

HEALTH AND SAFETY REQUIREMENTS

A. COVID-19 Vaccine

As is outlined in Arizona Revised Statutes 15-1650.05, students participating in clinical settings at a healthcare institution licensed under A.R.S. Title 36 which includes hospitals, nursing care institutions, residential care institutions, intermediate care facilities for individuals with intellectual disabilities (ICF-IID), group homes, or other medical facilities may be required to provide proof of COVID-19 vaccination and subject to regular health screening and testing as determined by the healthcare institutions. (See Arizona Revised Statutes 15-1650.05). Maricopa County Community College District will require all Allied Health and Nursing students to show proof of vaccination in order to ensure compliance with our clinical partner's health and safety requirements.

MCCCD cannot provide accommodation in the clinical setting and cannot force our clinical partners to provide accommodations to students. MCCCD will work with students in an effort to provide clinical experiences necessary for the completion of the program. When necessary, students are required to obtain accommodations from the clinical site by completing the clinical site's religious or medical disability accommodation process if the clinical site has identified a process. If you are unsure if the facility where you have been placed provides accommodations, please visit myClinicalExchange (mCE) to confirm and obtain directions for requesting accommodations from the site.

To meet this requirement:

Upload a copy of proof of COVID-19 vaccine proving vaccination.

1. Provide proof of two-dose vaccination of Pfizer-BioNTech or Moderna vaccine.

OR

2. Provide proof of one dose vaccination of Johnson & Johnson's Janssen vaccine.

OR

3. Upload a copy of your signed COVID-19 declination. Please note that a completed declination form does not guarantee clinical placement. Further, the declination notice does not guarantee an accommodation will be granted by a clinical partner or that you will be placed at a clinical site that does not require the COVID-19 vaccine, which may impact continuation in your clinical course.

Please Note: All documentation is required to have the student's full name, Date of Administration, Manufacturer, and Healthcare Professional or Clinical Site. Annual vaccination and/or renewal are not determined at this time.

B. MMR (Measles/Rubella, Mumps, & Rubella)

MMR is a combined vaccine that protects against three separate illnesses – measles, mumps and rubella (German measles) – in a single injection. Measles, mumps, and rubella are highly infectious diseases that

can have serious, and potentially fatal, complications. The full series of MMR vaccination requires two doses.

If you had all three illnesses OR you have received the vaccinations but have no documented proof, you can have an IgG MMR titer drawn, which provides evidence of immunity to each disease. If the titer results are POSITIVE, showing immunity to each disease, upload a copy of the lab results.

Options to meet this requirement:

1. Submit documentation of two MMR vaccinations on separate dates at least 4 weeks apart.
OR
2. Lab documentation of POSITIVE titer results for each disease (measles, mumps and rubella).
3. NEGATIVE or EQUIVOCAL titer results for measles, mumps or rubella shows lack of immunity, meaning you must submit documentation of one MMR booster (vaccination) dated after negative or equivocal titer.

Please Note: If the student has prior immunizations it is required for students to provide written documentation of all doses. If results are negative and documentation is not available it is required to start a new series.

Please Note: All documentation is required to have student full name.

C. Varicella (Chickenpox)

Chickenpox is a highly contagious disease caused by the varicella-zoster virus (VZV). Infection with chickenpox also makes people susceptible to develop herpes zoster (shingles) later in life. The best means of preventing chickenpox is to get the varicella vaccine.

Varicella vaccination is required for all healthcare workers who do not meet evidence of immunity by having met any of the following criteria: a). Documentation of receiving 2 doses of varicella vaccine, separated by at least 4 weeks or b). Laboratory evidence of immunity or laboratory confirmation of disease. If you haven't had the varicella vaccine or if you don't have a blood test that shows you are immune to varicella (i.e., no serologic evidence of immunity or prior vaccination) get 2 doses of varicella vaccine, 4 weeks apart.

Options to meet this requirement:

1. Documentation of two varicella vaccines, including dates of administration.
OR
2. Upload a copy of proof of a POSITIVE IgG titer for varicella. If the titer is NEGATIVE or EQUIVOCAL. Upload documentation of one varicella (vaccination) booster dated after negative or equivocal titer.

Please Note: If the student has prior immunizations it is required for students to provide written documentation of all doses. If results are negative and documentation is not available it is required to start a new series.

Please Note: All documentation is required to have student full name.

D. Tetanus/Diphtheria/Pertussis (Tdap):

Tetanus, diphtheria, and pertussis are serious bacterial illnesses which can lead to illness and death.

Tdap vaccination can protect against these diseases and is recommended for healthcare personnel with direct patient contact who have not previously received Tdap. Tdap vaccination can protect healthcare personnel against pertussis and help prevent them from spreading it to their patients.

The Td vaccine protects against tetanus and diphtheria, but not pertussis. Following administration of Tdap, a Td booster should be given if 10 years or more since the Tdap. Tdap may be given as one of these boosters if you have never gotten Tdap before. Tdap can be administered regardless of interval since the previous Td dose.

To meet this requirement:

Provide documentation of a Tdap vaccination administered after the age of 11 and then a Td vaccination every 10 years thereafter.

E. Tuberculosis (TB)

Tuberculosis (TB) is caused by a bacterium called *Mycobacterium tuberculosis* which usually infects the lungs, but can attack any part of the body such as the kidney, spine, and brain. Not everyone infected with TB bacteria develops tuberculosis. As a result, two TB-related conditions exist: latent TB infection (LTBI) and TB disease. If not treated properly, TB disease can be fatal.

All students entering a MCCCDC Healthcare program are required to upload documentation showing negative TB disease status. Documentation may include a negative 2-step Tuberculosis Skin Test (TBST) or negative blood test (QuantiFERON or T-Spot) performed within the previous six (6) months. The TBST or negative blood test must remain current throughout the semester of enrollment.

To maintain compliance with annual TB testing requirements, students who initially submitted a 2-step TBST may submit a current 1-step TBST for subsequent annual testing. A TBST is considered current if no more than 365 days have elapsed since the date of administration of the second of the 2-step TBST. Most recent skin testing or blood test must have been completed within the previous six (6) months.

If you have ever had a positive TBST, you must provide documentation of a negative blood test or negative chest X-ray from within the last 12 months. You will also need to complete a TB Symptom Screening Questionnaire annually.

To meet this requirement:

1. Proof of a negative 2-step TBST completed within the previous 6 months, including date given, date read, result, and name and signature of the healthcare provider.

Follow the steps below:



Step 1

1. Administer first TST following proper protocol
2. Review result
 - *Positive - consider TB infected, no second TST needed; evaluate for TB disease (x-ray)
 - * Negative - a second TST is needed. Retest in 1 to 3 weeks after first TST result is read.
3. Document result

Step 2

1. Administer second TST 1 to 3 weeks after first test is read
2. Review results
 - * Positive - consider TB infected and evaluate for TB disease (x-ray).
 - *Negative - consider person not infected.
3. Document result

OR

2. Submit documentation of a negative blood test (QuantiFERON or T-Spot) performed within the last six months.

OR

3. Submit documentation of a negative chest X-ray if TBST or Blood Testing is positive.
4. **POSITIVE RESULTS:** If you have a positive TBST, provide documentation of negative chest X-ray performed within the last twelve months or negative blood test and a completed MCCCC Tuberculosis Screening Questionnaire. The questionnaire can be found in the American DataBank Medical Document Tracker. This questionnaire must be completed annually.

Please Note: If the student has prior immunizations it is required for students to provide written documentation of all doses. If results are negative and documentation is not available it is required to start a new series.

Please Note: All documentation is required to have student full name.

F. Hepatitis B

MCCCCD students may be exposed to potentially infectious materials which can increase their risk of acquiring hepatitis B virus infection, a serious disease that can cause acute or chronic liver disease which can lead to a serious, lifelong illness. MCCCCD recommends that all students receive the hepatitis B 3-vaccine series administered over a 6 month period. Obtain the first vaccination; the second is given 1 - 2 months after the first dose and the third injection is 4 - 6 months after the first dose. Students may also obtain the Heplisav-B 2 dose series administered at least four weeks apart.

Effective immunization status can be proven by a titer confirming the presence of anti-Hbs or HepBSab antibodies in the blood. This titer is recommended but not mandatory.

Students may choose to decline the hepatitis B vaccine; however, lack of immunity to hepatitis B means that students remain at risk of acquiring the disease.

Options to meet this requirement:

1. Submit a copy of laboratory documentation of a positive HbsAb titer. Students will be required to receive a booster or recommendation from your healthcare provider that may indicate a booster, series (3 doses of the Hepatitis B vaccine, or 2 doses of the Heplisav-B vaccine), or declination form. 3 Post-Titer Hepatitis B Boosters or 2 Post-Titer Heplisav Boosters dated AFTER your titer.

OR

2. Upload a copy of your immunization record, showing completion of the three Hepatitis B injections or two Heplisav- B injections. If the series is in progress, upload a copy of the immunizations received to date. You must remain on schedule for the remaining immunizations and provide the additional documentation. One to two months after your last immunization, it is recommended that you have an HbsAb titer drawn.

OR

3. Upload a copy of your signed Hepatitis B declination noting that by declining the vaccine you continue to be at risk of acquiring hepatitis B, a serious disease. MCCCD declination form is available in American DataBank.

Please Note: If the student has prior immunizations it is required for students to provide written documentation of all doses. If results are negative and documentation is not available it is required to start a new series.

Please Note: All documentation is required to have student full name.

G. Influenza (Flu Vaccine)

Influenza is a serious contagious respiratory disease which can result in mild to severe illness. Susceptible individuals are at high risk for serious flu complications which may lead to hospitalization or death.

The single best way to protect against the flu is annual vaccination. A flu vaccine is needed every season because: 1). the body's immune response from vaccination declines over time, so an annual vaccine is needed for optimal protection; 2). because flu viruses are constantly changing, the formulation of the flu vaccine is reviewed each year and sometimes updated to keep up with changing flu viruses. The seasonal flu vaccine protects against the influenza viruses that research indicates will be most common during the upcoming season.

Students are required to be vaccinated every flu season and to upload documentation proving annual vaccinations.

To meet this requirement:

Upload a copy of proof of flu vaccine proving annual vaccination.

Please Note: All documentation is required to have student full name.

Please Note: Documentation must contain the following information (Student Name, Facility/Site Name, Date of Administration, and Renewal Date).

H. CPR (Basic Life Support) Certification

CPR is a procedure performed on persons in cardiac arrest in an effort to maintain blood circulation and to preserve brain function. MCCCCD students are required to learn CPR by completing an acceptable Basic Life Support course. CPR certification must include infant, child, and adult, 1-and 2-man rescuer, and evidence of a hands-on skills component.

CPR courses are offered at numerous locations throughout the greater Phoenix area. The American Heart Association provides in-person courses and an online course. Students who complete online courses must complete the hands-on skills training and testing. CPR training without the hands-on skills training and testing component will not be accepted. Students are required to maintain current CPR certification throughout enrollment in the program.

Please Note: If utilizing RQI, a third party vendor for the American Heart Association, it must include the AED component. If you are unsure please contact your program before enrolling into your CPR course.

To meet this requirement:

Upload a copy of the signed CPR card (front and back) or CPR certificate.

I. Level One Fingerprint Clearance Card

All students admitted to any MCCCCD healthcare program are required to obtain and maintain a valid Level One Arizona Department of Public Safety Fingerprint Clearance Card (FCC). The FCC must remain current throughout every semester of enrollment in the program.

If the FCC is suspended or revoked at any time during the program, the student must report this to the Program Director within five (5) school days and will be unable to continue in the program until the FCC is reinstated.

To meet this requirement:

Upload a copy (front and back) of a current Level One DPS Fingerprint Clearance Card. **Submit a copy of the front of your Fingerprint Clearance Card. The card will be accepted with or without restrictions. Name on front of card must match name on order. The renewal date will be set for expiration date on card. Notified 90 days prior to the date on the FCC card expiration date and a 60 day open date.**

J. Health Care Provider Signature Form

Must be completed and signed by a licensed healthcare provider (M.D., D.O., N.P., P.A.) within the past six (6) months of the start date.

To meet this requirement:

Upload a copy of the signed Health Care Provider Signature form completed within the past six (6) months of start date.

K. American DataBank Clearance Document

All students admitted to a MCCCDC healthcare program are required to show a "Pass" result on the MCCCDC-required supplemental background screening completed within the past six (6) months through American DataBank. Information regarding the background clearance is obtained from the MCCCDC healthcare program following your acceptance into the program.

Please note that results for the American DataBank self-check cannot be accessed by the program. If you have done a self-check, you will be required to do an additional background check through American DataBank using your program access code.

To meet this requirement:

Upload a copy of your American DataBank clearance completed within the previous six (6) months showing a "Pass" status.

IMPORTANT:

- MCCCDC requires all students to meet the placement requirements as set up by our program's most stringent clinical partner. We do this for ease of random placement.
- Healthcare students have a responsibility to protect themselves and their patients and families from preventable diseases. All students will purchase a supplemental background screen and Medical Document Tracker from American DataBank. Program requirements will be approved by American DataBank.
- Students are responsible for maintaining all health and safety requirements and to submit documentation by due date. Failure to maintain program health and safety requirements will result in inability to continue clinical experiences and may result in withdrawal from the program.
- All immunization records must include student name and the signature of healthcare provider.
- Health and safety requirements are subject to change depending on clinical agency requirements.

Name: _____ Student ID: _____ Date: _____

Cell Phone: _____ Home Phone _____ Email: _____

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. MCCCCD requires all students to meet the placement requirements as set up by our program's most stringent clinical partner. We do this for ease of random placement.

A. COVID-19 Vaccine: Documented evidence of COVID-19 vaccination or declination.

1. Date of 1st injection _____ Date of 2nd injection _____

OR

2. Date of single-dose injection _____

OR

3. Provide a signed declination form for medical or religious reasons.

B. MMR (Measles/Rubella, 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:

Booster: _____

Measles: _____

Mumps: _____

Rubella: _____

C. 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: _____,

Booster: _____

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) from within the last 5 years or negative QuantiFERON result and completed Tuberculosis Screening Questionnaire (available in (American DataBank).

Date: _____

E. Hepatitis B: Documented evidence of completed two or three dose 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. If you receive the two dose Heplisav-B series, they must be at least four weeks apart.

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. American DataBank 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. This declaration should not impede students with disabilities from applying or being accepted into the program.

I believe the applicant (print name) _____ Date: _____

_____ 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 of the start date.

Licensed Healthcare Examiner (M.D., D.O., N.P., P.A.):

Print Name: _____ Title: _____

Signature: _____ Date: _____

Address:

City: _____ State: _____ Zip Code: _____