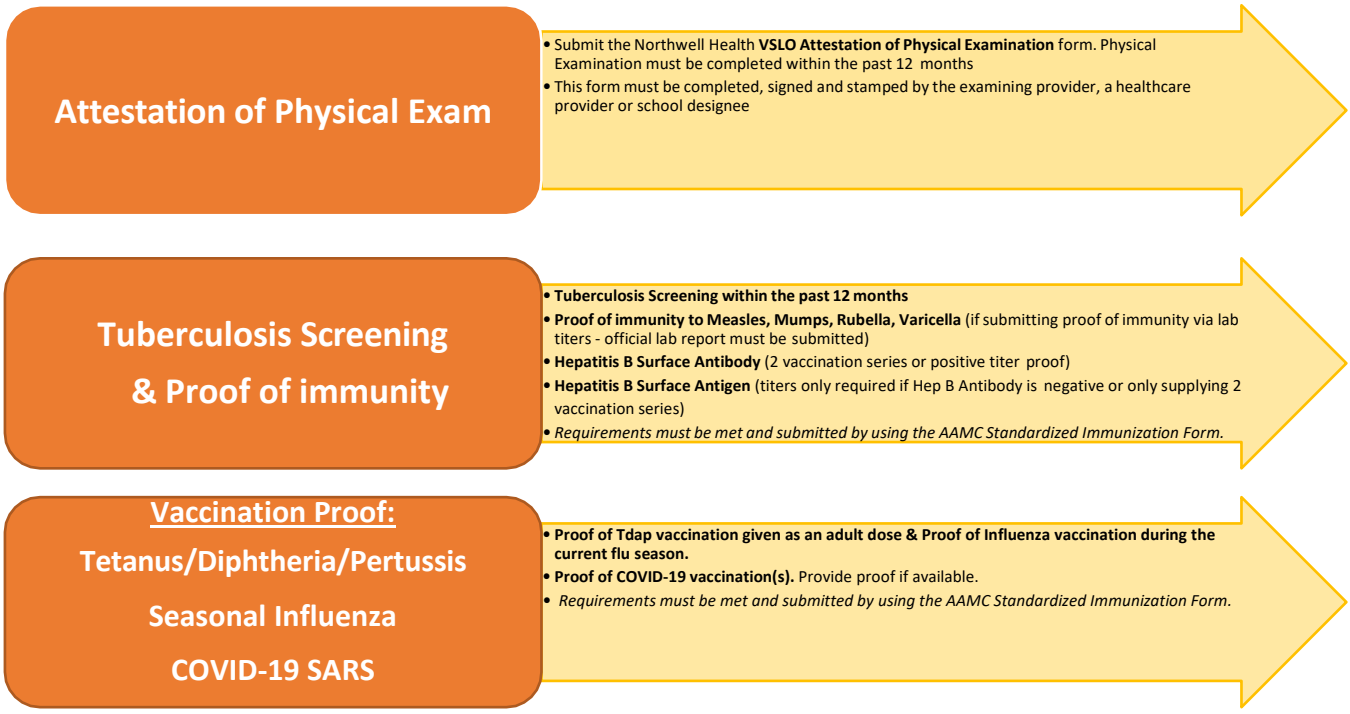
Medical Student Medical Clearance Instructions
Utilizing the AAMC Standardized Immunization Form

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 Learning Opportunities (VSLO) Medical Clearance requirements listed below to ensure that the AAMC Standardized Immunization form is completed in the appropriate sections.

Northwell Health Visiting Student Learning Opportunities (VSLO) Medical Student Clearance Requirements



Instructions for Submission:

- Once you have uploaded the AAMC Standardized Immunization Form and the Northwell Health VSLO Physical Examination Form in VSLO, **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: VSLO, your name and your rotation date in the subject line. Example: VSLO, 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.

Northwell Health®

Team Member Health Services

VSLO 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:_____/_____/ _____

Health 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:

STAMP

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

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				☐
	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:	❑ Positive ❑ Negative	
	Serologic Immunity (IgG antibody 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:	❑ Positive ❑ Negative	
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results:	_____ IU/ml	
Rubella *-1 dose of vaccine or positive serology*			**Serology Results**		
	Rubella Vaccine		Qualitative Titer Results:	❑ Positive ❑ Negative	☐
	Serologic Immunity (IgG antibody 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 dates of last Td and Tdap*					
	Tdap Vaccine (Adacel, Boostrix, etc)				☐
	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:	❑ Positive ❑ Negative	
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results:	_____ IU/ml	
Influenza Vaccine - *1 dose annually each fall*					
Date of last dose		**Date**			☐
	Flu Vaccine				
COVID-19 Vaccine - *1 dose of updated 2024-2025 COVID-19 vaccine if previously vaccinated with any COVID-19 Vaccine, administered >8 weeks after the last dose.*		**Date**			
	Pfizer-BioNTech COVID-19 vaccine				☐
	or Moderna COVID-19 vaccine				
	or Novavax COVID-19 vaccine (aged >12 yrs only)				

AAMC Standardized Immunization Form

Name: _____ **Date of Birth:** _____
(Last, First, Middle Initial) (mm/dd/yyyy)

Hepatitis B Vaccination - *3 doses of Engerix-B, PreHevbrio, Recombivax HB or Twinrix vaccines or 2 doses of Heplisav-B vaccine followed by a **QUANTITATIVE** Hepatitis B Surface Antibody test drawn 4-8 weeks after last vaccine dose. A test titer ≥10mIU/mL is positive for immunity. If the test result is negative, CDC guidance recommends that HCP receive one or more additional doses of Hepatitis B vaccine up to completion of a second series, followed by a repeat titer test 4-8 weeks after the last vaccine dose. If a single additional vaccine dose does not elicit a positive test result, administer additional vaccine doses to complete the second series using the schedule approved for the primary series of a given product. If the Hepatitis B Surface Antibody test is negative (<10 mIU/mL) after receipt of 2 complete vaccine series, a "non-responder" status is assigned. See: http://dx.doi.org/10.15585/mmwr.rr6701a1 for additional information.*				Copy Attached
Primary Hepatitis B Series Heplisav-B only requires two doses of vaccine followed by antibody testing	3-dose vaccines (Energix-B, PreHevbrio, Recombivax HB, Twinrix) or 2-dose vaccine (Heplisav-B)	**3 Dose Series**	**2 Dose Series**	☐
	Hepatitis B Vaccine Dose #1			
	Hepatitis B Vaccine Dose #2			
	Hepatitis B Vaccine Dose #3			
	QUANTITATIVE Hep B Surface Antibody Test		_____ mIU/ml	
Additional doses of Hepatitis B Vaccine *Only If no response to primary series* Heplisav-B only requires two doses of vaccine followed by antibody testing		**3 Dose Series**	**2 Dose Series**	☐
	Hepatitis B Vaccine Dose #4			
	Hepatitis B Vaccine Dose #5			
	Hepatitis B Vaccine Dose #6			
	QUANTITATIVE Hep B Surface Antibody Test		_____ mIU/ml	
Hepatitis B Vaccine Non-responder	If the Hepatitis B Surface Antibody test is negative (titer less than 10 mIU/mL) after a primary and repeat vaccine series, vaccine non-responders should be counseled and evaluated appropriately. Certain institutions may request signing an "acknowledgement of non-responder status" document before clinical placements.			
Additional Documentation				
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.*				

Vaccination, Test or Examination	**Date**	**Result or Interpretation**	
Physical Exam (if required)			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐

AAMC Standardized Immunization Form

Name: _____ **Date of Birth:** _____
(Last, First, Middle Initial) (mm/dd/yyyy)

TUBERCULOSIS (TB) SCREENING – *All U.S. healthcare personnel are screened pre-placement for TB. Two kinds of tests are used to determine if a person has been infected with TB bacteria: the TB skin test (TST) and the TB blood test (IGRA). Results of the last two TSTs or one IGRA blood test are required **regardless** of prior BCG status. If the TST method is used, record the dates and results of two 1-step annual TSTs over the last two years, or of one 2-step TST protocol (two TSTs performed with the second TST placed at least 1 week after the first TST read date). In either series, the second TST must have been placed within the past 12 months prior to clinical duties, and must have been performed in the U.S. If you have a history of a positive TST (PPD) >10mm or a positive IGR blood test, please supply information regarding any evaluation and/or treatment below. You only need to complete ONE section, A or B.*

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
History of Negative TB Skin Test or Blood Test	**TST #1**			____ mm	❑ Pos ❑ Neg ❑ Equiv
	TST #2			____mm	❑ Pos ❑ Neg ❑ Equiv
			Date	**Result**	
T-spots or QuantiFERON TB Gold blood tests for tuberculosis	**QuantiFERON TB Gold or T-Spot** (Interferon Gamma Releasing Assay)			❑ Positive ❑ Negative ❑ Indeterminate	
Use additional rows as needed	**QuantiFERON TB Gold or T-Spot** (Interferon Gamma Releasing Assay)			❑ Positive ❑ Negative ❑ Indeterminate	

Section B

		Date Placed	Date Read	Result
History of Positive Skin Test or Positive Blood Test	Positive TST			_____ mm
			Date	**Result**
	QuantiFERON TB Gold or T-Spot (Interferon Gamma Releasing Assay)			❑ Positive ❑ Negative ❑ Indeterminate
	Chest X-ray*			*Provide documentation or result
	Treated for **latent** TB infection (LTBI)?			❑ Yes ❑ No
	Date of Last Annual TB Symptom Questionnaire			

AAMC Standardized Immunization Form

Name: _____ **Date of Birth:** _____
(Last, First, Middle Initial) (mm/dd/yyyy)

Additional Information

MUST BE SIGNED BY A LICENSED HEALTHCARE PROFESSIONAL OR DESIGNEE:

Healthcare Professional Signature:		**Date:**
Printed Name:		Office Use Only
Title:		
Address Line 1:		
Address Line 2:		
City:		
State:		
Zip:		
Phone:	(____) _____-_____ **Ext:** _____	
Fax:	(____) _____-_____	
Email Contact:		

*Sources:

1. Haber P, Schille S. Chapter 10: Hepatitis B Pink Book. CDC https://www.cdc.gov/pinkbook/hcp/table-of-contents/chapter-10-hepatitis-b.html?CDC_AAref_Val=https://www.cdc.gov/vaccines/pubs/pinkbook/hepb.html
2. Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP), MMWR, Vol 60(7):1-45
3. CDC Guidance for Evaluating Health-Care Personnel for Hepatitis B Virus Protection and for Administering Postexposure Management, MMWR, Vol 62(RR10):1-19
4. Prevention of Hepatitis B Virus Infection in the United States: Recommendations of the Advisory Committee on Immunization Practices, MMWR Vol 67(1):1-31
5. Sosa LE, Nijie GL, Lobato MN, et.al. Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from National Tuberculosis Controllers Association and CDC, 2019. MMWR2019;68:439-443. https://www.cdc.gov/mmwr/volumes/68/wr/mm6819a3.htm?s_cid+mm6819a3_w