



School of Medicine

Dear Students,

Welcome to the Wayne State University School of Medicine! As a medical student and future member of the healthcare workforce, it is important for you to provide documentation that you have had all necessary vaccinations and have evidence of immunity from specific diseases. This documentation is essential, not only to show that you are protected, but also to protect those patients with whom you will come in contact during clinical rotations, visits to clinical facilities, and in the course of volunteer or relief programs. This documentation is also required by our affiliated clinical teaching facilities. You will find below the requirements for vaccination and immunity documentation. These very specific requirements are based upon current recommendations from the U.S. Center for Disease Control (CDC), the Michigan Department of Community Health (MDCH), and other expert authorities. Please review this information and the requirements very carefully and share it with your healthcare provider.

We are notifying you now so that you can obtain these vaccinations, titers, and documentation before the start of the upcoming school year. This information should be documented on the attached Health Certification form to be completed by your healthcare provider (also available on the School of Medicine website at: <http://admissions.med.wayne.edu/pdfs/healthcert.pdf>). You may receive vaccinations and have titers drawn with your personal healthcare provider, or alternatively you may wish to make an appointment with the Campus Health Center on the main WSU campus (<http://health.wayne.edu/>). If you choose to use the Campus Health Center, make sure when making an appointment that you indicate you are an incoming medical student.

In either case, you must provide us with a copy of the documentation of the vaccination administration and laboratory reports of the quantitative (IgG) titers. (Please note that annual TB testing and influenza vaccinations will be offered here at the School of Medicine at the appropriate times of each school year.)

Regardless of where you obtain documentation of immunization status, your health record will be housed at the Campus Health Center. We request that you sign the enclosed “**Authorization for Release of Protected Health Information**” form in case the School of Medicine requires access to your proof of immunization status for clinical purposes. For instance, clinical sites have requested specific immunization and/or titer dates for students exposed to measles or varicella while on rotation.

Your attention to meeting these requirements and providing the school with the necessary documentation in a timely manner will be greatly appreciated. Please send all forms and documentation **no later than June 15th** to: Wayne State University School of Medicine, 550 E. Canfield Ave., 361 Lande Building, Detroit, MI 48201. Please include on the envelope: “Attn: MD Program Health Records Office – Confidential”. Alternatively, you may scan and send your forms as attachments to an email addressed to MD Program Health Records Office at MDHealthRecords@wayne.edu or fax them with a cover sheet indicating “Confidential” to 313-577-0361. Please do not send your forms as smart phone images. **You will not be able to register for classes if we have not received your Health Certification and documentation of your vaccinations and evidence of immunity prior to your date for registering.**

Thank you.

Student Health Officer
Wayne State University School of Medicine

Required documentation of vaccinations and evidence of immunity:

(Please note: for all antibody titers, copies of the actual laboratory reports must be submitted for inclusion in the student's health file)

1. **Tdap** (**T**etanus toxoid, reduced **d**iphtheria toxoid and **a**cellular **p**ertussis vaccine): This is a somewhat different formulation than the DTaP or DPT vaccinations that most of our students received in infancy/early childhood and it is also different than the Td (commonly "Tetanus shot") that many may have received as adolescents or adults for tetanus prophylaxis for wounds. The Tdap has the standard dose of tetanus toxoid, a reduced dose of diphtheria and an acellular booster for pertussis ("whooping cough"). With the resurgence and increasing incidence of pertussis, the CDC and other authorities have recommended that all healthcare providers who have not received a Tdap **as an adult (i.e. at age 16 or older)** should receive one, regardless of the time since their last Td vaccination. The hospitals in which our students participate in clinical rotations are requiring **explicit documentation of the adult pertussis vaccination** in order for students to be in their facilities. As such, **please submit your Tdap documentation with your medical records.**
2. **Measles and Mumps:** Some of the clinical sites available to students for clerkships and electives require medical students to have **quantitative (IgG)** measles and mumps antibody titers indicating they are immune to these infections. Therefore, the School of Medicine requires **evidence of immunity**. We also request documentation of **two** doses of these vaccinations.
3. **Rubella:** Some of the clinical sites available to students for clerkships and electives require medical students to have **quantitative (IgG)** rubella antibody titers indicating they are immune to this infection. Therefore, the School of Medicine requires **evidence of immunity**. We also request documentation of at least **one** dose of this vaccination.
4. **Varicella:** All students should have a **quantitative (IgG)** varicella antibody titer drawn to assess their immunity to this infection. If a student has a history of receiving the vaccination, we also request documentation of **two** doses of this vaccination. **A history of having "had the disease" is not adequate documentation of immunity to varicella.**
5. **Hepatitis B:** The majority of clinical sites require documentation of **three** doses of this vaccination **and a quantitative (IgG) antibody titer (anti-HBs) indicating response to the immunizations.** Therefore the School of Medicine has the same requirement. Students must have evidence of three doses and immunity to Hepatitis B. (Please note that additional blood work and potential re-vaccination will be required in the event that immunity is not documented after the primary series. Students should consult with their healthcare provider in this event.)



Health Certification

540 East Canfield
Detroit, MI 48201

WSU Banner ID # _____ Date: _____

Name: _____ Date of Birth: _____
 Last First Middle Initial

Local Address: _____ City/State: _____ Zip Code: _____

Local Phone: _____ E-Mail Address: _____

Person to be notified in emergency: _____ Relationship: _____

Address: _____

Phone: (HOME) _____ (Cell) _____ (Work) _____

Immunizations/Assessment of Immunity

Vaccination	Date		Documented Immunity	Date
Tdap				
Measles First Dose		<u>AND</u>	Measles Titer (<u>Quantitative</u>) Demonstrating Immunity	
Measles Second Dose				
Rubella Single Dose		<u>AND</u>	Rubella Titer (<u>Quantitative</u>) Demonstrating Immunity	
Mumps First Dose		<u>AND</u>	Mumps Titer (<u>Quantitative</u>) Demonstrating Immunity	
Mumps Second Dose				
Varicella First Dose		<u>AND</u>	Varicella Titer (<u>Quantitative</u>) Demonstrating Immunity	
Varicella Second Dose				
Hepatitis B First Dose		<u>AND</u>	Hepatitis B (anti-HBs) Titer (<u>Quantitative</u>) Demonstrating Immunity	
Hepatitis B Second Dose				
Hepatitis B Third Dose				

AUTHORIZATION FOR RELEASE OF IMMUNIZATION/IMMUNITY TESTING RECORDS

The purpose of this authorization is to allow the Wayne State University School of Medicine and/or its agents to release information regarding a student's immunizations/immunity testing to affiliated health care facilities where students are participating in clinical educational activities which require confirmation that the students have completed the immunizations/immunity testing mandated by those facilities. This form authorizes only the release of immunization records and/or records of immunity testing.
I understand that this Authorization for Release does not authorize release of any other personal medical information.

I hereby authorize the disclosure of immunization records and /or records of immunity testing as described above.

Student Signature: _____ Date: _____

Health Assessment
(To be completed by practitioner)

I have obtained a complete history and performed an appropriate physical examination on the above named student. The following summarize my findings of this evaluation:

1. History of significant past medical, surgical, or mental health conditions including hospitalizations:

- a. NONE
- b. Significant History (Use additional pages if necessary):

2. Medications:

- a. NONE
- b. Current Medications:

3. Allergies:

- a. NONE
- b. Medication or Environmental Allergies (including latex and/or formalin)—Please specify nature of reaction:

4. Physical Examination Findings:

- a. Physical Examination within normal limits
- b. Abnormal findings as follows (Use additional pages if necessary):

I have been provided with and have reviewed the summary of the *Wayne State University School of Medicine Technical Standards* delineating the abilities, skills, and capacities required of medical students seeking to study for the MD degree at that institution. After doing so and understanding the physical and psychological demands required of a medical student, I find that the student currently (please check one):

Meets the technical standards required to be a medical student at the WSU School of Medicine

Meets the technical standards required to be a medical student at the WSU School of Medicine, but requires initial or continued care for medical or psychological conditions (Please explain on an additional page)

Does NOT meet the technical standards required to be a medical student at the WSU School of Medicine

Signature of Practitioner: _____ Date: _____
(MD/DO/NP/PA)

Name: _____ Title: _____ State License #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone #: _____ Email Address: _____

Wayne State University

School of Medicine

Technical Standards

The Admissions Committee of Wayne State University School of Medicine will consider for admission to the School of Medicine any applicant who demonstrates the ability to acquire the knowledge necessary for the practice of medicine, as well as the ability to perform or to learn to perform the skills as described in this document. Students will be judged not only on their scholastic accomplishments but also on their physical and emotional capacities to meet the full requirements of the school's curriculum and to graduate as skilled and effective practitioners of medicine.

The law requires that a student with a disability be provided with reasonable accommodations for his/her disability. However, there is no requirement to provide an accommodation that would alter the technical standards of a program or the essential elements of a course in a fundamental way. A reasonable accommodation is decided on a case-by-case basis through an interactive process with the requesting student.

A candidate for the MD degree must possess abilities and skills which include those that are observational, communicational, motor, intellectual-conceptual (integrative and quantitative), and behavioral and social. Those abilities and skills are outlined in detail below:

Observation:

The candidate must be able to acquire a defined level of required information as presented through demonstrations and experiences in the basic sciences, including but not limited to information conveyed through physiologic and pharmacological demonstrations in animals, microbiological cultures and microscopic images of microorganisms and tissues in normal and pathological states. Furthermore, a candidate must be able:

- to observe a patient accurately, at a distance, and close at hand, to acquire information from written documents, and to visualize information as presented in images from paper, films, slides or video.
- to interpret x-ray and other graphic images, and digital or analog representations of physiologic phenomenon (such as EKGs) with or without the use of assistive devices. A request for use of an assistive device is a request for an accommodation that will be evaluated as indicated above. Such observation and information acquisition necessitates the functional use of visual, auditory and somatic sensation while being enhanced by the functional use of other sensory modalities. In any case where a candidate's ability to observe or acquire information through these sensory modalities is compromised, the candidate must demonstrate alternative means and/or abilities to acquire and demonstrate the essential information conveyed in this fashion.

Communication:

A candidate must be able to speak, to hear and to observe patients by sight in order to elicit information, describe changes in mood, activity and posture, and perceive nonverbal communications. A candidate must be able to communicate effectively and sensitively with patients. Communication includes speech, reading and writing. The candidate must be able to communicate effectively and efficiently in oral and written form with all members of the health care team.

Motor Skills:

It is required that a candidate possess the motor skills necessary to directly perform palpation, percussion, auscultation and other diagnostic procedures. The candidate must be able to execute motor movements reasonably required to provide general and emergency medical care such as airway management, placement of intravenous catheters, cardiopulmonary resuscitation, application of pressure to control bleeding, suturing of wounds and the performance of simple obstetrical maneuvers. Such actions require coordination of both gross and fine muscular movements, equilibrium and functional use of the senses of touch and vision.

Intellectual-Conceptual (Integrative and Quantitative) Abilities:

The candidate must be able to measure, calculate, reason, analyze, integrate and synthesize. In addition, the candidate must be able to comprehend three-dimensional relationships and to understand the spatial relationships of structures. Problem solving, the critical skill demanded of physicians, requires all of these intellectual abilities. The candidate must be able to perform these problem-solving skills in a timely fashion.

Behavioral and Social Attributes:

The candidate must possess the emotional health required for full utilization of his/her intellectual abilities, the exercise of good judgment, the prompt completion of all responsibilities attendant to the diagnosis and care of patients, and the development of mature, sensitive, and effective relationships with patients. The candidate must be able to tolerate physically taxing workloads and to function effectively under stress. He/she must be able to adapt to changing environments, to display flexibility, and to learn to function in the face of uncertainties inherent in the clinical problems of patients. Compassion, integrity, concern for others, interpersonal skills, interest and motivation are all personal qualities that will be assessed during the admissions and educational processes.

Ability to Comply with Administrative Clinical Policies

Wayne State University School of Medicine students are required to comply with all patient safety standards and requirements at the sites of clinical rotations. This includes but is not limited to wearing hospital-approved operating room attire, following regulations related to sterilization procedures, and receipt of specific immunizations and/or have evidence of immunity from specific diseases. Students must undergo periodic health testing in order to receive instruction in clinical settings and perform the essential function of a medical student. Please see the Refusal of Required Immunizations or Medical Testing Policy for more information. It should be noted that failure to meet the requirements for patient safety, vaccination and/or health testing will result in the student not being permitted to train in affiliated clinical facilities, thereby preventing the student from completing the required curricular activities needed to receive the Medical Doctor (M.D.) degree.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

The individual or organization identified below as the Recipient ("Recipient") requested Nursing Practice Corporation, a Michigan non-profit corporation doing business as Campus Health Center (the "Center"), to collect and/or disclose certain Protected Health Information, as defined by HIPAA ("PHI"), about the Patient listed below. By law, we are required to obtain Patient's authorization prior to making such a disclosure.

I hereby AUTHORIZE DO NOT AUTHORIZE the Center to disclose to:

Name of Recipient of PHI: Wayne State University School of Medicine Fax: (313) 993-4333

Address: 540 E. Canfield Street, Detroit, MI 48201 Phone: (313) 577-1429
Street City State Zip Code

the following PHI:

- Confirmation of immunization record submission
- Results of Sickle Cell Trait test
- Results of Tuberculosis (TB) Testing
- Other: all immunization records, TB testing, UDS, Clearance forms, Titer results, Repirator Fit test results

Information about the Patient:

Patient Name: _____ DOB: _____
First Middle Initial Last MM / DD / YY

Phone: _____ Student ID: _____

Address: _____
Street City State Zip Code

If Other Than the Patient Listed Above, Information about the Person or Organization Authorizing the Release of PHI:

Name: _____ Phone: _____
First Middle Initial Last

Relationship to Patient: _____ Documents of Relationship to Patient Attached

Address: _____
Street City State Zip Code

I understand that authorizing the disclosure of PHI to the Recipient is voluntary and that it covers multiple requests for and disclosures of such information, and that this authorization authorizes the Center to respond to such requests. I also understand that I may refuse to provide authorization for disclosure of PHI to the Recipient, and the Center may not condition treatment, payment for services, or eligibility for benefits on whether I sign this Authorization. By signing this Authorization, I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the Recipient and the information may not be protected by federal or state privacy rules. I further understand that I may request a copy of this signed Authorization.

This Authorization may be revoked at any time in writing at any time by sending or delivering a signed revocation to the address listed above. The revocation is effective upon receipt but will have no impact on uses or disclosures of PHI made while the Authorization was valid. If not previously revoked, this Authorization shall expire on the date listed above or, if no date is given, this Authorization will be valid for 180 days only. For additional information on uses and disclosures of PHI by the Center please refer to our Notice of Privacy Practices.

I ACKNOWLEDGE AND AGREE THAT IF I REFUSE TO PROVIDE THIS AUTHORIZATION OR REVOKE THIS AUTHORIZATION PRIOR TO THE CENTER'S DISCLOSURE OF THE PHI REQUIRED OR REQUESTED BY THE RECIPIENT, THE CENTER IS NOT RESPONSIBLE FOR ANY CONSEQUENCES OF FAILURE TO DISCLOSE ANY INFORMATION TO THE RECIPIENT AND IS NOT RESPONSIBLE TO NOTIFY ME OR ANY THIRD PARTY OF ANY SUCH CONSEQUENCES. I AGREE THAT I WILL NOT HOLD THE CENTER AND/OR ITS AGENTS RESPONSIBLE FOR ANY LIABILITY, LOSS, DAMAGE OR EXPENSE CAUSED OR INCURRED AS A RESULT OF MY REFUSAL TO PROVIDE THIS AUTHORIZATION, REVOKING THIS AUTHORIZATION, AND/OR IN CONNECTION WITH ANY DISCLOSURE OF PHI PURSUANT TO THIS AUTHORIZATION.

Patient Signature: _____ Date: _____

Patient's Authorized Representative's Signature: _____ Date: _____

For Office Use Only:

If Patient is unable to sign, secure signature of Next of Kin or Legal Agent/Guardian and indicate reason why Patient is unable to sign:

- Minor
- Disoriented
- Incompetent
- Medically Unstable

Processor's Initial's _____ Date Sent Out: ____/____/____