



Date: March 25, 2025  
To: Class of 2027  
Re: Health Clearance Forms for Didactic Year

There are **3** 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** (hardcopy) 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 prior to June 30th. The document below titled “Checklist for PA Program Health Clearance” is for your reference so you can track your compliance. All corresponding paperwork must be collected.

Make an appointment with your health care provider and have these forms filled.

**Step 2:** All students must upload the following documents to Castle Branch (CB) by June 30<sup>th</sup>: The “Checklist for PA Program Health Clearance” form, physical examination form, laboratory reports (titers showing immunity), immunization records, and TB screening forms. SEE CB instructions on next page.

- a. Please note: a FIT test and urine drug screen are required for **clinical** students only. You will be required to receive the seasonal influenza vaccine in the fall once this season’s formulation becomes available.
- b. Questions regarding health clearance *requirements* should go to Gia Raponi at 516-463-4043 or email at [Gia.R.Raponi@Hofstra.edu](mailto:Gia.R.Raponi@Hofstra.edu).
- c. ALL clearance ‘how to’ or any related questions should be directed to CB (below).

**Step 3:** Clearance – Castle Branch. ALL entering students must be cleared prior to orientation. If you are in-progress of receiving boosters, and all other health forms are uploaded and completed, you may attend class.

Hello Everyone,

Please read everything.

The Class of 2027 health care tracker is now available for order placement!

The current **HM27 tracker** is named "**Clinical Requirements HM27 - Class of 2027.**" Students who have not yet ordered can use the package code **HM27im** to order the **Class of 2027 tracker**. This is the same company account used for your background check.

**Important Reminders:**


- **Ensure your name is on each document** before uploading.
- **Upload all available documents now**, even if you're waiting on boosters or additional requirements. You can upload updated records as you complete them.
- **Keep an eye on your CastleBranch emails** for any required follow-ups.

**Need Help?**

For any questions, please contact CastleBranch directly:

 **Phone:** 888-723-4263

 **Chat & Email:** UserExperience@CastleBranch.com

 **Hours:** Monday-Thursday, 8 AM - 8 PM EST | Friday, 8 AM - 6:30 PM EST

BE SURE TO SEE the **instructions attachment** here: [[myCB\\_SIF - hm27im.pdf](#)]

Thank you!

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All COVID-19 related information and updated guidelines can be found at the Hofstra University Student Health Center page: <https://www.hofstra.edu/student-health-services/> Please be sure to check this website frequently prior to matriculating into the program, as guidelines can change.

It is the responsibility of the student to be sure they are compliant with any COVID-19 guidelines stated by the University.

Please note that clinical rotations may have additional medical screening and immunization requirements. Check with your clinical coordinators for requirements when beginning clinical rotations and visit the **immunization website** for more information.

## CHECKLIST FOR PA PROGRAM HEALTH CLEARANCE

Student Name \_\_\_\_\_

Below indicates what is required from your primary care provider to complete this requirement: (items 1-9):

- ☐ **1. Physical Exam** - Must be current/within 1 year of September 1, 2024 (please fill out attached form). Must be signed, dated and stamped. **Note to healthcare provider: the clearance form may be signed independently of titer results. The form is more for student state of mind and capabilities. It is not contingent upon the titers.**
- ☐ **2. 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.
- ☐ **3. 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.
- ☐ **4. 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.
- ☐ **5. 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.
- ☐ **6. 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.
- ☐ **7. TB Exposure Screening** - Either PPD skin test (must note mm of induration, lot number, date planted/date read) 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. Please place results on health care provider prescription pad or a note on office letterhead.
- ☐ **8. Immunization Record** – to include proof of a dose of an adolescent/adult pertussis containing vaccine (Tdap) after completion of childhood Dtap series.
- ☐ **9. COVID-19 Vaccine.** Students must upload documentation of completion of full series of Moderna/Pfizer vaccine or 1 dose of Johnson and Johnson vaccine.

### Clearance

- ☐ **Medical Record Review/Clearance – Castle Branch**



**PHYSICAL EXAMINATION:**  
**To be completed by a health care provider**

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Hofstra ID #: \_\_\_\_\_

A thorough exam was completed on the above-named individual. I find him/her/them to be in good health. He/She/They 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.

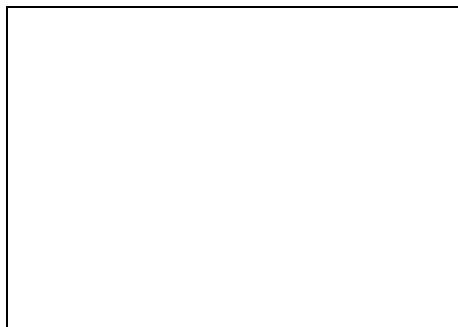
\_\_\_\_\_  
Signature of examining health care provider

\_\_\_\_\_  
Date

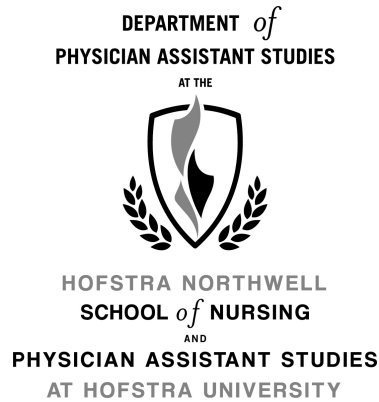
\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Telephone number

Practitioner's stamp (\*Required):



*\* Invalid without practitioner's stamp*



**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.

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Student Name

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Date of birth

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Student Hofstra ID (700 #)

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.

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Student Signature

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Date

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Student Name (PRINT)