TO: **MD Students Entering The University of Toledo College of Medicine and Life Sciences, Fall 2025**

FROM: **The University of Toledo Health Science Campus (UTHSC) Health Requirements Coordinator**

DATE: **January 30, 2025**

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 **REQUIRED** 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 July 31, 2025

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, 2025. 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 2025 - 2026

Instructions to Students:

COMPLETE and SUBMIT all documentation by July 31, 2025 "Health Requirement Form" sections:

1. **Physical exam**

   COMPLETE first exam after January 1, 2025 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%20Reported% 20Tuberculosis%20Incidence.pdf

3. **Tetanus, diphtheria and acellular pertussis** (Tdap) vaccine is required within past 10 years. If administered 10 or more years ago, a booster vaccine is required. All new boosters should be Tdap.

4. Record of two doses of **MMR vaccine** received after the first birthday at least 28 days apart or proof of immunity to measles, mumps, rubella by titers (Students who are not immune should receive 2 doses of MMR immunization at least 28 days apart).

5. Record of 3 dose series **of Hepatitis B vaccine** & a positive Hepatitis B Surface Antibody (anti-HBs) titer of 10mlU/ml or higher is required. (Titer is done 1-2 months after final dose of vaccination). Those who test negative for hepatitis B surface antibody (anti HBs) should receive a single "booster" dose of hepatitis B vaccine and be retested 1-2 months later. Those who test positive following the "booster" dose are immune and require no further vaccination or testing. Those who test negative should receive 2 more doses of hepatitis B vaccine on the usual schedule and be tested again 1-2 months after the last (6th) dose.
   p

6. Record of two doses of **varicella vaccine** received after the first birthday at least 28 days apart or proof of immunity to varicella by titer (Students who are not immune should receive two varicella immunizations at least 28 days apart.)

7. **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/

8. **Covid-19 Vaccination**

   The University of Toledo no longer requires COVID-19 vaccines for students; however the University does continue to strongly recommend COVID-19 vaccinations and boosters. Please provide proof of vaccination through the University's secure vaccine registry portal at https://utvaccinereg.utoledo.edu/. **Clinical rotation sites may require vaccination.**

9. **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.)

Services may be obtained through the health care provider of your choice or at Student Health Center -Suite 1650, Medical Pavilion (near Health Science Campus Pharmacy) 1125 Hospital Drive, Toledo, OH 43614, phone: 419.383.5000
Please check with your health insurance provider to ensure coverage.

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.

THE UNIVERSITY OF TOLEDO
Health Requirement Form

COLLEGE OF MEDICINE & LIFE SCIENCES
PROGRAM 2025-2026

Student Instructions: (Please review the following very carefully)

1. Complete the 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 indicated

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, 2025)** **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	*Have this test read 48-72 hours later* DATE READ: ____/____/____ Read by, name & title:	RESULT (check) [ ] 0 mm induration or [ ] ___mm induration
1 to 3 weeks later	----------	
PPD #2 / / placed	*Have this test read 48-72 hours later* DATE READ: ____/____/____ Read by, name & title:	RESULT (check) [ ] 0 mm induration or [ ] ___mm induration

IF - PPD is "Positive"			
CHEST X-RAY **(only for LTBI)**	***Note: DO ONLY IF PPD reads 10 mm or more of induration***	**(*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:**	**Plus (+):**	**Positive Quantitative Antibody Titer:**
Hepatitis B #2 vaccine	**Date received:**		
Hepatitis B #3 vaccine	**Date received:**		

TETANUS/ DIPHTHERIA /acellular PERTUSSIS (T-DAP) (per CDC, January, 2007)	**Date** **/ /**	**Or record of TETANUS/ DIPHTHERIA** **Needs to be within past 10 years.** **Date / /**

Varicella **(Chickenpox)** **2 doses of the Varicella vaccine required**	**Dose #1 date:**
	Dose #2 date:
	****Varicella titer only required if previously infected with the disease (chickenpox) or if proof of the vaccination is unable to be located****
	Positive Varicella antibody titer: Lab report attached ☐

Measles, Mumps, & Rubella (MMR) **2 doses of the MMR vaccine required**	**MMR #1 date:**
	MMR #2 date:
	****MMR titers only required if proof of vaccination is unable to be located****
	Positive Measles, Mumps, and Rubella antibody titers: Lab report attached ☐

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 purposes 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.

<table>
<tr><td colspan="6">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.)</td></tr>
<tr><td colspan="3">Name</td><td colspan="2">Job Title
Medical Student</td><td>Date</td></tr>
<tr><td>Weight</td><td>Age</td><td>Height</td><td colspan="3">Sex (circle one) Male Female</td></tr>
<tr><td colspan="2">Main Campus ☐</td><td colspan="2">Scott Park ☐</td><td colspan="2">Health Science Campus ☒</td></tr>
<tr><td colspan="6">1. Can you read (circle one) Yes No</td></tr>
<tr><td colspan="6">2. Phone number where you can be reached by the health care professional who reviews this questionnaire:</td></tr>
<tr><td colspan="6">3. Best time to reach you at the above phone number:</td></tr>
<tr><td colspan="6">4. Has your employer told you how to contact the health care professional who will review this questionnaire N/A</td></tr>
<tr><td colspan="6">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).</td></tr>
<tr><td colspan="3">6. Have you worn a respirator (circle one): Yes No</td><td colspan="3">If "yes," what type(s):</td></tr>
</table>

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) Air-Purifying

☐ (PAPR)

Air-Purifying (Half/Full Face)

☐ SCBA

☐ Other

Select level of work effort

☐ Light

x Moderate

☐ Heavy/Strenuo

us

Extent of usage

☐ On a daily basis

☐ Occasionally, but more than once a week 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: _____ Date: _____