

Part II. This section must be completely filled out by the Dean of Students or other authorized official of the applicant's medical school. Students will not be allowed to begin their rotation until all information is received.

1 The student listed in Part I (is (is not covered by a school sponsored health insurance policy while participating in this elective.

2 The student listed in Part I (has (has not been trained in Universal Precautions, Infection Control and Infectious Disease, General Health Safety including Back Injury, Chemical Safety, and Fire Safety.

3 A written evaluation (will (will not be required.

NOTE: Please attach evaluation forms to this form on or before the first day of the elective rotation. All evaluations are distributed and returned through the Center for Education.

4. Lehigh Valley Hospital reserves the right to remove any student from an elective at any time. The school will be notified of any such action within one working day.

I certify that _____ is a student in good standing at this medical/osteopathic school and has been approved to participate in the elective specified in Part I of this application.

This student will be in the _____ year of a _____ Year curriculum on the dates specified for this elective.

I further certify that the student is covered by liability insurance for all actions taken during this elective at Lehigh Valley Hospital.

Liability Insurance Carrier

Policy Number

Signature

Date

Name

Title

School

School Address

School Seal

Medical Student / Intern / Extern Health Certification

Part III. This section must be completed by a Healthcare Professional capable of certifying that the following requirements have been met. Student Health Center or family physician documentation is acceptable. This must be returned to Employee Health Services LVH-Cedar Crest Box 689, Allentown, PA 18105-1556, BEFORE your rotation begins.

Student Name _____

Department sponsoring rotation _____

Duties of rotation _____

I hereby certify that _____ is free from communicable diseases in the communicable state. This individual does not possess any health handicap or other physical limitation which would interfere with his or her ability to satisfactorily perform the duties to which assigned within the scope of duties normally performed in the services identified above. I also certify that the following immunization / immunity / testing requirements, as listed below, have been fulfilled:

1. A negative PPD skin test upon commencement of duties. Unless there is a documented history of positive reaction with adequate treatment for disease or adequate preventative therapy for infection.

Date of PPD Mantoux: _____

If history of positive PPD, recent chest x-ray required: (within 3 months)

Date done: _____ Attach results: _____

2. A second negative PPD skin test (given two weeks after the first) if no documentation of a negative test within the preceding 12 months.

Date of 2nd PPD Mantoux: _____

3. For those born in 1957 or later, documentation of two doses of measles vaccine (preferably MMR) received on or after the first birthday OR laboratory evidence of immunity. If born before 1957 one dose of measles or MMR required if no laboratory evidence of immunity or documentation of previous dose of vaccine.

Date of vaccine(s): _____

OR results of measles titer: _____

4. For those born in 1957 or later, documentation of one dose of mumps vaccine (or MMR) on or after the first birthday OR laboratory evidence of immunity to mumps.

Date of vaccine: _____

OR results of mumps titer: _____

5. One dose of rubella (German measles) vaccine (or MMR) on or after the first birthday OR laboratory evidence of immunity to rubella.

Date of vaccine: _____

OR results of rubella titer: _____

6 Laboratory evidence of immunity to Varicella.

Varicella antibody results:

If varicella antibody negative and providing direct patient care, 2 doses of varicella vaccine.

7. For those at risk of exposure to blood and body fluids, documentation of Hepatitis B vaccine (3 doses) or laboratory evidence of immunity.

Date of vaccines _____, _____, _____ or result of hepatitis antibody titer _____

8. For those providing direct patient care, recent HbsAg titer (Hepatitis B surface antigen).

Date: _____ Result: _____

Signature of certifying health care provider

Date