ROSS UNIVERSITY
SCHOOL OF MEDICINE

Ross University School of Medicine
2300 SW 145th Ave., Suite 200
Miramar, FL 33027
Phone: (754) 208-4589

Ross University Requirements for Entry to IMF/Clinical Rotations

Please review the following items for your entry into IMF/clinical rotations. All Health Documents must be in English. Health Documents (health assessment, Chest X-ray, PPD, Vaccines and Labs) must be done in the United States, or Canada. Please upload all of the documents below to **www.rusmhealthdocs.com**, once you have setup your account. *Physical copies that are mailed or dropped off will **not** be accepted. Documents that are faxed or emailed will **not** be accepted.* ***Please note: You must use your RUSM email as your primary email address when setting up your account.****

☐ RUSM Health Assessment Form (**Done within the last 6 months)** – Form must be completed in its entirety or it will be rejected. This includes the provider's license number and the facility address. **(Valid 1 year from exam date)**

☐ PPD – Negative (**Done within the last 6 months**) - If positive, a negative chest x-ray report from the radiologist's office must be provided. Report MUST be from the Radiologist that read and interpreted the x-ray. Documentation from your primary care provider alone will NOT be sufficient. Note: Quantiferon is NOT accepted. **(Valid 1 year from read date)**

☐ Positive Quantitative Titers - ***We need positive quantitative IGG Antibody results, followed by a reference range indicating the level of immunity. Students having their labs done in Canada must provide the lab report showing both quantitative and qualitative results, if the reference ranges are not available.*** – The collection date MUST be clearly stated on the report. If results are negative, you must get a booster vaccine and retest for immunity 4 weeks after vaccination. Submit negative titer report and vaccine document. **(Valid 5 years from collection date)**

- MMR IgG Quantitative (Measles, Mumps, Rubella)
- Varicella IgG Quantitative
- Hepatitis B Surface Antibody

☐ Tdap (Tetanus, Diphtheria, Pertussis) Vaccine (Completed less than 10 years prior) –"Td" alone is not sufficient **(Valid 10 years from administration date)**

☐ Seasonal Flu Vaccine – Lot Number MUST be included on the form. Exempt **ONLY** between June-August, which is the timeframe between flu seasons. **(Valid per flu season)**

☐ 10-Panel Drug Screen - MUST include all of the following drugs, which needs to be clearly listed on the report with the results. For any drug that is positive, you must also submit a copy of your prescription. **(Valid 1 year from collection/service date)**

- o Amphetamines
- o Methamphetamines
- o Barbiturates
- o Benzodiazepines
- o Marijuana
- o Cocaine
- o Opiates
- o Phencyclidine
- o Methadone
- o Propoxyphene

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Uploaded copy of the following:

☐ CV/Resume – (**DO NOT** send an edited copy that still shows the suggested edits. Ensure corrections are made prior to submission.)

☐ **COLOR** Government Issued ID- Such as U.S Driver's License or valid Passport; Non-US residents must provide a colored copy of their passport. – Must be in color. **(Valid per the document expiration date)**

☐ **COLOR** passport-size photo (2"x2") – JPG files, size no larger than 200x200px ---will be rejected if it is too large. Must be in color.

- Use a plain white or off-white solid background
- Submit a high resolution photo that is not blurry, grainy, or pixelated
- Use a clear image of your face (no stripes/lines over your face)

Note: Please be advise that the picture you upload to Complio will be used as your Cleveland Clinic Florida ID.

☐ Valid Health Insurance Card- U.S.A Health Plans Only - Travelers Insurance is not accepted. If you are a dependent on the plan and your name is **NOT** on the card, a proof of coverage letter from the insurance company on their letterhead stating you are a covered dependent **MUST** accompany the card. If you have Aetna through RUSM, submit the most recent-current year's card (can be downloaded from the Aetna website). **(Valid for 1 calendar year)**

iBook Certifications: - Completed prior to IMF.

☐ Infection Control Certificate (NYSED approved) **(Valid for 4 years from completion date)**

☐ OSHA/TB Protection/ BBP/ PPE Certificates **(Valid for 4 years from completion date)**

☐ HIPAA Certificate **(Valid for 2 years from completion date)**

Additional Certifications:

☐ ACLS, BLS & PALS Certificate – Completed during IMF. **(Valid for 2 years from completion date)**

Criminal Background Checks – Must be competed according to your citizenship/permanent resident status (US, Canadian, International)

☐ Level I Background Check - MUST be ordered through Complio

☐ Level II Background Check (VECHS Onsite) - MUST be ordered through Complio and the confirmation page presented to the vendor in order to complete your fingerprints.

Note: According to hospital and state regulations, all physical examinations and medical records are required to be less than one year old prior to the start of the first day of each rotation. Additionally, annual procedures (physical & PPDs, for example) cannot expire DURING a rotation.

This process is required for hospitals to receive proper documentation prior to the start of each rotation. Incomplete forms and/or missing documents will hold the student back from medical clearance.

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Health Assessment Form

All hospitals require a recorded medical history, physical examination, and proof of vaccination for Measles, Rubella, Hepatitis B, Tdap, and TB screening for all medical staff. Most medical centers also require documentation of titers for Measles, Mumps, Rubella, and Varicella (not more than 5 years old). **The Ross University Health Assessment Form must be completed by a licensed healthcare provider and must be received by the Florida office before any rotation schedule is assigned.** Physical examinations and TB screenings will not be accepted if the results are more than 1 year old. **(All fields are required to be completed)**

Part I: COMPLETED BY STUDENT

Name: _____

Date of Birth: _____/_____/_____

Student ID Number: @_____

Medical History: _____

Past History: _____

Recent Illnesses (If so, details): _____

Allergies: _____

_____

Current Medications (If yes, details): _____

_____

Part II: COMPLETED BY PHYSICIAN

BP: _____ Pulse: _____ Temp: _____ Weight: _____

HEENT: _____

Lungs: _____

Heart: _____

Abdomen: _____

Extremities: _____

Neuro: _____

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Other: _____

Current Medical Conditions under Treatment (e.g. diabetes mellitus, epilepsy, medic alert bracelet): _____

Antibody Titers (IgG results only):

Tests — Write "Immune" if positive titers (**attach lab report**) **OR** "Negative" if titers are Low / Equivocal **AND** indicate date(s) of booster vaccination(s).

Measles (Rubeola) _____ Vaccine Date: ____/_____/____ Provider's Signature: _____
Rubella _____ Vaccine Date: ____/_____/____ Provider's Signature: _____
Mumps _____ Vaccine Date: ____/_____/____ Provider's Signature: _____
Varicella _____ Vaccine Date: ____/_____/____ Provider's Signature: _____
Hepatitis B Antibody: _____ (1) _____ (2) _____ (3) _____ Provider's Signature: _____
PPD: Placed: __ /__ /____ Read: __ /___/____ Result: _____ Provider's Signature: _____

**If negative and patient has traveled to an endemic country within the last 30 days, the test must be repeated within 1 month of exam date.*

If PPD is positive, Chest X-Ray results (attach copy of **radiology** report):_____

******Please Note: Quantiferon and T-Spot will NOT be accepted******

BCG: _____

Tdap Vaccine (Tetanus-Diphtheria-Pertussis) within 10 years **(*Td NOT accepted*)**: ___/__/___ Signature: _____

Influenza Vaccine Date (attach documentation of vaccine with Lot#): ___/___/___ Signature: _____

Physician's Statement: (All fields are required to be completed)

I have determine that the above named person is free from any health impairment, which is of potential risk to patients or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, narcotics, alcohol, or other drugs or substances which may alter the individual's behavior.

Physician's Name: _____

Address of Facility: _____

Physician's Signature: _____

Physician's License Number: _____

Date of Exam: _____/_____/_____

By signing this statement, I authorize Ross University to release this medical documentation to all medical teaching institutions on my behalf. **(All fields are required to be completed)**

Student's Name: _____

Student's Signature: _____

Date: _____/_____/_____