Request for Medical Evaluation for Volunteer Faculty Performing Clinical Activities at University Clinical Sites

DATE: ....

TO: Personal Health Care Provider

FROM: .... Tel #...

☐ Office of the Dean ☐ Other..……………………………..

RE: Name............................…...
Last First Middle

University Department:... University Location: ……………….……………..

University Supervisor:... University Telephone:………..…………….……..

Completed by University Supervisor:

Proposed start date:...................................... Date of Birth:……………………………………

1. Exposure-prone patient care procedures to be performed: As defined by Centers for Disease Control and Prevention and in Exhibit A in University Policy #00-01-45-52.00 (see Attachment I).
☐ No ☐ CDC Category I (increased injury risk with possible HBV transmission) ☐ CDC Category II

2. Potential exposure to infectious sources (eg, patient contact, blood/body fluids, human tissue, TB, lab-based):
☐ No Yes (specify): ☐ Tuberculosis* ☐ Hepatitis B Virus* ☐ Other ………………………...

3. Other potential hazardous exposures? ☐ No ☐ Yes (specify)……….……………...……..……...........

4. Is respiratory protection required: ☐ No Yes (specify): ☐ N-95 ☐ PAPR ☐ Other ……

Completed by Personal Health Care Provider: Medical Classification

I certify that the University Volunteer Faculty Member named on this form has been thoroughly evaluated and

☐ Is medically qualified for the assignment being considered without limitations or restrictions.
☐ Is medically qualified for the assignment being considered with the following limitations:
……………………………………………………………………………………………………...
☐ Is respiratory protection required for any clinical activity?
☐ May not currently be medically qualified for the assignment being considered. (Note: you ***must*** check this if the individual has any of the following conditions. If checked, a review of findings by the School will be required.)
1) Active Tuberculosis Disease.
2) Hepatitis B infection and performs CDC Category I patient care procedures.
3) Other diseases or conditions that could interfere with the ability to do the tasks.
4) Additional evaluation is required.

☐ Other comments: ………………………………………………………………………………………..

Evaluator's Signature……………………………………………………… Date……………...……………….

Name (please print)………………………………………………………… Telephone Number…....................

Footnote:
* **If checked**, personal health care provider **must** evaluate the individual for current tuberculosis status (TB skin test or Interferon Gamma Release Assay and if positive, symptom survey and chest x-ray) and/or hepatitis B immunity (hepatitis B surface antigen, hepatitis B surface antibody and hepatitis B core antibody).