for the duration of participant's and/or faculty's interactions within Northwell Health facilities and provide appropriate supporting documentation upon request.***

Healthcare Provider or Facility: _____ Phone: _____

Healthcare Provider or Facility Signature: _____ Date: ___/___/___

Provider/Facility Stamp with Address and Telephone Number:



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AAMC Standardized Immunization Form

Last Name:	First Name:	Middle Initial:
DOB:	Street Address:	
Medical School:	City:	
Cell Phone:	State:	
Primary Email:	ZIP Code:	
Student ID:		

MMR (Measles, Mumps, Rubella) – 2 doses of MMR vaccine or two (2) doses of Measles, two (2) doses of Mumps and (1) dose of Rubella; or serologic proof of immunity for Measles, Mumps and/or Rubella. Choose only one option.				Copy Attached
Option 1	Vaccine	Date		
MMR -2 doses of MMR vaccine	MMR Dose #1	_/_/____	<input type="checkbox"/>	
	MMR Dose #2	_/_/____		
Option 2	Vaccine or Test	Date		
Measles -2 doses of vaccine or positive serology	Measles Vaccine Dose #1	_/_/____	Serology Results	
	Measles Vaccine Dose #2	_/_/____	Qualitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
	Serologic Immunity (IgG, antibodies, titer)	_/_/____	Quantitative Titer Results:	_____ IU/ml
Mumps -2 doses of vaccine or positive serology	Mumps Vaccine Dose #1	_/_/____	Serology Results	
	Mumps Vaccine Dose #2	_/_/____	Qualitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
	Serologic Immunity (IgG, antibodies, titer)	_/_/____	Quantitative Titer Results:	_____ IU/ml
Rubella -1 dose of vaccine or positive serology			Serology Results	
	Rubella Vaccine	_/_/____	Qualitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
	Serologic Immunity (IgG, antibodies, titer)	_/_/____	Quantitative Titer Results:	_____ IU/ml
Tetanus-diphtheria-pertussis – One (1) dose of adult Tdap. If last Tdap is more than 10 years old, provide date of last Td and Tdap				
	Tdap Vaccine (Adacel, Boostrix, etc)	_/_/____	<input type="checkbox"/>	
	Td Vaccine (if more than 10 years since last Tdap)	_/_/____		
Varicella (Chicken Pox) -2 doses of vaccine or positive serology				
	Varicella Vaccine #1	_/_/____	Serology Results	
	Varicella Vaccine #2	_/_/____	Qualitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
			Quantitative Titer Results:	_____ IU/ml
Influenza Vaccine -- 1 dose annually each fall				
Second flu vaccine is for updating your form only		Date		
	Flu Vaccine	_/_/____	<input type="checkbox"/>	
	Flu Vaccine	_/_/____		



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Hepatitis B Vaccination --3 doses of <i>Energix-B, Recombivax</i> or <i>Twinrix</i> or 2 doses of <i>Heplisav-B</i> followed by a QUANTITATIVE Hepatitis B Surface Antibody (titer) preferably drawn 4-8 weeks after 3 rd dose. If negative, complete a second Hepatitis B series followed by a repeat titer. If Hepatitis B Surface Antibody is negative after a secondary series, additional testing including Hepatitis B Surface Antigen should be performed. See: http://www.cdc.gov/mmwr/pdf/rr/rr6210.pdf for more information. Documentation of Chronic Active Hepatitis B is for rotation assignments and counseling purposes only.				Copy Attached
Primary Hepatitis B Series <small>Heplisav-B only requires two doses of vaccine followed by antibody testing</small>	3-dose vaccines (<i>Energix-B, Recombivax, Twinrix</i>) 2-dose vaccines (<i>Heplisav-B</i>)	3 Dose Series	2 Dose Series	<input type="checkbox"/>
	Hepatitis B Vaccine Dose #1	_ / _ / _	_ / _ / _	
	Hepatitis B Vaccine Dose #2	_ / _ / _	_ / _ / _	
	Hepatitis B Vaccine Dose #3	_ / _ / _		
	QUANTITATIVE Hep B Surface Antibody	_ / _ / _	_____ IU/ml	
Secondary Hepatitis B Series <u>Only If no response to primary series</u> <small>Heplisav-B only requires two doses of vaccine followed by antibody testing</small>		3 Dose Series	2 Dose Series	<input type="checkbox"/>
	Hepatitis B Vaccine Dose #4	_ / _ / _	_ / _ / _	
	Hepatitis B Vaccine Dose #5	_ / _ / _	_ / _ / _	
	Hepatitis B Vaccine Dose #6	_ / _ / _		
	QUANTITATIVE Hep B Surface Antibody	_ / _ / _	_____ IU/ml	
Hepatitis B Vaccine Non-responder <small>(If Hepatitis B Surface Antibody Negative after Primary and Secondary Series)</small>	Hepatitis B Surface Antigen	_ / _ / _	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/>
	Hepatitis B Core Antibody	_ / _ / _	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
Chronic Active Hepatitis B	Hepatitis B Surface Antigen	_ / _ / _	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/>
	Hepatitis B Viral Load	_ / _ / _	_____ copies/ml	
Additional Documentation				
<i>Some institutions may have additional requirements depending upon rotation, school requirements or state law. Examples include meningitis vaccine which is mandated in some states if you live in dormitory style housing. If you will be participating in an international experience you may also be required to provide proof of vaccines such as yellow fever or typhoid. Respiratory Fit Testing, etc</i>				
Vaccination, Test or Examination	Date	Result or Interpretation		
Physical Exam (if required)	_ / _ / _			<input type="checkbox"/>
Respiratory Fit Testing	_ / _ / _			<input type="checkbox"/>
	_ / _ / _			
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	_ / _ / _			



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TUBERCULOSIS SCREENING – Results of last (2) TSTs (PPDs) or (1) IGRA blood test are required **regardless** of prior BCG status. If you have a history of a positive TST (PPD) ≥ 10 mm or IGRA please supply information regarding any evaluation and/or treatment below. You only need to complete ONE section.

Skin test or IGRA results should not expire during proposed elective rotation dates
or
must be updated with the receiving institution prior to rotation.

Tuberculosis Screening History

Please complete only one TB section based on your history	Section A		Date Placed	Date Read	Result	Interpretation
	Negative Skin or Blood Test History	TST #1	___/___/___	___/___/___	___ mm	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv
		TST #2	___/___/___	___/___/___	___ mm	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv
		TST #3	___/___/___	___/___/___	___ mm	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv
		TST #4	___/___/___	___/___/___	___ mm	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv
	Last two skin test or IGRAs required T-spots or QuantiFERON TB Gold blood tests for tuberculosis Use additional rows as needed			Date	Result	
		QuantiFERON TB Gold or T-Spot <small>(Interferon Gamma Releasing Assay)</small>	___/___/___		<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	
		QuantiFERON TB Gold or T-Spot <small>(Interferon Gamma Releasing Assay)</small>	___/___/___		<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	
		QuantiFERON TB Gold or T-Spot <small>(Interferon Gamma Releasing Assay)</small>	___/___/___		<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	
		QuantiFERON TB Gold or T-Spot <small>(Interferon Gamma Releasing Assay)</small>	___/___/___		<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	
	Section B		Date Placed	Date Read	Result	
	History of Latent Tuberculosis, Positive Skin Test or Positive Blood Test	Positive TST	___/___/___	___/___/___	___ mm	
				Date	Result	
		QuantiFERON TB Gold or T-Spot <small>(Interferon Gamma Releasing Assay)</small>	___/___/___		<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	
		Chest X-ray	___/___/___			
		Treated for latent TB?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
		If treated for latent TB, list medications taken:				
		Total Duration of treatment latent TB?			___ Months	
	Date of Last Annual TB Symptom Questionnaire			___/___/___		
	Section C			Date		
History of Active Tuberculosis	Date of Diagnosis			___/___/___		
	Date of Treatment Completed			___/___/___		
	Date of Last Annual TB Symptom Questionnaire			___/___/___		
	Date of Last Chest X-ray			___/___/___		



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Additional Information

MUST BE COMPLETED BY YOUR HEALTH CARE PROVIDER OR INSTITUTIONAL DESIGNEE:

Authorized Signature:		Date: ___/___/___
Printed Name:		Office Use Only
Title:		
Address Line 1:		
Address Line 2:		
City:		
State:		
Zip:		
Phone:	(___) ___-_____ Ext: _____	
Fax:	(___) ___-_____	
Email Contact:		

*Sources:

- [Hepatitis B In: Centers for Disease Control and Prevention. Epidemiology and Prevention of Vaccine-Preventable Diseases. Hamborsky J, Kroger A, Wolfe S, eds. 13th ed. Washington D.C. Public Health Foundation, 2015](#)
- [Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices \(ACIP\), MMWR, Vol 60\(7\):1-45](#)
- [CDC Guidance for Evaluating Health-Care Personnel for Hepatitis B Virus Protection and for Administering Postexposure Management, MMWR, Vol 62\(RR10\):1-19](#)
- [Prevention of Hepatitis B Virus Infection in the United States: Recommendations of the Advisory Committee on Immunization Practices, MMWR Vol 67\(1\):1-31](#)