PHLEBOTOMY U
EDUCATING. IT'S IN OUR BLOOD

Palomar Health Externship Prerequisites

To be eligible to go on a clinical externship to Palomar Health, students must submit the following prerequisites to the PhlebotomyU Admin at info@phlebotomyu.com.

Program Prerequisites

Must be submitted before the first day of class.

1. **Valid Government Issued Photo ID that indicates date of birth**
   e.g. Driver's License, State Identification Card or Passport
2. **Proof of U.S. High School Education or Equivalent**
   You must submit one of the following:
   - Copy of High School or accredited college transcript (official or unofficial)
   - Proof of passing the GED, HiSET or CHSPE exams
   - If your education is outside the U.S., please let us know and we will give you further instructions on what is required.
   - Post-secondary or vocational school certificates and transcripts are not acceptable

Externship Prerequisites

1. **Cleared Background Check & Drug Screen**
   Instructions on how to sign up will be given on the first day of class.
2. **Immunizations**
   - **MMR (Measles, Mumps & Rubella)**
     You must submit one of the following:
     - Proof of 2 doses of MMR vaccine
     - Positive titers for MMR
     - Signed Palomar Health Declination Form
   - **Varicella**
     You must submit one of the following:
     - Proof of 2 doses of Varicella vaccine
     - Positive titer for Varicella
     - Signed Palomar Health Declination Form
   - **Hepatitis B**
     You must submit one of the following:
     - Proof of completion of HBV vaccination series (2 or 3 doses depending on the HBV vaccine)
     - Positive titer for Hep B
     - Signed Palomar Health Declination Form
   - **TDAP**
     You must submit one of the following:
     - Proof of TDAP within the last 10 years (not TD or dTAP)
     - Signed Palomar Health Declination Form
   - **COVID**
     You must submit one of the following:
     - Proof of annual COVID-19 vaccine
     - Signed Palomar Health Declination Form
   - **Seasonal Flu**
     You must submit one of the following:
     - Proof of annual Flu vaccine
     - Signed Palomar Health Declination Form
3. **Negative TB Test**
   - If you **do not** have any history of positive T and the current screening results are negative, you will need to submit one of the following:
     - **2-Step Negative TB Skin Test** dated at least 7 days apart
     - **Negative Quantiferon Blood Test** dated within 90 days of your rotation start date
     - **Initial Blood Test + Skin Test**
       Negative Quantiferon Blood test completed within the last year **AND** negative TB Skin test dated within 90 days of your rotation start date.
   - If you have a history of positive TB or the current screen results are positive, you will need to provide the following:
     - Completed TB Symptom Questionnaire
     - Proof of positive TB Skin Test or positive Quantiferon Blood Test
     - Cleared Chest X-Ray dated within the last year

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Palomar Health Specific Prerequisites

1. **Immunization Requirements**
    - **Declination Waivers**
      The easiest and quickest way to ensure you meet Palomar's requirements is to sign the attached declination waivers and return it to me. Note, signing the declination form will not negatively affect your placement. It will only ensure you are in compliance with Palomar's student requirements.
        - **Palomar Health_COVID-19 Vaccine Declination Form**
        - **Palomar Health_Annual Influenza Declination**
        - **Palomar Health_Student Vaccine Declination Form (HBV, MMR, VZV, and TDAP)**
    - **Health Clearance Packet**
      If you do not wish to sign the Declination waivers, you will need to have the appropriate licensed healthcare professional complete the attached **Palomar Health_Student Health Clearance Packet.**

2. **TB Requirements**
   Palomar Health requires a 2-step TB skin test or a recent Quantiferon TB Blood Test dated within 90 days of the start of your rotation.

   Therefore you will either need to obtain:
    - 2-Step Negative TB PPD (Skin) Test dated at least 7 days apart
    - TB Quantiferon (Blood) test dated within 90 days of your rotation start date

   You will need to have the appropriate licensed healthcare professional complete the attached **Palomar Health_TB Testing Verification Form**.

Health Clearance Packet

Palomar Health is committed to protecting the health of our students, instructors, staff, and patients. The environment of the student experience necessitates that students/on-site instructors complete immunization and TB screening to obtain clearance to enter our facilities for their experience. Some of the requirements are meant to prevent potential harm to our immunocompromised patient population, while other requirements are meant to protect the student/instructor from potential harm. There are inherent risks in a healthcare setting, such as exposure to transmissible diseases, and Palomar Health cannot eliminate these risks regardless of the care taken to avoid them.

Contents and Instructions

This packet contains required/supplemental forms that are to be completed and uploaded to the appropriate item in Complio. **The student/ instructor must take their medical records to a licensed medical provider to transcribe their records onto our forms.**

STEP 1 | Gather supporting documentation (medical records) for the requirements

STEP 2 | Schedule an appointment with a licensed medical provider

STEP 3 | **Print** the ***Immunization Verification Form*** and the appropriate ***Tuberculosis (TB) Testing Verification Form*** and complete the *Student/Instructor Information* section of the forms prior to the scheduled appointment with the licensed medical provider and bring these forms to the appointment

STEP 4 | Licensed medical provider verifies and transcribes the medical records onto the provided forms and completes the "Licensed Medical Provider Information" box on ***both*** the immunization and TB forms, and adds the clinic stamp

STEP 5 | School verifies that the forms are complete and that the student/instructor completed any necessary supplemental documentation

STEP 6 | Student/instructor/school uploads the completed forms in full to Complio and applies them as supporting documentation to the appropriate items for each applicable category in Complio

The following documentation must be completed by a licensed medical provider *(refer to the particular document for the appropriate providers to complete the form*):

- Immunization Verification Form
- Tuberculosis (TB) Testing Verification Form – Negative ***or*** Tuberculosis (TB) Testing Verification Form – History of Positive TB

The following supplemental documentation may also need to be completed by the student/instructor based on the licensed medical provider completed forms:

- HBV, MMR, VZV, and Tdap Vaccine Declination Form
- Annual Influenza Declination
- COVID-19 Vaccine Declination

Form Completion Requirements

- Must be completed using standard blue or black ink/font
- The student/instructor's legal first and last name and DOB must match the information provided to Complio to run the background check
    - If the student/instructor provides an alias on any documentation, they must provide a form of photo identification that includes the alias name in addition to the photo identification with their legal name (or the alias must be on their background check)
- Forms completed by a licensed medical provider can only be accepted if the "Licensed Medical Provider Information" is completed in full and includes the clinic stamp

Immunization Requirements at a Glance

Vaccine	Option 1	Option 2	Option 3	Option 4	Option 5
HBV	Initial 2-dose series (**adult only**) or 3-dose series	**Positive** Hepatitis B Surface Antibody Titer	**Negative** Hepatitis B Surface Antibody titer **+** complete initial series **+** 1 booster dose after negative titer	**Negative** Hepatitis B Surface Antibody titer **+** full series (2-3 doses) of HBV completed after the negative titer	HBV, MMR, VZV and Tdap Vaccine Declination Form
MMR	Initial 2-dose series	**Positive** Measles, Mumps, and Rubella IgG Antibody Titers	**Any negative** value for Measles, Mumps, or Rubella IgG Titers **+** complete initial series **+** 1 booster does after negative titer(s)	**Any negative** value for Measles, Mumps, or Rubella IgG Titers **+** full series completed after any negative titer(s)	HBV, MMR, VZV and Tdap Vaccine Declination Form
VZV	Initial 2-dose series	**Positive** Varicella IgG Antibody titer	**Negative** Varicella IgG Antibody Titer + complete initial series **+** 1 booster does after negative titer	**Negative** Varicella IgG Antibody Titer **+** full series completed after any negative titer(s)	HBV, MMR, VZV and Tdap Vaccine Declination Form
Tdap/TD	Tdap within the last 10 years	Lifetime Tdap + TD Booster completed within the last 10 years	Student Vaccine Declination Form	N/A	N/A
Annual Influenza	Yearly between 8/1-3/31	Annual Influenza Declination	N/A	N/A	N/A
COVID-19 Vaccine	2-doses	COVID-19 Declination	N/A	N/A	N/A
	Refer to the Immunization Verification Form for acceptable manufacturers				

Tuberculosis (TB) Screening Requirements

Refer to the ***Tuberculosis (TB) Testing Verification Forms*** for information about the options. **The last TB test completed must have been completed within 90 days of the anticipated start date.**

Immunization Verification Form

This form must be completed by a licensed medical provider (MD, DO, NP, PA, RN, PharmD (only immunizations) or LVN only) and must include a clinic stamp. The student/instructor must demonstrate **either full immunization or appropriate titer(s) demonstrating immunity** (if applicable).

The student/instructor may decline HBV, MMR, VZV, Tdap, annual influenza, or COVID-19 by indicating that on this form and completing the appropriate declination form. If they have not yet completed the required doses for a vaccination series or do not have a titer demonstrating immunity, they must complete the declination form. ***Refer to the table Immunization Requirements at a Glance for compliance options.***

Student/Instructor Information

Legal First and Last Name: _____ **DOB:** _____

Lifetime Immunization or Titer History

Requirement	Immunization	OR	Titer(s)
Hepatitis B (HBV) ☐ Does not meet requirement or declines and will complete the declination form *Appropriate declination form: "HBV, MMR, VZV, and Tdap Vaccine Declination Form"*	**Initial Series** **Select one:** ☐ 2-dose series (*adult **Heplisav-B** formulation only*) **or** ☐ 3-dose series Date 1: _____ Date 2: _____ Date 3: _____ *Any doses received after a non-immune titer should be entered as boosters in Complio.* **Booster** (*if applicable*) Date 1: _____ Date 2: _____ Date 3: _____		**Hepatitis B Surface Antibody titer** Result Date: _____ **Immunity Status:** ☐ **Positive**, demonstrates immunity ☐ **Negative**, does not demonstrate immunity **<u>Repeat Titer</u>** (*<u>if applicable</u>*)**<u>:</u>** Result Date: _____ **Immunity Status:** ☐ **Positive**, demonstrates immunity ☐ **Negative**, does not demonstrate immunity *You'll only enter the most current titer into Complio.*

Requirement	Immunization	OR	Titer(s)
Measles, Mumps, Rubella (MMR) ☐ Does not meet requirement or declines and will complete the declination form *Appropriate declination form: "HBV, MMR, VZV, and Tdap Vaccine Declination Form"*	**Initial Series** 2-dose series Date 1: _____ Date 2: _____ *Any doses received after a non-immune titer should be entered as boosters in Complio.* **Booster** (*if applicable*) Date 1: _____ Date 2: _____		**Measles IgG Antibody titer** Result Date: _____ **Immunity Status:** ☐ **Positive**, demonstrates immunity ☐ **Negative**, does not demonstrate immunity **Repeat Titer** (*if applicable*)**:** Result Date: _____ **Immunity Status:** ☐ **Positive**, demonstrates immunity ☐ **Negative**, does not demonstrate immunity *You'll only enter the most current titer into Complio.*
			Mumps IgG Antibody titer Result Date: _____ **Immunity Status:** ☐ **Positive**, demonstrates immunity ☐ **Negative**, does not demonstrate immunity **Repeat Titer** (*if applicable*)**:** Result Date: _____ ☐ **Positive**, demonstrates immunity ☐ **Negative**, does not demonstrate immunity *You'll only enter the most current titer into Complio.* *Rubella Titer on next page (Page 3)*

Requirement	Immunization	Titer(s)
Measles, Mumps, Rubella (MMR) **CONTINUED**		**Rubella IgG Antibody titer** Result Date: _____ **Immunity Status:** ☐ **Positive**, demonstrates immunity ☐ **Negative**, does not demonstrate immunity **Repeat Titer** (*if applicable*)**:** Result Date: _____ **Immunity Status:** ☐ **Positive**, demonstrates immunity ☐ **Negative**, does not demonstrate immunity *You'll only enter the most current titer into Complio.*
Varicella (VZV) ☐ Does not meet requirement or declines and will complete the declination form *"HBV, MMR, VZV, and Tdap Vaccine Declination Form"*	**Initial Series** 2-dose series Date 1: _____ Date 2: _____ *Any doses received after a non-immune titer should be entered as boosters in Complio.* **Booster** (*if applicable*) Date 1: _____ Date 2: _____	**Varicella IgG Antibody titer** Result Date: _____ **Immunity Status:** ☐ **Positive**, demonstrates immunity ☐ **Negative**, does not demonstrate immunity **Repeat Titer** (*if applicable*)**:** Result Date: _____ **Immunity Status:** ☐ **Positive**, demonstrates immunity ☐ **Negative**, does not demonstrate immunity *You'll only enter the most current titer into Complio.*

Immunization History

Requirement	Immunization
Tetanus/Diphtheria/ Pertussis (Tdap) ☐ Does not meet requirement or declines and will complete the declination form *"HBV, MMR, VZV, and Tdap Vaccine Declination Form"*	**Select one:** ☐ Tdap *within the last 10 years* **or** ☐ Lifetime Tdap + 1 dose of TD Booster within the last 10 years Tdap Date: _____ TD Booster* Date (if applicable): _____ *If the booster was Tdap, put the date in Tdap, not TD Booster
Annual Influenza ☐ Does not meet requirement or declines and will complete the declination form *Appropriate declination form: "Annual Influenza Declination"*	Administered between 8/1-3/31 yearly Date: _____ **Expires on 7/31 yearly**

Requirement	Immunization
COVID-19 Vaccine ☐ Does not meet requirement or declines and will complete the declination form *It is strongly recommended that students remain up-to-date with their COVID-19 vaccination to protect themselves and our patients since not having the vaccine may put themselves or persons around them at risk, resulting in fatal consequences such as illness, disability, or death when exposed.* *Appropriate declination form: "COVID-19 Vaccine Declination"*	**Dose 1** **Select One:** ☐ Pfizer-BioNTech ☐ Moderna ☐ Novavax ☐ Johnson and Johnson/Janssen **Date 1** **Dose 2** **Select One:** ☐ Pfizer-BioNTech ☐ Moderna ☐ Novavax ☐ Johnson and Johnson/Janssen **Date 2**

Licensed Medical Provider Information Box on Next Page (Page 5)

Licensed Medical Provider Information

Date Completed: _____

Printed Name, Title: _____ **License #:** _____

Address: _____ **Phone Number:** _____

_____ **Fax Number:** _____

Signature: _____

All fields in this section must be completed

Clinic Stamp Here:

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Tuberculosis (TB) Testing Verification Form

Negative Result

This form must be completed by a licensed medical provider (MD, DO, NP, PA, RN, PharmD or LVN only) and must include a clinic stamp.

This form should only be completed if the student/instructor does not have any history of positive TB and the current screening results are negative. If the student/instructor has a history of positive TB or their current result is positive complete the "Student Tuberculosis (TB) Testing Verification Form - History of Positive TB" instead of this form.

A TB test must be completed **within 90 days of the rotation start date** for clearance. **TB tests expire annually** and must be updated before the expiration date in Complio to avoid suspension from our facilities during the student experience.

Student/Instructor Information

Rotation Start Date: _____

Legal First and Last Name: _____ **DOB:** _____

Only one of the following options is required for facility clearance

Option	Test	Result
Tuberculin Skin Test for TB Infection *Upload to 2-Step PPD Step 1 and 2-Step PPD Step 2 in Complio*	**Mantoux tuberculin skin test (TST)** AKA tuberculin purified protein derivative (PPD) 2nd Step PPD must be placed 7 or more days after the placement date for the 1st Step PPD, but no more than 365 days after the placement date for the 1st Step PPD placement AND 2nd Step PPD read date must be within **within 90 days of the listed "Rotation Start Date"**	**PPD Step 1** Placement Date: _____ Read Date: _____ Induration (Numeric Value): _____ Result Interpretation (select if true): ☐ Negative **PPD Step 2** Placement Date: _____ Read Date: _____ Induration (Numeric Value): _____ Result Interpretation (select if true): ☐ Negative *If either is positive, complete the "Tuberculosis (TB) Testing Verification Form - History of Positive TB" instead of this form.*

Option	Test	Result
Blood Test for TB Infection *Upload to Initial QuantiFERON/ T-Spot in Complio* *Enter the "Date of Result" for the date in Complio*	**Interferon-Gamma Release Assays(IGRAs)** Either a QuantiFERON®-TB Gold In-Tube test (QFT-GIT) or T-SPOT® TB test (T-Spot) completed **within 90 days of the listed "Rotation Start Date"**	**Select one:** ☐ QFT-GIT ☐ T-Spot Date of Specimen Collection: _____ **Date of Result: _____** Result Interpretation (select if true): ☐ Negative *If positive, complete the "Tuberculosis (TB) Testing Verification Form - History of Positive TB" instead of this form.*
Initial Blood Test + PPD *Upload to Initial QuantiFERON/T-Spot + Current PPD 1-Step in Complio* *For the QuantiFERON/ T-Spot, enter the "Date of Result" in Complio*	A QuantiFERON®-TB Gold In-Tube test (QFT-GIT) or T-SPOT® TB test (T-Spot) completed within the last year AND Mantoux tuberculin skin test (TST) completed **within 90 days of the listed "Rotation Start Date"** AKA tuberculin purified protein derivative (PPD)	**QFT/T-Spot Result** **Select one:** ☐ QFT-GIT ☐ T-Spot Date of Specimen Collection: _____ **Date of Result: _____** Result Interpretation (select if true): ☐ Negative **AND** **PPD Result** Placement Date: _____ Read Date: _____ Induration (Numeric Value): _____ Result Interpretation (select if true): ☐ Negative *If either is positive, complete the "Tuberculosis (TB) Testing Verification Form - History of Positive TB" instead of this form.*

See next page to complete the Licensed Medical Provider Information box

Licensed Medical Provider Information

Date Completed: _____

Printed Name, Title: _____ **License #:** _____

Address: _____ **Phone Number:** _____

_____ **Fax Number:** _____

Signature: _____

All fields in this section must be completed

Clinic Stamp Here:

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Tuberculosis (TB) Testing Verification Form

History of Positive TB

This form should only be completed if the student/instructor has a **history of positive TB** (i.e., tested positive on a previous TB screening test). The student/instructor must have completed a chest x-ray within the last year that shows no signs of active TB and demonstrate no signs or symptoms of active TB within the last year to be eligible for clearance.

A licensed medical provider (**MD, DO, NP, or PA only**) must review the student/instructor's answers to the Tuberculosis Symptom Questionnaire and complete the History of Positive TB and Licensed Medical Provider Information sections of the form.

Upload this completed form to the item "Chest X-Ray and Initial Symptom Screening" in Complio and put the Chest X-ray "Read Date" in the date field.

Student/Instructor Information

Legal First and Last Name: _____ **DOB:** _____

Student/Instructor Tuberculosis Symptom Questionnaire

This section must be completed by the student/instructor and be reviewed by a licensed medical provider.

In the past year, have you experienced any of the following symptoms NOT associated with a specific illness (i.e. cold or flu) and lasting more than 3 weeks?

Symptom	NO	YES	Comments
Cough	☐	☐	
Blood streaked sputum	☐	☐	
Unexplained weight loss	☐	☐	
Night sweats (*excluding menopause*)	☐	☐	
Fever	☐	☐	

Student/Instructor Signature _____ **Today's Date** _____

A licensed medical provider (MD, DO, NP, or PA only) must complete the next page of this document.

History of Positive TB

This section must be completed by a licensed medical provider (**MD, DO, NP, or PA only**).

PPD Conversion

Date: _____

Induration (Numeric Value): _____

Interpretation: _Positive_

OR

QFT/T-spot Conversion

Date: _____

Interpretation: _Positive_

Chest X-Ray

Date Completed: _____

Date Read: _____

Result: __Negative, no signs of active TB__

For the Chest X-Ray, enter the "Read Date" for the date in Complio

Licensed Medical Provider Attestation

By signing my signature below in the Licensed Medical Provider Information box, I am certifying that the student does not demonstrate any signs or symptoms of active TB within the last year.

Licensed Medical Provider Information

Date Completed: _____

Printed Name, Title: _____ **License #:** _____

Address: _____ **Phone Number:** _____

_____ **Fax Number:** _____

Signature: _____

All fields in this section must be completed

Clinic Stamp Here:

HBV, MMR, VZV, and Tdap Vaccine Declination Form

Student/Instructor Information

Legal First and Last Name: _____ **DOB:** _____

During your student experience you may be exposed to transmissible diseases. You may be at risk of acquiring infection with Hepatitis B, Measles, Mumps, Rubella (MMR), Varicella (Chicken Pox Vaccine), Tdap (Tetanus, Diphtheria & Pertussis), influenza, and other known/not yet known transmissible diseases.

For your safety, it is strongly recommended that you complete all recommended vaccinations prior to your student experience.

If you choose not to obtain vaccination for the following transmissible diseases and still participate in your student experience, you are knowingly assuming the risk of exposure to these diseases.

Declination of Recommended Vaccinations

Initial next to the vaccine you are declining and sign and date the declination below.

Student Initials	Declination
	I have declined the Hepatitis B (HBV) vaccine.
	I have declined the Measles, Mumps, Rubella (MMR) vaccine.
	I have declined the Varicella (VZV) vaccine.
	I have declined Tetanus, Diphtheria, & Pertussis (Tdap) vaccine.

I understand that there are inherent risks in a healthcare setting and that Palomar Health cannot eliminate these risks regardless of the care taken to avoid them. I have been given the opportunity to obtain the recommended vaccinations prior to starting the student experience. I understand that by declining the recommended vaccines, I am at risk of acquiring disease from the pathogens above. By choosing to participate in this experience, I voluntarily take responsibility for this risk. I understand that as a student/instructor, I am not eligible for workers compensation and agree to hold Palomar Health and its affiliates harmless.

_____ _____

Student/Instructor Signature **Today's Date**

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Seasonal Influenza Vaccination
STUDENT/INSTRUCTOR DECLINATION

Name (print): _____

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease; on average, 36,000 Americans die every year from influenza-related causes.
- Influenza virus may be shed for up to 24 hours before symptoms begin, increasing the risk of transmission to others.
- Some people with influenza have no symptoms, increasing the risk of transmission to others.
- Influenza virus changes often, making annual vaccination necessary. Immunity following vaccination is strongest for 2 to 6 months. In California, influenza usually begins circulating in early January and continues through February or March.
- I understand that the influenza vaccine cannot transmit influenza and it does not prevent all disease.
- I have declined to receive the influenza vaccine for the current flu season. I acknowledge that influenza vaccination is recommended by the Centers for Disease Control and Prevention for healthcare personnel in order to prevent infection from and transmission of influenza and its complications including death, to patients, coworkers, my family, and my community.

My signature below acknowledges I am aware of the information contained on this form and that I choose to decline vaccination at this time. I understand if I decline influenza vaccination I will be required to wear a surgical type mask while in any Palomar Health entity patient care area and areas designated by Palomar Health administration. I also understand I may change my mind and accept vaccination later, if vaccine is available. I have read and fully understand the information on this declination form.

I am declining influenza vaccine because (please check one):

1. ☐ I believe I will get influenza if I get the vaccine
2. ☐ I do not like needles
3. ☐ My religious beliefs prohibit vaccination
4. ☐ I request medical exception (have severe allergy to eggs or vaccine components or have had Guillian-Barre Within six (6) weeks of receiving an influenza vaccine)

Signature: _____ **Date:** _____

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SARS-CoV-2 (COVID-19) Vaccination
DECLINATION

Name (print): _____ **DOB:** _____ **Employee ID:** STUDENT/ INSTRUCTOR

I acknowledge that I am aware of the following:

- I have received a recommendation for COVID-19 vaccination to protect patients, co-workers, myself, and my family.
- I understand that COVID-19 has caused a pandemic that involves risk to the health and life of individuals.
- I understand that in the absence of vaccination, I may acquire COVID-19 that may put my patients, colleagues, family, friends, or persons around me at risk resulting in fatal consequences such as illness, disability, or death when exposed.
- In light of these matters, I have received information or educational materials with regard to the vaccine against COVID-19. I have had the opportunity to ask questions and the answers were explained to me to my satisfaction. I understand that COVID-19 is a serious respiratory disease that has caused death globally. In case I have been exposed to an individual with COVID-19, I may be infected with it as well and spread the virus to the people around me.
- However, it is my decision to decline the vaccination at this time, regardless of the information that I have received about its importance and the risk of not receiving it. I understand the consequences of my decision, including the continuity of risk of endangering my health and of others from being infected due to COVID-19. I understand that I may return anytime for receiving a vaccination, should I decide to receive it in the future as to its availability.

By signing below, I am aware of the information contained on this form and I decline vaccination at this time.

I am declining COVID-19 vaccine:

Signature: _____ **Date:** _____