



Last Name:	First Name:	MI:
DOB:	Last 4 SS#:	
Street Address:		
City:	State:	
Zip Code:	Phone Number:	
Email Address:		

COVID VACCINE - Documentation of being "fully vaccinated."

The term "fully vaccinated" shall mean:

- 1) Two (2) weeks after receiving the second vaccine dose in a 2-dose series, such as the Pfizer or Moderna vaccines, or
- 2) Two (2) weeks after receiving a single-dose vaccine, such as Johnson & Johnson's Janssen vaccine.
- 3) The definition of "fully vaccinated" as used in this Policy may be amended from time to time in accordance with any changes to such definition adopted by the Centers for Disease Control and Prevention ("CDC").

EXEMPTION: Medical Students who wish to request an exemption from COVID-19 vaccination must submit the appropriate form for either [Medical Exemption](#) or [Religious Exemption](#). The form must be submitted to Georgetta Ellis, Clinical Coordinator, Division of Occupational Health and Wellness, 1600 Medical Center Dr., Huntington, WV 25701 or email at ellisg@marshall.edu. Occupational Health will consult with SOM/MH Human Resources and the Marshall Health's Executive Management Team to review the requested medical or religious exemption form along with any supporting information and shall inform the requesting individual as soon as possible as to whether his or her request is approved or denied.

☐ Copy of COVID vaccine record or exemption forms attached

MMR (Measles, Mumps, Rubella) – 2 doses of MMR vaccine, and serologic proof of immunity for Measles, Mumps and Rubella.

Vaccine/Titer		Date	
MMR - 2 Doses of MMR Vaccine	MMR Dose #1		
	MMR Dose #2		
Measles	Serologic Immunity (IgG antibodies titer)		<input type="checkbox"/> Copy Attached
Mumps	Serologic Immunity (IgG antibodies titer)		<input type="checkbox"/> Copy Attached
Rubella	Serologic Immunity (IgG antibodies titer)		<input type="checkbox"/> Copy Attached

Hepatitis B Vaccination—3 doses of vaccine followed by a QUANTITATIVE Hepatitis B Surface Antibody Titer. If negative, complete a second Hepatitis B series followed by a repeat titer. If Hepatitis B Surface Antibody is negative after a second series, additional testing including Hepatitis B Surface Antigen testing should be performed.

Primary Hepatitis B Series	Hepatitis B Vaccine Dose #1		Result_____ml/ml <input type="checkbox"/> Copy Attached
	Hepatitis B Vaccine Dose #2		
	Hepatitis B Vaccine Dose #3		
	QUANTITATIVE Hep B Surface Antibody		
Secondary Hepatitis B Series	Hepatitis B Vaccine Dose #4		
	Hepatitis B Vaccine Dose #5		
	Hepatitis B Vaccine Dose #6		
	QUANTITATIVE Hep B Surface Antibody		
Hepatitis B Vaccine Non-Responder (If Hep B Surface Antibody Negative after primary and secondary series)	Hepatitis B Surface Antigen (if 2 nd titer negative)		<input type="checkbox"/> Copy Attached
	Hep B Core Antibody (if 2 nd titer negative)		<input type="checkbox"/> Copy Attached
Chronic Active Hepatitis B	Hep B Surface Antigen		<input type="checkbox"/> Copy Attached
	Hep B Viral Load		<input type="checkbox"/> Copy Attached

NAME _____ DATE OF BIRTH _____

Varicella (Chicken Pox) – 2 Doses of vaccine and positive serology, or positive serology only

	Date		
	Varicella Vaccine #1		
	Varicella Vaccine #2		
	Serologic Immunity (IgG antibodies titer)		<input type="checkbox"/> Copy Attached

Tetanus-diphtheria-pertussis – One dose of adult Tdap within the last 10 years

	Vaccine	Date	
	Tdap Vaccine (Adacel, Boostrix, etc.)		

Influenza vaccine – One dose annually, each fall.

	Vaccine	Date	
	Flu Vaccine		<input type="checkbox"/> Copy Attached

TUBERCULOSIS SCREENING- Results of last 2 TST's (PPDs) or 1 IGRA blood test are required regardless of prior BCG status. If you have a history of a positive TST >10mm or IGRA, please provide information regarding an evaluation and/or treatment below. You only need to complete one section. Most recent test must be after January, 2022.

<u>Section A</u>		Date Placed	Date Read	Reading	Interpretation
Negative Skin or Blood Test History	TST #1			mm	<input type="checkbox"/> Pos <input type="checkbox"/> Neg
	TST #2			mm	<input type="checkbox"/> Pos <input type="checkbox"/> Neg
	TST #3			mm	<input type="checkbox"/> Pos <input type="checkbox"/> Neg
			Date	Result	
	IGRA Blood Test			<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	<input type="checkbox"/> Copy Attached

<u>Section B</u>		Date Placed	Date Read	Reading	Interpretation
History of Latent Tuberculosis, Positive Skin Test, or Positive Blood Test	Positive TST			_____ mm	
				Result	
	Date of Positive IGRA			_____ IU	<input type="checkbox"/> Copy Attached
	Date of Chest X-Ray				<input type="checkbox"/> Copy Attached
	Prophylactic Medications for latent TB taken?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	Total Duration of prophylaxis				_____ Months

<u>Section C</u>				
History of Active Tuberculosis	Date of Diagnosis			
	Date Treatment was Completed		<input type="checkbox"/> Copy Attached	
	Date of Last Annual CXR		<input type="checkbox"/> Copy Attached	

Additional Comments:

HISTORY AND PHYSICAL EXAMINATION

NAME: _____

DATE OF BIRTH: _____

HT: _____ WT: _____ BP: _____ Pulse: _____ Temp: _____

PMH: _____

PSH: _____

MEDS: _____

ALLERGIES: _____

	NORMAL	ABNORMAL
HEENT		
NECK		
NODES		
HEART		
LUNGS		
ABDOMEN		
EXTREMITIES		
SKIN		
BACK		
NEURO		
OTHER		

Remarks/Recommendations: _____

I have performed and recorded a physical examination and the medical history of the above named student which failed to reveal any health impairment which may be of potential risk to patients or which might interfere with the performance of his/her duties nor any habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which alter mood or behavior.

Signature of Physician: _____

Printed Name: _____

Address: _____

Phone: _____

Date: _____

Special Instructions: Hepatitis B, MMR and Varicella titer results MUST be attached to this report.

Once completed, return this report to:

Georgetta Ellis RN, MSN, MUSOM Family Medicine, 1600 Medical Center Drive, Suite 1500, Huntington, WV 25701
Phone: 304-691-1110, Fax: 304-691-1134, Email: ellisg@marshall.edu

*****The deadline to receive this information is July 1**