Residency/Fellowship Clearance Requirements

Welcome to the University of Florida! In order to make your clearance process smooth, please follow these instructions when completing your forms. Be sure to provide documentation as outlined. If you have any questions, please email them to occmedclinic-riskassessment@ahc.ufl.edu and we will respond via email.

1. **Post-Employment Screening Patient Contact Form and Respiratory Medical Evaluation Questionnaire** – Complete, sign electronically and click the submit button. Make sure you provide explanations and dates for any "yes" answers.
2. **Post-Employment Screening Immunization Form** – This form is not required if you have alternate records of all of the required vaccines and/or titers outlined below. We will accept records from your Occupational/Employee Health, Student Health, County Health Department, your PCP, etc.

    ☐ If you use this form:
    - It must be **signed, dated and stamped by a qualified medical provider.** This form may not be signed by a family member or yourself.
    - **If your identifying information is not filled in completely, the form must be resubmitted.**

*****ALL FORMS/RECORDS MUST BE SUBMITTED AS FILES ATTACHED TO AN EMAIL (PDF, SCANNED FILE). WE WILL NOT ACCEPT RECORDS THAT ARE PART OF THE MESSAGE BODY*****

Immunization Requirements:

☐ **Measles, Mumps, Rubella Immunity**
- Record of two valid doses of MMR vaccine or two doses of the individual vaccine for each disease – OR – positive titers. You must submit lab reports to verify the positive titer.

☐ **Varicella Immunity**
- Record of two valid doses of varicella vaccine – OR – positive titer. You must submit lab reports to verify the positive titer.

☐ **Hepatitis B Immunity**
- Record of a complete and valid Hepatitis B vaccine series. **We do not accept a positive titer as proof of immunity, per CDC recommendations for healthcare providers.**

☐ **Tetanus, Diptheria, Pertussis (Tdap)**
- Record of a Tdap vaccine within the last 10 years. It must not expire before your start date.

☐ **Tuberculosis Screening**

*****NOTE: All TB screening components (TST, IGRA, CXR) must have been completed no more than one year before your start date (if your start date is 7/1/24, TST/IGRA/CXR completed after 7/1/23) unless otherwise noted.**

- Record of two TSTs, or one IGRA TB blood test. **The IGRA is the preferred TB screening tool**.
- If you have **record of a past positive TB screening test**, you must submit that record, complete the TB Surveillance form and:
    - If you have completed TB prophylaxis, submit proof of completion and last chest xray.
    - If you have not completed TB prophylaxis, submit record of a chest xray done within 12 months of start date.
    - If you have had a negative IGRA blood test after your positive TST, submit record of an IGRA blood test within 12 months of start date

Remember to submit all forms/records as file attachments, not in the body of your email.

UF UNIVERSITY of FLORIDA
Occupational Medicine Program

Post-Offer Screening
Patient Contact Form
UF Residency/Fellowship

The information requested on these pages is necessary in order to minimize any occupational risks to you and to insure that you can safely perform the essential functions of your new job.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information.

Must complete ALL sections.

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

UF ID #: _____ **Gender at Birth:** ○ **Male** ○ **Female**

Email Address: _____ **Cell number:** _____

Address: _____

City, State Zip: _____

Work Site: ○ **Gainesville** ○ **Jacksonville** ○ **Other:** _____

Department: _____ **Supervisor/Program Director:** _____

Job Title: ○ **Resident** ○ **Fellow** **(MUST select one)**

Section I - Medical History

Do you have now, have you ever had, or have you received treatment for the following:

	Yes	No	If ***YES*** use as many lines below as needed to explain with dates.
Alcohol abuse/alcoholism	○	○	_____
Allergies to medications/foods	○	○	_____
Asthma	○	○	_____
Back or neck injury	○	○	_____
Carpal Tunnel syndrome	○	○	_____
Chronic back pain	○	○	_____
Current Medications: doses and Frequency	○	○	_____
Diabetes (type)	○	○	_____
Difficulty hearing/hearing aides	○	○	_____
Drug abuse/addiction	○	○	_____
Hospitalizations/Surgeries	○	○	_____
Immunosuppression	○	○	_____
Infectious Disease	○	○	_____

	Yes	No	If ***YES*** use as many lines below as needed to explain
Latex allergy or other skin sensitivities	○	○	_____
Other hand/wrist problems	○	○	_____
Other liver disease (type)	○	○	_____
Seizures	○	○	_____
Tuberculosis	○	○	_____
Visual loss (one or both eyes)	○	○	_____

Have you ever had a work-related illness or injury? ○ Yes ○ No

If yes, explain: _____

Have you been cleared by a medical provider to return to full duty without restrictions? ○ Yes ○ No

Date: _____

Are you currently recovering from any significant illness, surgery or injury? ○ Yes ○ No

If yes, explain: _____

Have you been cleared by a medical provider to return to full duty without restrictions? ○ Yes ○ No

Date: _____

Do you have any medical or psychological conditions that you feel may prevent you from completely and safely performing the duties outlined in your job description, or do you require/request any modifications to your job duties?

○ Yes ○ No If yes, explain: _____

_____

Would you like to speak to a UF Occupational Medicine clinician about any of the information you have given above?

○ Yes ○ No If yes, daytime phone _____

Print Name: _____ **UFID#:** _____

Signature: _____ **Date**: _____

UF UNIVERSITY of FLORIDA
Occupational Medicine Program

Post-Offer Screening
Patient Contact Form
UF Residency/Fellowship

Today's Date:			
Last Name:	First Name:		MI:
Phone:	Date of Birth:	Gender at Birth: ○ Male ○ Female	
Job Title:	Height: (ft) (in)	Weight: (lbs)	

Do you know how to contact the Healthcare professional who will review this?	○ Yes	○ No
Can you read English:	○ Yes	○ No
Do you exercise:	○ Yes	○ No
Have you worn a respirator in the past?	○ Yes	○ No
Physical exertion while wearing a respirator:	○ Yes	○ No

Medical Questionnaire

Do you *currently* smoke tobacco, or have smoked tobacco in the last month? ○ Yes ○ No
If "yes" to any of the following, how many packs per day?
How any years have you smoked?

Have you ever had any of the following conditions?

	YES	NO		YES	NO
Seizures (fits)	○	○	Claustrophobia (fear of closed-in places)	○	○
Diabetes (sugar disease)	○	○	Trouble smelling odors	○	○
Allergic reaction that interfere with your breathing				○	○

If yes, please explain:

Have you *ever had* any of the following pulmonary or lung problems?

	YES	NO		YES	NO
Asbestosis	○	○	Pneumothorax (collapsed lung)	○	○
Asthma	○	○	Lung Cancer	○	○
Chronic bronchitis	○	○	Broken ribs	○	○
Emphysema	○	○	Any chest injuries or surgeries	○	○
Pneumonia	○	○	Silicosis	○	○
Tuberculosis	○	○	Any other lung problem you've been told about	○	○

Please explain **ALL** Yes answers:

Do you *currently* have any of the following symptoms of pulmonary or lung illness

	YES	NO		YES	NO
Shortness of breath	○	○	Shortness of breath that interferes with your job	○	○
Shortness of breath when walking fast on level ground or walking up a slight hill/incline	○	○	Shortness of breath when walking with other people at ordinary pace on level ground	○	○
Shortness of breath when washing or dressing yourself	○	○	Have to stop for breath when walking at your own pace walking on level ground	○	○
Coughing that produces phlegm (thick sputum)	○	○	Coughing that wakes you early in the morning	○	○
Coughing that occurs mostly when you are lying down	○	○	Coughing up blood in the last month	○	○
Wheezing	○	○	Chest pain when you breathe deeply	○	○
Wheezing that interferes with your job	○	○	Any other pulmonary/lung symptoms	○	○

Please explain **ALL** Yes answers:

Have you *ever had* any of the following cardiovascular or heart problems?

	YES	NO		YES	NO
Heart attack	○	○	Heart arrhythmia (heart beating irregularly)	○	○
Stroke	○	○	High blood pressure	○	○
Heart failure	○	○	Swelling in your legs not caused by walking	○	○
Angina	○	○	Any other heart problem you've been told about	○	○

Please explain **ALL** Yes answers:

Have you *ever had* any of the following cardiovascular or heart symptoms:

	YES	NO		YES	NO
Frequent pain or tightness in your chest	○	○	Skipping/missing heartbeat (in last 2 years)	○	○
Pain or tightness in your chest during physical activity	○	○	Heartburn-like symptoms not related to eating	○	○
Pain or tightness in your chest that interferes with your job	○	○	Any other symptoms that you think may be related to heart or circulation problems	○	○

Please explain ALL Yes answers:

Do you *currently* take medications for any of the following?

	YES	NO		YES	NO
Breathing or lung problems	○	○	Blood pressure	○	○
Heart trouble	○	○	Seizure (fits)	○	○

Please explain ALL Yes answers:

If you've used a respirator, have you ever had any of the following problems while using a respirator?

	YES	NO		YES	NO
Eye Irritation:	○	○	General weakness or fatigue:	○	○
Skin allergies or rashes	○	○	Anxiety	○	○
Any other problem that interferes with your use of a respirator				○	○

If yes to any of above, please explain:

Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? ○ ○

Additional comments:

To the best of my knowledge, the information I have provided is true and accurate.

Resident/Fellow Signature: Date: Submit Button

OCCMED CLINIC USE ONLY

TO BE COMPLETED BY EXAMINER/REVIEWER

- ○ The mandatory questionnaire has been reviewed.
- ○ The Resident/Fellow has been found to be physically able to use Single use, filter mask (four attachment points) N95 or PAPR.
- ○ PAPR Only
- ○ There is insufficient information to make a determination at this time.
- ○ This Resident/Fellow has been found to be physically NOT able to use a respirator.

Reviewer's Name (print) Reviewer's Signature Date

Post-Offer Screening Patient Contact Form

Name: Date of Birth: UF ID #:

Required Immunizations

Positive titer for immunity will substitue for shots on numbers 1 - 4. Titers must have labs attached.*

	Mo/Day/Year	Mo/Day/Year	Mo/Day/Year	Titer Date & Result*
1. **Measles** (2 doses after 1st birthday)			\\\\\\\\\\	
2. **Mumps** (2 doses after 1st birthday)			\\\\\\\\\\	
3. **Rubella** (2 doses after 1st birthday)			\\\\\\\\\\	
4. **Varicella** (Chicken Pox; 2 doses)			\\\\\\\\\\	
5. **Hepatitis B** (3 doses required)				Titer does not substitue
6. **Tdap** (adult booster within 10 years)		\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		

Required Tuberculosis Screening

Tuberculosis screening must be either: 2 negative TST's** (PPD's) or a negative Interferon Assay within 12 months prior to start date. **TST's(PPD's) placements should be at least 7 days apart and cannot be placed within 28 days after a live virus immunization like measles, mumps, rubella, or varicella. TST's(PPD's) should be read within 48 - 72 hours after placement.BCG is not a substitute for a previous positive screening for TB. If there is a history of a prior positive TB screening result then see below.

PPD** #1 Skin Test (Tuberculosis Screening)	Date Placed	Date Read	MM	Neg or Pos
PPD** #2 Skin Test (Tuberculosis Screening)	Date Placed	Date Read	MM	Neg or Pos
Interferon-based Assay* (instead of PPD's)		Date	Result	

(OR)

If past positive PPD or positive Interferon Assay you must submit documentation: 1) the positive screening BCG is not a substitute for a previous positive screening for TB, 2) chest x-ray within 12 months prior to start date (record below), and 3) UF TB surveillance form.

Past positive PPD Skin Test	Date Placed	Date Read	MM	Neg or Pos
Interferon-based Assay* (attach copy of lab)		Date	Result	
CXR* (only if past positive PPD)		Date	Result	

*All titers, assays, and chest X-rays must have results attached

Official Office Stamp Here **Authorized Signature** **Date**

An official stamp from a doctor's office, clinic, or health department AND an authorized signature must appear here or this form will not be approved. You may not be the authorized signator of your own form.

University of Florida
Occupational Medicine Program
Email: occmedclinic-riskassessment@ahc.ufl.edu

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