Mount Sinai

MEDICAL REGULATORY REQUIREMENTS FOR ROTATORS

Sponsoring Institution Name: _____ **Rotator Last, First Name:** _____

Rotator Date of Birth: _____ **Rotator Email Address:** _____

MSHS Facility Name: _____ **MSHS Department Name:** _____

MSHS Mgr/Admin's Name: _____ **MSHS Mgr/Admin Email Address:** _____

Rotation Start Date: _____ **Rotation End Date:** _____

In order to comply with Federal and State regulations and Mount Sinai Health System (MSHS) policies, departmental managers/administrators responsible for affiliated healthcare profession rotator/student/intern ("Rotator") must submit a completed and signed copy of the form below for each rotator working in their department. This form must remain on file in the department for the entire academic year of the rotator's affiliation. If the rotator does not provide a completed form, the rotator will not be allowed to participate in clinical education programs in the Mount Sinai Health System.

Sponsoring Institution: Person responsible at the sponsoring institution/employer: Please attest that the following documentation for the named individual is on file with your institution by signing below.

Rotator: It is the Rotator's responsibility to ensure the form is completed by the sponsoring institution. Please forward the completed and signed form to the departmental supervisor/administrator at least two (2) weeks prior to beginning placement within the Mount Sinai Health System. Returning rotators must submit a new Medical Regulatory Requirements form every academic year.

1. An Initial Health Assessment granting fitness for duty in a health care facility.
2. Evidence of an Annual Health Assessment (or Initial Health Assessment) within the past twelve (12) months certifying no illness or conditions found that would jeopardize or impair ability to work.
3. Record of immunity or full vaccination to Rubella, Rubeola, and Mumps.
   MMR Dose #1 Date:___/___/___ MMR Dose #2 Date:___/___/___ OR Measles Immune Titer Date:___/___/___
4. Record of immunity or full vaccination to Varicella.
5. For rotators with a possible predictable exposure to blood or infectious body fluids, proof of either:
   - Immunity to Hepatitis B (by vaccination or natural immunity) OR
   - If declined, proof of declination
6. A record of annual Influenza vaccination. Date of the Influenza vaccination for current season: _____

   Name of vaccinator_____; Clinic where vaccine administered _____
7. A record of one Tetanus, Diphtheria & Acellular Pertussis (Tdap) vaccine. If Tdap was received more than 10 years ago, an updated Tdap or a Tetanus & Diphtheria (Td) vaccine within the past 10 years is required.
8. Record of Tuberculin Skin Test (TST/PPD) and risk assessment for Tuberculosis (TB) prior to placement and an annual TB symptom screening. Alternately, a blood test (IGRA) for TB done prior to placement and TB symptom screening yearly thereafter is also acceptable. If either TST or IGRA is positive, appropriate clinical follow-up must be documented and clearance established by private physician or the Department of Health or the employer's medical department. Annual TB symptom screening including a TB risk assessment may require follow up testing.
9. Evidence of infection control training and standard precautions in-service to comply with OSHA regulations.
10. If applicable, OSHA Respiratory Program Training and Medical Clearance for Fit-Testing.
11. Urine toxicology panel consisting of Amphetamines, Barbiturates, Benzodiazepines, Cocaine, Opiates, Opioids, Oxycodones, and Phencyclidine (PCP) using chain of custody protocol from current institution if rotating 30 days or more. Toxicology on file must be within the academic year. No toxicology required if rotating for less than 30 days.

FOR THE SPONSORING INSTITUTION NAMED ABOVE:

Physician, Licensed Provider, or Director of Occupational Health /Healthcare profession Faculty Representative at above sponsoring institution must sign to attest to the requirements above being completed with regard to this Rotator. **Office stamp or attached letterhead with name and title of approved institutional representative required.*

_____ _____ _____/_____/_____

(Print name) (Signature) (Date)

_____ _____ STAMP (if available):

(Title/Person of responsibility) (Telephone #)