Must attach documentation (copies of lab reports, immunization records, CPR card, etc.) as indicated for each of the following to be in compliance with Maricopa Community College requirements. Fingerprint clearance card, CPR certification and TB skin test must be current through the semester of enrollment or duration of practicum experiences. See “Explanation of Requirements” in the Allied Health Shared Student Policies handbook for specific detail.

A. MMR (Measles/Rubeola, Mumps and Rubella): Requires documented proof of a positive IgG MMR titer or documented proof of One MMR series.
   1. MMR vaccination: Dates: #1__________  #2__________
   OR
   2. Date & titer results:
      Measles: __________  _____________
      Mumps: __________  _____________
      Rubella: __________  _____________

B. Varicella (Chickenpox): Requires documented proof of positive IgG titer or documented proof of Varicella series.
   1. Varicella vaccination dates: #1__________  #2__________
   OR
   2. Date & results of varicella IgG titer: Date: ___________  Result: ______________

C. Tetanus/Diphtheria/Pertussis (Tdap): You must provide proof of a one-time Tdap vaccination and Td booster if 10 years or more since Tdap vaccination
   1. Tdap vaccine: Date: __________
   OR
   2. Td booster: Date: __________

D. Tuberculosis: Documentation is required for all tests. For individuals who have not received a TB test within the past year, will need to receive a 2-Step TB test. This consists of two separate TB test; an initial TB skin test and a second TB skin test 1-3 weeks apart. After completion of the 2-step, an annual update of TB skin test is sufficient. If you have a positive skin test, provide documentation of a QuantiFERON test or negative chest X-ray and annual documentation of a TB disease-free status. Most recent skin testing or blood test must have been completed within the previous six (6) months.

1. Negative 2-step TB Skin Test (TBST), including date of administration, date read, result, and name and signature of healthcare provider.
   Initial Test (#1)  Date: _________  Date Read: _________  Results: Negative or Positive
   Boosted Test (#2) Date: _________  Date Read: _________  Results: Negative or Positive
2. Annual 1-step TBST (accepted only from continuing students who have submitted initial 2-step TBST)
   Date: __________ Date Read: __________ Results: Negative or Positive
   OR
3. Negative blood test (Either QuantiFERON or TSpot)
   QuantiFERON Date: __________
   T-Spot Date: __________
   OR
4. Negative chest X-ray
   OR
5. Documentation of a negative chest X-ray (x-ray report) or negative QuantiFERON result and completed Tuberculosis Screening Questionnaire (available in CastleBranch).
   Date: __________

   **E. Hepatitis B:** Documented evidence of completed series or positive antibody titer or signed declination form. If you have not received any injections, do not get a titer. The second injection of the series is 1 to 2 months after the first dose and the third injection is 4 to 6 months after the first dose.

   Date Titer received: ________________ Results: _______________________

   Date of 1st injection: __________ Date of 2nd injection: __________ Date of 3rd injection: __________
   OR
   HBV Vaccination Declination Attached

   **F. Influenza:** Documented evidence of influenza vaccination for the current flu season or declination.

   Date of Injection: ________________ OR Signed Declination Form Attached

   **G. For Dental programs- Documented evidence of completed Ophthalmic Exam**
   Date of Exam: __________________________

   **H. For Dental programs- Documented evidence of completed Dental Exam (Excluding Mesa Community College)**
   Date of Exam: __________________________

   **I. For Dental programs-Documented evidence of completed Physical Exam**
   Date of Exam: __________________________

   **J. CPR Card (Healthcare Provider level):** An official certification is required (In-Person or Hybrid training courses are only accepted)

   Date card issued: ________________ Expiration Date: ________________

   **K. Level One Fingerprint Clearance Card:** Date card issued: __________ Expiration Date: __________

   **L. CastleBranch Clearance Document:** Passed Date: ________________
M. Clearance for Participation in Clinical Practice

It is essential that allied health students be able to perform a number of physical activities in the clinical portion of their programs. At a minimum, students will be required to lift patients and/or equipment, stand for several hours at a time and perform bending activities. Students who have a chronic illness or condition must be maintained on current treatment and be able to implement their assigned responsibilities. The clinical allied health experience also places students under considerable mental and emotional stress as they undertake responsibilities and duties impacting patients’ lives. Students must be able to demonstrate rational and appropriate behavior under stressful conditions.

I believe the applicant __________ WILL OR __________ WILL NOT be able to function as an allied Health student as described above.

If not, explained:
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Health Care Provider Form: Reviewed and signed by a licensed health care provider (M.D., D.O., nurse practitioner, or physician’s assistant) within the past six (6) months.


Print Name: ________________________________________ Title: ________________________________

Signature: __________________________________________ Date: ________________________________

Address:

_____________________________________________________________________________________

City: ________________________ State: ______________ Zip Code: ___________________________