IU HEALTH CLINICAL STUDENT/FACULTY VALIDATION FORM

School and Educational Program: _____

Student or Faculty Name: _____

This form must be completed by the School for each Student or Faculty participating in a rotation at IU Health. All source documentation required by this form must be kept on file at the School and must be produced within 24 hours of a request by IU Health.

General Checklist

- ☐ Medical Insurance Company: _____ Policy #: _____
- ☐ FCRA-compliant Criminal Background Check
- ☐ Student-signed Written Consent to release Background Check
- ☐ Department of Transportation compliant Drug Screen Results (minimum 5-panel, completed within the last 12 months)
- ☐ Copy of Active American Heart Association Basic Life Support (BLS) card or equivalent, including validation of skill demonstration (*if applicable*)
- ☐ N95 fit testing (*if applicable*). Students must show proof of fit testing to preceptor/department manager/charge RN prior to working with patients where N95 mask-wearing is required.

Vaccination Checklist:
☐ Influenza (for current flu season from September 1-March 31 yearly) ☐ or School approved exemption
☐ TB test-2 Step Skin Test within 12 months of starting rotation or IGRA blood test
☐ Varicella (2-shot Vaccine)
☐ Hepatitis Vaccine (multiple doses or declination form)
☐ MMR Vaccine (2-shot Vaccine)
☐ COVID Vaccine - NOT Mandatory

I certify that this information is correct and accurate, according to the information supplied by the above-named Student/Faculty, and I certify that supporting documentation is on file at the School and available upon request.

School Official Signature _____ Title _____ Date _____

Indiana University Health

Employee Occupational Health Services Tuberculosis Questionnaire

Academic Health Center | IUHP
1633 N Capital Ave, Suite 760
Indianapolis, IN 46202
P: 317.962.8495 F: 317.962.8349
Email: eohs@iuhealth.org

Bloomington | Bedford | Paoli | SIP
PO Box 1149
Bloomington, IN 47403
P: 812.353.9369 F: 812.353.5465
Email: Screhs@iuhealth.org

Arnett | Frankfort | White
5165 McCarty Lane
Lafayette, IN 47905
P: 765.838.5842 F: 765.448.7680
Email: Wcrehs@iuhealth.org

Tipton
1000 S. Main St
Tipton, IN 46072
P: 765.675.1757
F: 765.675.1487

West
1111 N Ronald Reagan
Pkwy Avon, IN 46123
P: 317.217.3478 F: 317.217.2028
Email: westeohs@iuhealth.org

North | Saxony
11725 N Illinois Street
Carmel, IN 46032
P: 317.688.2764 F: 317.688.2824
Email: northaohs@iuhealth.org

Ball | Blackford | Jay | Ft. Wayne
2401 W University Ave
Muncie, IN 47303
P: 765.747.3458 F: 765.751.1322
Email: ballehs@iuhealth.org

Name (Last, First, Middle I)

HISTORY	Yes	No
Any unexplained fever in recent weeks to months?	☐	☐
Any unexplained cough in recent weeks to months?	☐	☐
Any drenching sweats in recent months?	☐	☐
Any unexplained weight loss in recent months?	☐	☐
Any chest pain in recent weeks?	☐	☐
Any known exposure to TB? If yes, when?	☐	☐
Current or past diagnosis of immune deficiency, sugar diabetes, silicosis, renal failure, cirrhosis, HIV infection, or been treated with cortisone, methotrexate, cytoxan, cyclosporine, imuran, prednisone, or chemotherapy (cancer drugs)?	☐	☐
Any major stomach or intestinal surgery?	☐	☐
Any loss of appetite?	☐	☐
Any bloody sputum?	☐	☐
Use of Zantac, Tagamet, Pepcid, Axid or Prilosec, or other prescription medicines to control stomach acids?	☐	☐
Have you lived outside of the United States, Canada, Australia, New Zealand, or Northern or Western Europe for longer than 1 month?	☐	☐
Are you currently immunosuppressed or plan to have immunosuppression?	☐	☐
Have you been in close contact with someone who has had infectious TB disease since your last TB test?	☐	☐

If History of Positive PPD

History of a positive PPD? ☐ Yes ☐ No
Did you receive BCG? ☐ Yes ☐ No
When did you first convert to positive TB skin test regarding? _____
Did you ever take INH? ☐ Yes ☐ No If yes, how long? _____
Who followed up your conversion? _____
When was your last chest x-ray? _____ Results? _____

_____ _____
Signature of Applicant Date