



TO: MD Students Entering The University of Toledo College of Medicine and Life Sciences, Fall 2022
FROM: The University of Toledo Health Science Campus (UTHSC) Health Requirements Coordinator
DATE: April 22, 2022
RE: Medical Student Health Requirements

It is a pleasure to welcome you to The University of Toledo Health Science Campus (UTHSC) College of Medicine and Life Sciences. Congratulations on your acceptance!

One of the advantages of the medical school curriculum at The University of Toledo is that students begin patient care during their first year. For this reason there are **MANDATORY** health requirements you must complete to start your studies.

It is important that you, your family and your health providers understand that you may be exposed to various infectious agents during your education. Our health requirements conform to the CDC (Centers for Disease Control) recommendations and the Ohio Department of Health (ODH) recommendations for health care providers. These are the most current requirements for health care providers; as a result, the requirements exceed the standard requirements for the general adult population.

Enclosed are forms you will need to complete and return immediately to the Health Requirements Coordinator:

Fax: 419-530-3966

Email: StudentHealthRequirements@utoledo.edu

All forms MUST be completed and returned by August 1, 2022

IMPORTANT: Be sure to make a copy for your personal records before turning in. You will be responsible for maintaining copies of all of your health documentation throughout your entire course of study.

Submission of the forms is necessary to process your requirements for Orientation. The exception to this rule will be students admitted after July 15, 2022. In the case of late acceptance to the medical school program, incoming students will have 2 weeks from receipt of their acceptance letter to fulfill their initial requirements and submit their forms.

*It is important to understand these requirements must be completed **PRIOR** to starting classes. **Please note that not completing these healthcare requirements could affect your ability to continue in your program or keep you from registering for further classes. Failure to comply with all health requirements will result in withholding of your grades until all requirements are met.** You must submit a written request for special permission to register without completed health requirements. This permission is obtained from the program of which you have been accepted.*

If you have questions or concerns about your enclosed program health requirements contact **Nicolasa Wilson, Health Requirements Coordinator** at (419) 383-5239 or StudentHealthRequirements@utoledo.edu.

Again, congratulations on your acceptance! We look forward to seeing you in the fall.

Enclosures



CHECKLIST OF HEALTH REQUIREMENTS FOR ACADEMIC YEAR 2022 - 2023

Instructions to Students:

COMPLETE and SUBMIT all documentation by August 1, 2022

“Health Requirement Form” sections:

1. Physical exam

COMPLETE first exam after January 1, 2022 by: MD, DO, NP, or PA. Use enclosed form:

MUST include documentation of: _____ “free of communicable disease”
_____ “fit for clinical duties”

2. 2-Step PPD testing

To be completed at a health office within the United States prior to start of classes.

*A TB Quantiferon test completed within the United States will be required in lieu of a 2-step PPD test if you have visited any of the countries listed in this link or received the BCG vaccine:

<http://www.utoledo.edu/cisp/international/pdfs/Countries%20with%20Estimated%20or%20Report%20Tuberculosis%20Incidence.pdf>

3. Tetanus, diphtheria, and acellular pertussis (T-DAP), IF NEEDED per CDC recommendations OR Tetanus-diphtheria (Td) within the past 10 years*.

4. Hepatitis B vaccination series (3 doses required)

MUST have AT LEAST ONE DOSE (minimum) prior to matriculation

We ask you make an effort to complete your vaccine requirements prior to the start of classes if possible. However, the remaining doses may be completed at the Student Health and Wellness Clinic (Ruppert Health Center, Suite 0013A/B) after matriculation.*

5. Positive antibody titers showing proof of immunity for the following vaccinations:

Measles, Mumps, Rubella, Varicella (chicken pox) and Hepatitis B. The Hepatitis B quantitative surface antibody titer needs to be completed six to eight weeks after you received your third Hepatitis B vaccine. This can be done at Student Health and Wellness (Ruppert Health Center, Suite 0013A/B, phone number (419) 383-5000) after matriculation.* Vaccine boosters are required if antibody titer is non-immune. The antibody titer for the non-immune result only will need to be re-tested six to eight weeks after receipt of booster vaccine.

Note: Only lab reports with reference ranges will be accepted.

6. Influenza Vaccination

Documentation of receiving the annual influenza vaccine is due by **December 1** annually. You will be notified by email when the annual influenza vaccine becomes available to receive on campus for free. Your Influenza vaccination record must be submitted to The University of Toledo vaccine registry website at <https://utvaccinereg.utoledo.edu/>

7. Covid-19 Vaccination

Due to early involvement in clinical settings, documentation of receiving the Covid-19 vaccine or an approved medical or religious exemption is due by **August 1**. Please know that if you have an approved medical or religious exemption your assigned clinical site may or may not approve the exemption. Your Covid-19 vaccination record must be submitted to The University of Toledo vaccine registry website at <https://utvaccinereg.utoledo.edu/>

8. Respirator Medical Evaluation Questionnaire

Respirators must be used in workplaces in which employees are exposed to hazardous airborne contaminants. When respiratory protection is required, employers must have a respirator protection program as specified in OSHA’s Respiratory Protection standard (29 CFR 1910.134). Because medical students will experience these environments as part of their medical school training, it is important that students have the same protections as healthcare employees.

NOTE: SOME SITES MAY HAVE ADDITIONAL HEALTH REQUIREMENTS (drug screen, etc.)

**There is a charge at the Student Health and Wellness Clinic for vaccine(s) and titers based on acquisition costs. There is a charge at the Student Health and Wellness Clinic for pre-matriculation vaccine(s) and titers and physical exams.*



Viewing Your Health Records

Once you have submitted your program health forms and have activated your UTAD account through MyUT portal you may view your student health records on file.

To view:

- log in to your **UTAD account**
- On the left side of the page under the section headed **Personal Information**, click on *More Personal Information Options* (this will bring up a new page)
- Click on **Individual Immunization Compliance Report**

This report contains your program health requirements that you have fulfilled, are coming up due for (such as an annual TB test including the date due), or are past due for. Please note that any updates to your records take approximately 24 hours to be reflected in your Individual Immunization Compliance Report.

If you fulfill program health requirements at the Student Health and Wellness Clinic please notify Nicolasa Wilson of your visit at (419) 383-5239 or StudentHealthRequirements@utoledo.edu.

If you fulfill program health requirements at your personal health care provider fax a copy of your documentation to Attention Health Requirements Coordinator at (419) 530-3966 or email to StudentHealthRequirements@utoledo.edu.

If you have questions or concerns regarding your health records in your Individual Immunization Compliance Report contact the Health Requirements Coordinator at (419) 383-5239 or StudentHealthRequirements@utoledo.edu.



**COLLEGE OF MEDICINE & LIFE SCIENCES
PROGRAM 2022-2023**

Student Instructions: (Please review the following very carefully)

1. Complete first portion of this form prior to appointment with healthcare provider of your choice.
2. The rest of the form is to be completed by the student's health care provider(s).
3. IMPORTANT: Please be sure to attach lab results report(s) from your healthcare provider where an asterisk (*) is indicated for our records as proof of protection for your educational experiences.

Student's Name _____ Date of Birth _____

Current Address _____

Phone Number _____ Rocket Number _____

Email Address _____

Student Records Release: (Please read and sign.) I understand and agree that the health information in this document may be used for verification of health requirements during my program of study. Documentation of annual tuberculosis screening and vaccine titer results may also be used for educational, accreditation and training purposes. The necessary uses may include demonstrating compliance with health requirements for clerkship or preceptor experiences.

Student signature _____ Date _____

Healthcare Provider, please complete:

NOTE: These are current recommendations of the U.S. Centers for Disease Control (CDC) for health care providers and the Ohio Department of Health (ODH).

| | | | |
|--|---|-----|----|
| PHYSICAL EXAM (after January 1, 2022) Date / / | (Circle one answer for each question, per Ohio Dept. of Health) | | |
| | IS THIS PATIENT 'FIT FOR DUTY' FOR PATIENT CARE? | YES | NO |
| | IS THIS PATIENT FREE OF COMMUNICABLE DISEASE? | YES | NO |

IF 'NO' ANSWER, PLEASE EXPLAIN AND ATTACH TO THIS FORM.

| Tuberculosis testing (PPD) = 2-Step PPD SKIN TESTING | | Mantoux Test ONLY (no TINE TESTS) |
|---|--|--|
| PPD #1 / / placed 1 to 3 weeks later | <i>Have this test read 48-72 hours later</i> DATE READ: ____/____/____ Read by, name & title: | RESULT (check) <input type="checkbox"/> 0 mm induration or <input type="checkbox"/> ____mm induration |
| PPD #2 / / placed | <i>Have this test read 48-72 hours later</i> DATE READ: ____/____/____ Read by, name & title: | RESULT (check) <input type="checkbox"/> 0 mm induration or <input type="checkbox"/> ____mm induration |

| IF - PPD is "Positive" | | | |
|--|---|---|---|
| CHEST X-RAY (only for LTBI) | <i>Note: DO ONLY IF PPD reads 10 mm or more of induration</i> | (*Must include copy of x-ray report, within past 12 months) | Was treatment initiated? _____ yes _____ no Please list drugs and dosage used: |
| HEPATITIS B VACCINE SERIES | | (SERIES OF 3 vaccine doses) | |
| Hepatitis B #1 vaccine | Date received: | | |
| Hepatitis B #2 vaccine | Date received: | | |
| Hepatitis B #3 vaccine | Date received: | | |
| TETANUS/ DIPHTHERIA /acellular PERTUSSIS (T-DAP) <small>(per CDC, January, 2007)</small> | Date / / | Or record of TETANUS/ DIPHTHERIA Needs to be within past 10 years. Date / / | |

PROOF OF IMMUNITY (PLEASE ATTACH LAB REPORTS)
Proof of immunity WILL NOT be accepted without Lab Reports

| | DATE | LAB RESULTS (immune, not immune, or equivocal) |
|--|-------|---|
| MEASLES TITER RESULT | _____ | _____ |
| MUMPS TITER RESULT | _____ | _____ |
| RUBELLA TITER RESULT | _____ | _____ |
| VARICELLA TITER RESULT | _____ | _____ |
| HEPATITIS B SURFACE ANTIBODY TITER RESULT (only if Hepatitis B vaccination series has been completed) | _____ | _____ |

*Must be Quantitative Antibody

Signature of Healthcare Provider: _____
Date: _____ Office address: _____

Please return completed forms and antibody titer lab reports to:
Health Requirements
Fax: 419-530-3966
Email to StudentHealthRequirements@utoledo.edu.



THE UNIVERSITY OF TOLEDO

Respirator Medical Evaluation Questionnaire

Respirators must be used in workplaces in which employees are exposed to hazardous airborne contaminants. When respiratory protection is required, employers must have a respirator protection program as specified in OSHA’s Respiratory Protection standard (29 CFR 1910.134). Because medical students will experience these environments as part of their medical school training, it is important that students have the same protections as healthcare employees.

Before wearing a respirator, all medical students must first be medically evaluated using the mandatory medical questionnaire below or an equivalent method.

The medical questionnaire and examinations must be administered confidentially by a physician or other licensed health care professional. The information collected in this form will be solely used for the purpose outlined above. Faculty, staff, and administrators from the Office of Admissions, Office of Student Affairs, or any other professional who will come into contact with students in an academic or clinical setting will not have access to the student’s responses, and the questionnaire will be reviewed by Student Health Services and maintained separately from the student’s admission, academic and other files.

| | | | | | |
|--|-----|-------------------------------------|-------------------------------------|---|--------|
| Part A Section 1 (Mandatory) The following information must be provided by every medical student who has been selected to use any type of respirator. (Please type or print.) | | | | | |
| Name | | | Job Title Medical Student | | Date |
| Weight | Age | Height | Sex (circle one) | Male | Female |
| Main Campus <input type="checkbox"/> | | Scott Park <input type="checkbox"/> | | Health Science Campus <input checked="" type="checkbox"/> | |
| 1. Can you read (circle one) Yes No | | | | | |
| 2. Phone number where you can be reached by the health care professional who reviews this questionnaire: | | | | | |
| 3. Best time to reach you at the above phone number: | | | | | |
| 4. Has your employer told you how to contact the health care professional who will review this questionnaire N/A | | | | | |
| 5. Check the type of respirator you will use (you can check more than one category) | | | | | |
| a. _____ N, R, or P disposable respirator (filter-mask, non- cartridge type only) | | | | | |
| b. _____ Other type (for example, half- or full-face-piece type, powered-air purifying, supplied-air, self-contained breathing apparatus). | | | | | |
| 6. Have you worn a respirator (circle one): Yes No | | | If “yes,” what type(s): | | |

| Part A Section 2 (Mandatory) Questions 1 through 9 below must be answered by every student who has been selected to use any type of respirator. (Please check "yes" or "no.") | Yes | No |
|--|------------|-----------|
| 1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? | | |
| 2. Have you ever had any of the following conditions? | | |
| a. Seizures (fits) | | |
| b. Diabetes (sugar disease) | | |
| c. Allergic reactions that interfere with your breathing | | |
| d. Claustrophobia (fear of closed-in places) | | |
| e. Trouble smelling odors | | |
| 3. Have you ever had any of the following pulmonary or lung problems? | | |
| a. Asbestosis | | |
| b. Asthma | | |
| c. Chronic bronchitis | | |
| d. Emphysema | | |
| e. Pneumonia | | |

| Part A Section 2 (Continued) | Yes | No |
|---|------------|-----------|
| f. Tuberculosis | | |
| g. Silicosis | | |
| h. Pneumothorax (collapsed lung) | | |
| i. Lung Cancer | | |
| j. Broken ribs | | |
| k. Any chest injuries or surgeries | | |
| l. Any other lung problem that you've been told about | | |
| 4. Do you currently have any of the following symptoms of pulmonary or lung illness? | | |
| a. Shortness of breath | | |
| b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline | | |
| c. Shortness of breath when walking with other people at an ordinary pace on level ground | | |
| d. Have to stop for breath when walking at your own pace on level ground | | |
| e. Shortness of breath when washing or dressing yourself | | |
| f. Shortness of breath that interferes with your job | | |
| g. Coughing that produces phlegm (thick sputum) | | |
| h. Coughing that wakes you early in the morning | | |
| i. Coughing that occurs mostly when you are lying down | | |
| j. Coughing up blood in the last month | | |
| k. Wheezing | | |
| l. Wheezing that interferes with your job | | |
| m. Chest pain when you breathe deeply | | |
| n. Any other symptoms that you think may be related to lung problems | | |
| 5. Have you ever had any of the following cardiovascular or heart problems? | | |
| a. Heart Attack | | |
| b. Stroke | | |
| c. Angina | | |
| d. Heart Failure | | |
| e. Swelling in your legs or feet (not caused by walking) | | |
| f. Heart arrhythmia (heart beating irregularly) | | |
| g. High blood pressure | | |
| h. Any other heart problems that you've been told about? | | |
| 6. Have you ever had any of the following cardiovascular or heart symptoms? | | |
| a. Frequent pain or tightness in your chest | | |

| Part A Section 2 (Continued) | Yes | No |
|---|------------|-----------|
| b. Pain or tightness in your chest during physical activity | | |
| c. Pain or tightness in your chest that interferes with your job | | |
| d. In the past two years, have you noticed your heart skipping or missing a beat | | |
| e. Heartburn or indigestion that is not related to eating | | |
| f. Any other symptoms that you think may be related to heart or circulation problems | | |
| 7. Do you currently take medication for any of the following problems? | | |
| a. Breathing or lung problems | | |
| b. Heart trouble | | |
| c. Blood pressure | | |
| d. Seizures (fits) | | |
| 8. If you've used a respirator, have you ever had any of the following problems? (If you've never used a respirator, check the following space and go to question 9) | | |
| a. Eye Irritation | | |
| b. Skin allergies or rashes | | |
| c. Anxiety | | |
| d. General weakness or fatigue | | |
| e. Any other problem that interferes with your use of a respirator | | |
| 9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? | | |

Medical Clearance for Respirator Use/Fit Test Record

| | | |
|---|-----------------------------------|------------------------|
| Name: | Date of Birth: | SS#: |
| Department: COMLS | Job Title: Medical Student | Daytime Phone#: |
| Type of respirator(s) to be used by the employee: x Air-Purifying (N-95 Disposable) <input type="checkbox"/> SCBA <input type="checkbox"/> Air-Purifying (PAPR) <input type="checkbox"/> Other <input type="checkbox"/> Air-Purifying (Half/Full Face) | | |
| Select level of work effort <input type="checkbox"/> Light <input type="checkbox"/> On a daily basis x Moderate <input type="checkbox"/> Occasionally, but more than once a week <input type="checkbox"/> Heavy/Strenuous <input type="checkbox"/> Rarely, or for emergency situations only | | |
| Length of time of anticipated effort (hours): Special work considerations (i.e., high places, temperature, hazardous materials, protective clothing, etc.) | | |

A Licensed Health Care Professional (LHCP) will review questions 1-9 in Part A, Section 2. If a student marks NO to all 9 questions, the LHCP will mark the box indicating "No restrictions on respirator use." If a student marks YES to any of the first 9 questions, the LHCP will forward to a physician for review by marking the box indicating "Follow-up medical evaluation needed."

CLEARANCE (CHECK ONE)

No restrictions on respirator use Follow-up medical evaluation needed

Reviewing Nurse: _____ (Signature)

The reviewing physician will determine the student's ability to wear a respirator. The follow-up medical examination shall include any medical tests, consultations, or diagnostic procedures that the PLHCP deems necessary to make a final determination.

FOLLOW UP MEDICAL EVALUATION (CHECK ONE)

Respirator use not Permitted Respirator use with restrictions
 No restrictions on respirator use Noted Restrictions:

Examining Physician: _____ (Signature)

FIT TEST (circle one)

| Respirator Selected | Size | Fit Test Method |
|---------------------|-------|-----------------|
| 3M 1860S | Small | Bitrex |
| 3M 9210 | | Saccharin |
| Other | | Port-A-Count |

Sensitivity Test Pass Fail **Fit Test** Pass Fail

Student Signature: _____ Date: _____

Test Conductor Signature: _____

Please return completed RPP Questionnaire to:
 Student Health and Wellness Center
 Ruppert Health Center Suite 0013
 or Fax to 419-383-6251