HOFSTRA UNIVERSITY
DEPARTMENT OF PHYSICIAN ASSISTANT STUDIES

Date: April 22, 2019
To: Class of 2021
Re: Health Clearance Forms for Didactic Year

There are 4 steps to completing health clearance for incoming didactic students. In general, please read and review all paperwork carefully, before and after leaving any health care providers office. It is your responsibility to ensure that these forms are properly completed. ***Make a photocopy of all paperwork (including all results of blood work) as you WILL need these papers to see patients, for clinical clerkships, and again when you are employed as a PA.

Step 1: This step must be completed by **June 20, 2019**. The document below titled “Checklist for PA Program Health Clearance” must be filled out. All corresponding paperwork must be collected.

There are two options to complete step 1:

1) Make an appointment with your health care provider and have the forms filled out.
2) Make an appointment with Hofstra’s Student Health Center to have the forms filled out. This option is helpful if you do not have a primary care provider or your insurance will not allow you to obtain a physical exam now. For this option, contact the student health center at 516-463-6745 to make an appointment. **Specifically** state you are an **incoming didactic PA student** and that the appointment is for a Physical Exam. The cost is $20. Prior to your exam, upload any available immunization records and lab reports (titers) to the Hofstra Medicat system (see below for Medicat instructions).

Step 2: All students, regardless of which option you chose to complete Step 1, must upload documents to Medicat by **June 22**. The “Checklist for PA Program Health Clearance Form, physical examination form, laboratory reports (titers showing immunity), immunization records, and TB screening forms must be uploaded to Medicat; Hofstra’s electronic medical records system. Below are instructions on how to access Medicat.

a. Medicat can be found by logging into the Hofstra portal (https://My.Hofstra.edu), then going to the APP menu (waffle icon) in the top right corner. Click on the Medicat app, which will take you to https://hofstra.medicatconnect.com/home.aspx. Once you get to the home page click on the Forms tab and complete the Medical Record Form and Consent to Treatment form. Upload required documents.

b. Questions regarding health clearance requirements should go to Gia Raponi at 516-463-4043 or email at Gia.R.Raponi@Hofstra.edu.

c. For questions regarding Medicat, please call Student Health Center at 516-463-6745.

Step 3: All students, regardless of which option you chose to complete Step 1, must make an appointment with Hofstra’s Student Health Center for free Medical Record Review. Contact the student health center at 516-463-6745 to make an appointment. **Specifically** state you are an **incoming didactic PA student** and that the
appointment is for Medical Record Review. It is recommended that you schedule this appointment prior to August 1st as there may be outstanding requirements that need to be obtained prior to beginning the program. If it is impossible for you to get on campus before this date, please contact Gia Raponi at 516-463-4043 or email at Gia.R.Raponi@hofstra.edu to discuss alternative dates.

Step 4: Upon completion of the Medical Record Review, if you are in compliance with requirements, you will receive a signed paper indicating that you have been medically cleared to begin the PA program. This paper should be emailed to Gia.R.Raponi@hofstra.edu. If you have not met all requirements, staff at the student health center will advise you of what is necessary to be cleared. If you require additional vaccine boosters or lab testing, this can be done at the student health center at cost.
CHECKLIST FOR PA PROGRAM HEALTH CLEARANCE

Below indicates what is required from either your primary care provider or if you are optionally using the Student Health Center to complete this requirement:

☐ **Physical Exam** - Must be current within 1 year of September 1, 2018 (fill out attached form). Must be signed, dated and stamped.

☐ **Varicella Immunity** - Positive **numerical** titer. If numerical titer is negative, student must provide proof of receiving full primary series, plus one booster. Must repeat titer after booster. **MUST** provide laboratory copies of titers.

☐ **Measles Immunity** - Positive **numerical** titer. If numerical titer is negative, student must provide proof of receiving full primary series, plus one booster. Must repeat titer after booster. **MUST** provide laboratory copies of titers.

☐ **Mumps Immunity** - Positive **numerical** titer. If numerical titer is negative, student must provide proof of receiving full primary series, plus one booster. Must repeat titer after booster. **MUST** provide laboratory copies of titers.

☐ **Rubella Immunity** - Positive **numerical** titer. If numerical titer is negative, student must provide proof of receiving full primary series, plus one booster. Must repeat titer after booster. **MUST** provide laboratory copies of titers.

☐ **Hepatitis B Immunity** - Positive titer. If negative, require proof of primary series, then recommend that students start booster series. Either way, Hep B declination form must be signed. **MUST** provide laboratory copies of titers.

☐ **TB Screening** - Either PPD skin test, Quantiferon Gold Immunoassay or TB Spot – current within 1 year of September 1. If there is a history of latent TB or a patient is PPD positive, a yearly CXR is required.

☐ **Immunization Record** – to include proof of a pertussis containing vaccine (Tdap) within the last 12 years.

☐ **Medical Record Review at Student Health Services (see Step 3 above)**

____________________________________________           _______________________
Signature of examining health care provider                             Date

____________________________________________           _______________________
Print Name                                                                                 Telephone number
PHYSICAL EXAMINATION:
To be completed by a health care provider

Student Name:_______________________________________        Date of Birth:__________________

A thorough exam was completed on the above-named individual. I find him/her to be in good health. He/She is free of any health impairments which may pose potential risk to patients or personnel, or which may interfere with the performance of clinical responsibilities. Habituation to alcohol or other drugs which may alter the individual’s behavior has been considered in this evaluation. After a review of all health information I certify that this student is found to be in good physical and mental health and appears able to perform physician assistant student responsibilities with ______ or without _____ accommodations.

____________________________________________           Date___________________
Signature of examining health care provider

____________________________________________           _______________________
Print Name                                                                                 Telephone number

Practitioner’s stamp (Required):
HEPATITIS VACCINE REFUSAL FORM
To be filled out by student (if necessary)

To be signed by any student who has declined to be vaccinated against Hepatitis B OR who is in the process of becoming immunized but does not have a demonstrable immunity by HbsAb antibody titer (blood work) at this time.

______________________________  ___________________________
Student Name                  Student ID

I understand that due to my occupational exposure to blood and other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection.

I have been given the opportunity to be vaccinated with Hepatitis B vaccine. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease.

If in the future I continue to have occupation exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series from my private health care provider at any time.

______________________________  ____  ___________________________
Student                      Date                           Student Name (PRINT)