Clinical Experience Requirements

If you plan to attend clinical experience it is important that you begin working on getting your vaccinations up to date and complete your medical physical ASAP. You will not be able to go to clinicals until this is complete. Delays could result in additional fees due to rescheduling. Your physical (and vaccines) may be included with your health insurance plan.

1. If you do not have copies of your vaccines and lived your first few years in Florida after birth, visit https://flshotsusers.com/resources/frequently-asked-questions/ to request vaccine records.
2. Once you receive your records, make an appointment with your physician for your medical physical and completion of required forms. Baycare Urgent Care Centers offer special rates for HCC students if needed.
    a. Have the physician review the immunization records, run any blood tests to determine immunity (titers) if necessary and complete the **Immunization Form.**
    b. Have the physician do a PPD skin test on you (must be read 72 hours later in clinic) and complete the TB Screening Form if you have no history of BCG vaccination or past positive TB results. If you've ever received a BCG vaccination or have a history of past positive TB results, you may take a Quantiferon-Gold blood draw or have a chest X-ray performed to meet the TB screening requirement
    c. Receive any additional vaccines from your doctor along with any necessary boosters based on titer results. Please note that some vaccines require more than one injection over a period of time (see vaccine chart below).
3. The physician needs to complete, stamp and sign the **Physical Form**, **Immunization Form** and **TB Screening Forms.**
4. HCC uses a clinical document review company called **Castlebranch.** ***You will receive access to Castlebranch after your register and pay for the clinical course*.** You should collect all documents for submission now. Submit your completed documents for review and approval to **Castlebranch** as soon as they are completed to allow time for review and corrections.

If you have any questions about the submission and approval of your required clinical documents, please contact Castlebranch directly (not HCC). You will not be released for clinicals until all documents are approved.

Forms:

Immunizations/Physical Forms:

- Immunization Form (completed by doctor and student submits to Castlebranch)
- Medical Physical Form (completed by doctor and student submits to Castlebranch)
- TB Screening Form (completed by doctor and student submits to Castlebranch)
- Authorization for Release of Immunization Records (if you want HCC to pull your immunization records from the State of Florida database)

Background check and Drug Test Forms (will be provided <u>after clinical course registration fee is received</u>)

- Drug Test Form for Baycare Urgent Care (provided in Clinical Canvas course)
- HCC Background check form (provided through Castlebranch)

Clinical Experience Requirements

Immunizations

All students attending clinical experience must submit proof of immunizations to Castlebranch for approval to attend. **Failure to comply will result in delays and/or the student not being able to attend clinical experience. The Allied Health Department will not refund tuition fees for non-compliance.** The cost for the medical physical and immunizations/titers are the responsibility of the student. The Allied Health Department will not make any arrangements for the services to be completed.

NOTE: Students have the right to decline all vaccinations but may not be able to attend clinical experience.

Vaccination documentation is required. The proof of positive titers may be done in lieu of proof of vaccination. Please include all copies of laboratory test results when titers are performed.

Immunization Requirement, Description and Required Documentation
Tuberculosis: 1. 2-Stage TB Skin test (TST) - Documentation MUST include: Date administered, arm used and date read with result completed within the past 12 months. (Those assigned to any HCA hospital may be asked to provide a TB test within 90 days of starting the clinical, per HCA regulations.) OR 2. QuantiFERON-TB-Gold Blood Test (QFT-G) - All QFT-G documentation MUST include the date and result. If documentation indicates a positive result, supplementary documentation of a negative Chest x-ray (CXR) is required. CXR documentation must include the date and result accompanied by a completed TB annual questionnaire form signed by a physician. (Please see the ICCE Allied Health Office for clarification.)
Influenza or Flu (Required annually): • Influenza documentation MUST include the following**: Lot #, Expiration date, administration location (i.e.: R or L Arm) and method (i.e.: nasal, vaccination, etc.).** • Students can decline the flu shot if there is a physician-documented medical reason. To decline, students should complete a flu vaccine declination form and submit to Castlebranch with a physician-signed letter with the medical reason(s).
Measles (Rubeola) (Part of MMR): All students must have documentation of rubeola immunity (positive titer) OR documentation of **TWO** live MMR or MR vaccines after 12 months of age.
Mumps (Part of MMR): All students must have documentation of mumps immunity (positive titer) OR documentation of **TWO** live mumps or MMR vaccines after 12 months of age.
Rubella (German Measles) (Part of MMR): All students must have documentation of rubella immunity (positive titer) OR documentation of **ONE** live rubella or MMR vaccine after 12 months of age.
Chickenpox (Varicella): All students must have documentation of varicella immunity (positive titer) or documentation of **TWO** varicella vaccines or **ONE with the doctor's note**.
Hepatitis B: The Hepatitis B vaccine series is **STRONGLY RECOMMENDED** for all students prior to patient contact as healthcare workers face potential exposure to blood or infectious body fluids daily. Documentation must include at least one of the following: 1. HBV immunity (positive titer) or documentation of **the THREE administered** vaccines. 2. Initiation of the Hep B vaccination series with at least **ONE of the three** vaccines administered. 3. Signed HBV declination form.
Tdap (Tetanus, Diptheria, and Pertussis) Students who have not had a Tdap should receive one. All students must have documentation of Tdap vaccination or booster within the past 10 years.
COVID-19: Initial injection plus at least one booster • Students can decline the COVID-19 vaccine shot if there is a medical or religious reason. To decline, students should complete a flu vaccine declination form and submit to Castle Branch with a physician-signed letter with the medical reason(s).

Health Sciences Physical Form

Health Examiner: Please provide your assessment of the following student's physical and mental ability to perform the "Essential Functions and Standards for Clinical Courses" indicated below. Mandatory to any clinical rotation, please complete this Physical form and with review and signature/stamp by a licensed health care professional (Physician/ARNP/PA).

Student's Full Name:	Date of Birth (month/day/year):
Course Name:	

The student may participate in clinical experience that includes an invasive procedure such as phlebotomy. Is the **student** free from communicable disease(s) to be able to work in this capacity? (choose one)

- ☐ Yes
- ☐ Yes, pending TB test
- ☐ No (Please explain):_____

Please acknowledge that the student can do essential functions and standards for clinical courses, including:

Environmental Conditions:
Potential exposure to blood borne pathogens
Potential exposure to infectious pathogens
Work with latex, chemicals, water and detergents
Work alone or in groups

Clinical Tasks and Skills:
Fine motor manipulation of hands and fingers
Fitting/use of personal protective equipment
Use latex protective gloves and N-95 Respirator mask
Work irregular hours or work different shifts

Physical Requirements:
Ability to carry, lift, push, and pull 50-75 pounds
Gross motor skill to manipulate equipment
Assist in transferring and lifting patients
Frequent reaching, grabbing and grasping
Seated and standing work, ranging minutes to hours
Frequent twisting, bending, and reaching overhead
Occasional climbing to heights less than six (6) feet
Occasional stooping and kneeling
Frequent trunk rotation

Sensory and Cognitive Requirements:
Binocular vision. Note if monocular
Near and far vision, uncorrected and corrected
Vision required 20/20 OU; Snellen may be used
Screen for color deficiency
Ability to hear; whisper test at 12 feet. Note if aid needed
Ability for multi-tasking
Ability to communicate by speech clearly
Ability for analytical thinking, reasoning, make calculations
Ability to function in high stress, complex situations

Examiner Comments and Opinions (Please check what applies):

- ☐ In my opinion, **the student meets** the essential physical standards noted above for participation in a clinical health care setting.
- ☐ In my opinion, **the student will require the accommodations** or restrictions (e.g., corrective lenses) to participate without harm to self/others in a clinical health care setting: _____
- ☐ In my opinion, based on the following comments, **the student does not meet** the essential physical and mental standards noted above and is not able to participate without harm to self/others in a clinical health care setting: _____

REQUIRED: Examiner's (Physician/ARNP/PA) Signature with Office Stamp (address, phone, etc.):

Examiner's Printed Name: _____

Professional License # _____

Examiner's Signature: _____Date:_____

Examiner Stamp (include address and phone)

_____

_____

Immunization Requirements Form

Student Full Name: _____Date of Birth (month/day/year): ____/____/_____

To the healthcare examiner: Please complete and sign EACH section below.

<table>
<tr><td colspan="4">✱ <u>Tdap</u> (Must be within the past <u>ten (10) years</u>): Date administered: ____/____/____</td></tr>
<tr><td colspan="4">Provider's Attestation Signature:</td></tr>
<tr><td colspan="2">✱ <u>Varicella</u> (Must have received two (2) doses OR a positive titer)</td><td>1st dose: ____/____/____</td><td>2nd dose: ____/____/____</td></tr>
<tr><td colspan="3">Titer Date: ____/____/____ Titer Results: ☐ Positive ☐ Negative
If negative MUST receive two (2) vaccines, or one (1) vaccine with provider's note saying it is safe to do your clinical experience.</td><td>Provider's Attestation Signature:</td></tr>
<tr><td colspan="4">✱ <u>Measles, Mumps, Rubella (MMR)</u> (Must have received all MMR doses OR a positive MMR titer)</td></tr>
<tr><td colspan="2">MMR</td><td>1st dose: ____/____/____</td><td>2nd dose: ____/____/____</td></tr>
<tr><td colspan="2">Measles Titer Date: ____/____/____
Titer Results: ☐ Positive ☐ Negative</td><td>If negative MUST receive two (2) vaccines, or one (1) vaccine with provider's note saying it is safe to do your clinical experience.</td><td>Provider's Attestation Signature:</td></tr>
<tr><td colspan="2">Mumps Titer Date: ____/____/____
Titer Results: ☐ Positive ☐ Negative</td><td>If negative MUST receive two (2) vaccines, or one (1) vaccine with provider's note saying it is safe to do your clinical experience.</td><td>Provider's Attestation Signature:</td></tr>
<tr><td colspan="2">Rubella Titer Date: ____/____/____
Titer Results: ☐ Positive ☐ Negative</td><td>If negative MUST get at least one (1) vaccine.</td><td>Provider's Attestation Signature:</td></tr>
<tr><td colspan="4">✱ <u>Hepatitis B</u> (Must have three (3) vaccines OR a positive titer OR Hep B Vaccine Declination Form)</td></tr>
<tr><td colspan="4">☐ Student is declining the Hep B vaccine and will complete a declination form (if checked, simply sign below)</td></tr>
<tr><td>Three (3) Vaccines Dates:</td><td>1st dose: ____/____/____</td><td>2nd dose: ____/____/____</td><td>3rd dose: ____/____/____</td></tr>
<tr><td colspan="3">Titer Date: ____/____/____ Titer Results: ☐ Positive ☐ Negative
If negative MUST receive two (2) vaccines, or one (1) vaccine with provider's note saying it is safe to do your clinical experience.</td><td>Provider's Attestation Signature:</td></tr>
</table>

I attest that the above is accurate and that records exist proving the student has received the vaccines OR has positive titers.

Examiner completing this form: (Printed name) _____ Prof. License #: _____

Signature: _____Date: _____

Examiner Stamp (include address and phone)

_____

_____

Influenza (FLU) Vaccine Form

The Influenza (FLU) vaccine is annual and is required unless you have a medical reason.
The FLU season starts every year on September 1 and end the following March 31.

Example: September 1, 2018 to March 31, 2019. The 2018-2019 FLU vaccine will no longer be valid starting April 1, 2019. You must get the 2019-2020 FLU vaccine in late August 2019.

TO HEALTH PROVIDERS: Please fill out ALL sections completely.

Student Full Name: _____Date of Birth (month/day/year): ____/____/____

Influenza vaccine (September 1 – March 31)

Date administered: ____/____/____

Route: ☐ IM ☐ SQ

Expiration Date: ____/____/____

Site Given (select one):
☐ Right Deltoid ☐ Left Deltoid
☐ Right Gluteus ☐ Left Gluteus
☐ Right Nostril ☐ Left Nostril

Lot #: _____

I, _____ (PRINT PROVIDER NAME), with license number _____, attest that records exist proving this student received the most current season's Influenza vaccine.

CLINIC/ORGANIZATION STAMP with ADDRESS & PHONE NUMBER (in area below)

OR

Provider's Signature: _____ Date: _____

Clinic/Organization Name: _____

Address: _____

Phone Number: (_____)_____-_____

RELIGIOUS EXEMPTION FROM COVID-19 VACCINATION

Employee Name	**Date of Birth**	**Phone Number**
Employer Name		**Date of Request**

Exemption Statement Pursuant to section 381.00317, Florida Statutes: I hereby declare that I decline the COVID-19 vaccination because of a sincerely held religious belief, which may include a sincerely held moral or ethical belief.	
Employee Signature	**Date**
Employee Name (print)	

NOTE: An employer shall not inquire into the veracity of the employee's religious beliefs. Pursuant to section 381.00317(2), Florida Statutes, this completed exemption statement requires the employer to allow the employee to opt-out of the employer's COVID-19 vaccination mandate.

MEDICAL EXEMPTION FROM COVID-19 VACCINATION

PART 1 – TO BE COMPLETED BY THE EMPLOYEE

Employee Name	**Date of Birth**	**Phone Number**
Employer Name		**Date of Request**
Please select yes if this exemption is on the basis of pregnancy or anticipated pregnancy. **YES ☐**		

PART 2 – TO BE COMPLETED BY THE EMPLOYEE'S MEDICAL PROVIDER

Employee's Name	
Physician, Physician Assistant, or Advanced Practice Registered Nurse It is my professional opinion as a physician or physician assistant who holds a valid, active license under chapter 458 or chapter 459, Florida Statutes, or an advanced practice registered nurse who holds a valid, active license under chapter 464, Florida Statutes, that COVID-19 vaccination is not in the best medical interest of the employee.	
Medical Provider Signature	**Date**
Medical Provider Name (print)	**Medical Provider License Number**

NOTE: Pursuant to section 381.00317(2), Florida Statutes, this completed exemption statement requires the employer to allow the employee to opt-out of the employer's COVID-19 vaccination mandate.

Tuberculosis (TB) Screening Form

Name: _____

Date of Birth: _____

You must submit *ALL* labs and documentation of either a negative TB skin test (TST) ***OR*** blood test QFT-TB/T-SPOT within 1 year prior to starting clinical/patient contact. **If BCG Vaccine Received, screening blood test or X-Ray is required.** PPD (Mantoux) Test is required, not a Tine Test. Must be read within 48-72 hours.

Prior history of BCG Vaccine? (PPD recommended unless BCG given.)

- ☐ Yes (enter date) _____ **(No skin test needed. Complete TB blood screening or X-ray section below)**
- ☐ No (continue completing this form)

Tuberculosis Skin Test:

Date Administered:	Site Administered:	☐ Left Arm	☐ Right Arm	Lot #: Exp Date:
Date and Time Read:	Result (in mm): _____	☐ Positive for TB	☐ Negative for TB	
Name of Reader:		License #:		

TB Blood QFT-TB/T-SPOT Test Screening Results Date: _____ ☐ Positive for TB ☐ Negative for TB

IF NEGATIVE RESULT, GO TO PART B. IF POSITIVE RESULT, SUPPLEMENTARY DOCUMENTATION OF A NEGATIVE CHEST X-RAY (CXR) IS REQUIRED FROM THE EXAMINER. CONTINUE BELOW:

If positive PPD (> 6 mm) induration, are there any symptoms of TB or known exposures? ☐Yes ☐ No	Was prophylaxis medication (INH) taken and completed? ☐Yes ☐ No
Date of Chest X-Ray: _____	Chest X-Ray Result ☐ Positive for TB ☐ Negative for TB

PART A- (completed by the student if positive result)

1. Have you experienced any of the following symptoms in the past year?
   a). Productive cough for more than 3 weeks? Yes___ No___
   b). Hemoptysis (coughing up blood) Yes___ No___
   c). Unexplained weight loss? Yes___ No ___
   d). Fever, Chills, or night sweats for no known reason? Yes___ No___
   e). Persistent shortness of breath? Yes___ No___
   f). Unexplained fatigue? Yes___ No___
   g). Chest pain? Yes___ No___
   h). Recurrent kidney or bladder infections? Yes___ No___
   i). Swollen glands usually in the neck? Yes___ No___
   j). Recent diagnosis of diabetes? Yes ___ No___
2. Have you had contact with anyone with active TB disease in the past year? Yes___ No___
3. Do you have medical condition or take medications that suppress your immune system? Yes___ No___

I declare that my answers and statements are correctly recorded, complete, and true to the best of my knowledge.

Student Signature: _____Printed Name:_____Date: _____

PART B- (Completed by the medical examiner)

Upon review of the TB results, responses to the above (if applicable) and the discussion with the patient/student I recommend as follows:

- ☐ There is no indication this person has active tuberculosis at this time.
- ☐ Further evaluation including Interferon Gamma Release Assay or other medical evaluation is indicated and should be completed prior to work placement or admission to a facility.

Examiner Stamp
(include address and phone)

_____

_____

Printed Examiner Name: _____ Signature: _____ Date:_____

Health Insurance Form

Student's Name: _____ Program/Course: _____

Working as a healthcare professional carries a certain amount of risk to exposure to bloodborne or fluid borne pathogens while working with patients. Any costs related to a student accident or illness requiring treatment while participating in clinical experience are the responsibility of the student. It is recommended that you have health insurance with documentation uploaded to Castle Branch.

If you do not have health insurance and are unable to afford it, please see the health insurance flyer for resources that may help you.

Please complete and sign below:

(Choose one)

- ❑ I have health insurance **(Upload this document and a copy of your insurance card front and back to Castle Branch.)**
- ❑ I do not have health insurance and understand that any costs related to treatment are my responsibility

I, _____ (PRINTED NAME), attest that I am responsible for any expenses related to treatment for any accident or illness requiring treatment that occurs during my clinical experience.

Student's Signature: _____ Date: _____