

## PREREGISTRATION HEALTH REQUIREMENTS FOR CLINICAL STUDENTS

**Clinical Programs: Dental, Medical, Nursing, Occupational Therapy, Physical Therapy, Genetic Counseling**

Dear New Student,

Welcome to Columbia University Irving Medical Center (CUIMC). Here at Student Health Service (SHS), we look forward to working with you to achieve optimal health and academic success.

This packet lists the required information you must provide in order to register for classes in the clinical programs listed above. **Incomplete information will prevent registration for classes.** If you have any questions, do not hesitate to contact us at [shsregistration@cumc.columbia.edu](mailto:shsregistration@cumc.columbia.edu)

We look forward to welcoming you on campus, and to working with you during your time here.

Sincerely,  
CUIMC Student Health Service

## How to Submit Your Preregistration Requirements

### Deadline Dates:

- Summer 2020 Enrollment: **April 24, 2020**
- Fall 2020 Enrollment: **June 26, 2020**
- Spring 2021 Enrollment: **December 18, 2020**

**We *strongly recommend* you submit your preregistration requirements via our secure Web Portal.**

- Upload your immunization records or completed immunization form and required attachments via our secure Web Portal: [cuhs.studenthealthportal.com](https://cuhs.studenthealthportal.com).
- Once logged in, select "Document Upload."
- In the "Document Type" menu, select "Immunization Form" or "Preregistration Forms."
- Use the browse button to locate the PDF or TIFF files (JPEG files will not be accepted), and select "Save."

**If you are unable to submit preregistration documents via our Web Portal, please allow an additional three weeks for processing via the following methods:**

- **Email:** [shsregistration@cumc.columbia.edu](mailto:shsregistration@cumc.columbia.edu)
- **Fax Number:** 212-342-3955
- **Postal Mail is strongly discouraged. Be sure to keep original copies if mailed:**

U.S. Postal Address: CUIMC Student Health Service, 100 Haven Avenue, 2nd Floor, New York, NY 10032

FedEx Address: CUIMC Student Health Service, 100 Haven Avenue, 2nd Floor, New York, NY 10032

(accepted 8 a.m.-5 p.m.)

## CUIMC PREREGISTRATION CLINICAL REQUIREMENT CHECK LIST

Please read through the requirement check list and leave yourself enough time (*approximately **two months** prior to your deadline date, listed on front page*) to collect medical information and obtain immunizations and titers. It may take time for past providers to send records to you, or you may need immunizations that must be spaced at least a month apart. **Please submit the actual laboratory report for each titer.**

### STEP 1: ENTER YOUR HEALTH HISTORY AND MENINGOCOCCAL RESPONSE ONLINE

Once your Columbia UNI has been assigned, you can access our secure online **Web Portal** to enter your health history and meningococcal response. You will need to create a new account using your UNI. Please activate and use your Columbia email account or use a personal email for registration if your Columbia email account has not yet been activated.

**HEALTH HISTORY**

- Must be completed online after you receive your Columbia UNI.
- Enter at [cuhs.studenthealthportal.com](http://cuhs.studenthealthportal.com).

**MENINGOCOCCAL MENINGITIS RESPONSE FORM**

- Must be completed online, after you receive your Columbia UNI, at: [cuhs.studenthealthportal.com](http://cuhs.studenthealthportal.com).
- Receipt of the vaccine is optional.
- Information on the vaccine is available at: [cdc.gov/meningococcal/vaccine-info.html](http://cdc.gov/meningococcal/vaccine-info.html).

### STEP 2: GATHER IMMUNIZATION RECORDS AND SCHEDULE A PHYSICAL EXAM APPOINTMENT WITH YOUR HEALTH CARE PROVIDER.

The Immunization and Physical Exam forms can be found at the end of these instructions. You will need to visit a medical provider to conduct your physical exam and complete the immunization form. Be sure to take copies of all past immunizations, titers, and tuberculosis screening to your provider at the time of your physical exam. **Bring the CUIMC Physical Exam and CUIMC Immunization forms to your appointment** to outline clinical requirements for your provider. Have your provider complete and sign the Immunization Form validating the dates on which you received physical exam, immunizations, titers, and tuberculosis screening to meet CUIMC healthcare requirements. If you receive services outside the U.S., please submit documents in English. You **MUST** submit copies of titer reports from the laboratory.

**VERY IMPORTANT - Keep a copy of your past records for your own files!**

REQUIRED TO SUBMIT	REQUIRED DATA
<input type="checkbox"/> <b>PHYSICAL EXAM</b>	<b>Physical Exam within 12 months of program start date</b> <ul style="list-style-type: none"> <li>• Must be completed and signed by a clinician (<i>who is not a relative</i>).</li> </ul>

<input type="checkbox"/> <b>MMR REQUIREMENT</b> (NYS Public Health Law)	<b>Two Doses of MMR Vaccine OR Two Doses of Measles, Two Doses of Mumps, and One Dose of Rubella</b>  <b>OR</b> <b>Serologic Proof of Immunity for Measles, Mumps and Rubella</b> <ul style="list-style-type: none"> <li>• Must submit lab reports.</li> </ul>
<input type="checkbox"/> <b>VARICELLA</b>	<b>Two Doses of Varicella Vaccine OR Positive Varicella IgG Antibody Titer</b> <ul style="list-style-type: none"> <li>• If you have a negative or indeterminate titer, obtain two doses of vaccine at least 30 days apart.</li> </ul>
<input type="checkbox"/> <b>TETANUS, DIPHTHERIA, ACELLULAR PERTUSSIS</b>	<b>One-time Dose of Tdap Vaccine</b> <ul style="list-style-type: none"> <li>• Tdap is required regardless of date of last tetanus shot.</li> <li>• Tetanus boosters every 10 years thereafter.</li> </ul>
<input type="checkbox"/> <b>HEPATITIS B</b>	<b>Three Doses of Hepatitis B vaccine and Positive Quantitative Hepatitis B IgG Surface Antibody Titer (HBsAb) at least one month after your last dose of Hepatitis B vaccine – Lab Report Required</b>  <b>AND</b> <b>HEPATITIS B SURFACE ANTIGEN</b> *If you have completed the Hepatitis B vaccine series and your titer did not convert to positive: you must obtain and submit the date for a fourth dose. You must submit dates of all Hepatitis B vaccines received along with negative titer results.  *If you have a history of Hepatitis B infection, submit Core antibody and antigen titers.
<input type="checkbox"/> <b>HEPATITIS C</b>	<b>Hepatitis C Antibody – Lab Report Required</b> <ul style="list-style-type: none"> <li>• Hepatitis C antibody within six months of program start date.</li> <li>• If positive, a quantitative hepatitis C RNA test is required within six months of program start date.</li> </ul>
<input type="checkbox"/> <b>TUBERCULOSIS SCREENING</b>  <b>*Testing is required regardless of BCG status</b>  <b>NOTE:</b> Tuberculin skin tests (TST) may NOT be placed in the 30 days after administration of a live virus vaccine (including MMR and varicella). TSTs placed in the 30 days after receipt of a live virus vaccine are invalid and must be repeated. Same day administration of TST and live virus vaccines are acceptable.	<b>Two-step PPD Skin Testing:</b> <ul style="list-style-type: none"> <li>• Two PPD (tuberculosis screening) skin tests administered <b>at least one week</b> apart, within six months of program start date.</li> </ul> <b>OR</b> <b>IGRA Blood Test (QuantiFERON or T-SPOT):</b> <ul style="list-style-type: none"> <li>• Documentation of a negative QuantiFERON Gold or T-SPOT test completed within six months of program start date. – Lab Report Required</li> <li>•</li> </ul>
<input type="checkbox"/> <b>FOR PEOPLE WITH A POSITIVE SKIN TEST OR A POSITIVE IGRA BLOOD TEST</b>	<b>For People with a POSITIVE Skin Test (Reading &gt; 10 mm) History:</b> <ul style="list-style-type: none"> <li>• <u>Prophylaxis taken:</u> Submit date and mm reading of your positive PPD and report of a chest x-ray completed after positive test.</li> </ul> <b>OR</b> <ul style="list-style-type: none"> <li>• <u>Prophylaxis taken:</u> Submit date and mm reading of your positive PPD and report of a chest x-ray taken at time of conversion along with latent TB infection treatment.</li> </ul>

### **STEP 3: SUBMIT YOUR COMPLETED IMMUNIZATION FORM AND REQUIRED ATTACHMENTS PRIOR TO DEADLINE DATE**

**Submit only when complete immunization form and required attachments are available and after your Columbia UNI has been assigned.**

\*\*See front page of this booklet for important deadline dates and submission instructions\*\*

### **STEP 4: CHECK YOUR IMMUNIZATION RECORD ON THE WEB PORTAL AND YOUR SSOL ACCOUNT TO VERIFY YOUR INFORMATION HAS BEEN PROCESSED**

Please wait until **three weeks after your deadline date** to verify the status of your submission. Log into your Web Portal at [cuhs.studenthealthportal.com](http://cuhs.studenthealthportal.com), click on “My Profile” and select “Immunization History.” If all requirements have been met, you will see “Cleared for Registration”. If some requirements are still pending, you will see “Preregistration Incomplete.” In that case, check your secure messages for information on the pending requirements. If neither entry is present, your submission has either not been received or reviewed.

You can also check your “Health Hold” status online in your Student Services On-Line (SSOL) account. CUMC places a hold on your student account until your preregistration requirements are met. SSOL may state that the hold is due to a missing MMR requirement; please ensure that ALL CUIMC-specific health requirements are met. This hold blocks you from registering for class or being eligible for student health insurance. The hold will be released after your healthcare requirements are submitted **and** verified—this occurs within 48 hours of the “Cleared for Registration” status being visible on your immunization record. If at this time you have submitted all your information and you continue to see a health hold, please email us at [shsregistration@cumc.columbia.edu](mailto:shsregistration@cumc.columbia.edu).

### **OTHER QUESTIONS TO CONSIDER:**

**What happens if I do not submit my completed documentation by the time I try to register?**

You **CANNOT** register unless all requirements are met.

**What if I have a medical condition that interferes with my ability to meet the requirements?**

If you have a medical condition that interferes with your ability to meet the requirements listed above, please email us at [shsregistration@cumc.columbia.edu](mailto:shsregistration@cumc.columbia.edu).

**Will any of my TB or immunization data impact my admissions status?**

No! This data will not be reviewed by your school. SHS only reports compliance or non-compliance with the requirements.

**What if I did not get my form signed or do not have somewhere to go for services?**

For a \$95 fee, plus the cost of any immunization and/or titers, SHS can perform this service for you. SHS can only do this for those entering students who are local since it must be completed prior to the first day of orientation. Be careful not to wait, as the process can take some time. We do not accept any type of insurance for these services, and full payment is due at the time of service (*via cash, check or credit card*). See the complete list on the SHS website: [cumc.columbia.edu/student-health/especially/new-students/health-requirement-fee-schedule](http://cumc.columbia.edu/student-health/especially/new-students/health-requirement-fee-schedule). Appointments can be scheduled by calling 212-305-3400, and selecting prompt 1.

**What should I do if I do not have my completed preregistration information?**

**WAIT!** Sending partial information delays the clearance process. Please submit only when complete immunization form and required attachments are available.

**Who do I contact for questions about preregistration requirements?**

For questions concerning preregistration requirements, email [shsregistration@cumc.columbia.edu](mailto:shsregistration@cumc.columbia.edu). For questions concerning insurance, email [shsinsurance@cumc.columbia.edu](mailto:shsinsurance@cumc.columbia.edu).

***Thank you! We look forward to serving as your healthcare partner while you are at CUIMC!***

## IMMUNIZATION FORM: CLINICAL PROGRAMS

This form must be completed by an MD/DO, NP, or PA who is not a relative. **Attach physical exam, immunization records, and copies of all titers, antigens, and x-rays.** All reports must be submitted in English. Failure to do so will result in registration delays.

**This section to be completed by the student:**

**Name:** \_\_\_\_\_ **UNI:** \_\_\_\_\_  
Last First Middle Initial

**Date of Birth:** \_\_\_\_\_ **CUIMC School:** \_\_\_\_\_  **Full-time**  **Part-time**  
mm/dd/yyyy

**Contact Telephone:** (\_\_\_\_\_) - \_\_\_\_\_

**This section to be completed by a medical provider:**

<b>PHYSICAL EXAM</b>	Completed form <i>(included at the end of this packet)</i> . <b>Must include clinician signature and stamp.</b>
<b>MEASLES (RUBEOLA), MUMPS, RUBELLA (MMR)</b>  • Items <b>A, B, or C</b> on right will meet requirements.	<b>A. MMR Immunizations</b> <i>(On or after first birthday and at least 28 days apart)</i> MMR Dose 1 date: ____/____/____ MMR Dose 2 date: ____/____/____  <p style="text-align: center;"><b>OR</b></p> <b>B. Positive MMR IgG Antibody titers</b> <i>(lab reports required)</i> Measles (Rubeola) titer date ____/____/____ Result: _____ <input type="checkbox"/> Copy Attached Mumps titer date ____/____/____ Result: _____ <input type="checkbox"/> Copy Attached Rubella titer date ____/____/____ Result: _____ <input type="checkbox"/> Copy Attached  <p style="text-align: center;"><b>OR</b></p> <b>C. Measles, Mumps and Rubella Immunizations</b> <i>(On or after first birthday and at least 28 days apart)</i> Measles Dose 1 date: ____/____/____ Measles Dose 2 date: ____/____/____ Mumps Dose 1 date: ____/____/____ Mumps Dose 2 date: ____/____/____ Rubella Dose 1 date: ____/____/____
<b>POLIO</b> <i>(Recommended, not required)</i>	<b>Polio vaccine</b> <i>(most recent)</i> Dose date: ____/____/____ <input type="checkbox"/> IPV <input type="checkbox"/> OPV <i>(check one)</i>
<b>TETANUS, DIPHTHERIA, ACELLULAR PERTUSSIS*</b>	<b>Tdap vaccine</b> <i>(required)</i> Dose date: ____/____/____  *One time dose of Tdap vaccine is required regardless of date of last tetanus shot. Tetanus boosters every 10 years thereafter.  Td/Tdap vaccine dose date: ____/____/____ <i>(if more than 10 years since last Tdap)</i>

<p><b>VARICELLA</b></p>	<p><b>Positive Varicella IgG Antibody titer</b></p> <p>Titer date ____/____/____ Result: _____ <input type="checkbox"/> Copy Attached</p> <p style="text-align: center;"><b>OR</b></p> <p><b>Varicella Immunizations</b> (two doses required at least 28 days apart)</p> <p>Dose 1 date: ____/____/____ Dose 2 date: ____/____/____</p>
<p><b>HEPATITIS B</b></p> <ul style="list-style-type: none"> <li>• Items <b>A or B</b> on right will meet requirements.</li> </ul>	<p><b>A. Three doses of Hepatitis B vaccine AND Positive Hepatitis B IgG surface antibody titer AND Hepatitis B Antigen titer:</b></p> <p>Dose 1 date: ____/____/____</p> <p>Dose 2 date: ____/____/____</p> <p>Dose 3 date: ____/____/____</p> <p><b>Hepatitis B Surface Antibody Quantitative titer:</b> (Lab report required)</p> <p>Titer date ____/____/____ Result: _____ <input type="checkbox"/> Copy Attached</p> <p><b>Hepatitis B Surface Antigen titer:</b> (Lab report required)</p> <p>Titer date ____/____/____ Result: _____ <input type="checkbox"/> Copy Attached</p> <p><b>If you received vaccination and titer did not convert to positive:</b> If you have completed the Hepatitis B series of three immunizations and your titer is negative/equivocal one to two months after your last vaccine, you must obtain and submit the date for a fourth dose of Hepatitis B. Also submit the date of the previous three immunizations and negative/non-reactive titer. If you have already received two full courses of Hepatitis B vaccination (six doses—two series of three shots) submit the dates of ALL doses of vaccine and negative titers.</p> <p>Dose 4 date: ____/____/____</p> <p>Dose 5 date: ____/____/____</p> <p>Dose 6 date: ____/____/____</p> <p><b>Hepatitis B Surface Antibody Quantitative titer (required if above series complete):</b></p> <p>Titer date ____/____/____ Result: _____ <input type="checkbox"/> Copy Attached</p> <p style="text-align: center;"><b>OR</b></p> <p><b>B. History of Hepatitis B infection:</b></p> <p>Core antibody and surface antigen titer results (these titers submitted in instance of prior infection). Only positive titers reflect history of past disease.</p> <p>If BOTH of these titers are negative you should be immunized and check the surface antibody titer one to two months after last dose of vaccine.</p> <p><b>Hepatitis B Core Antibody Quantitative titer (within six months of start date):</b></p> <p>Titer date ____/____/____ Result: _____ <input type="checkbox"/> Copy Attached</p> <p><b>Hepatitis B Surface Antigen titer (within six months of program start date):</b></p> <p>Titer date ____/____/____ Result: _____ <input type="checkbox"/> Copy Attached</p>

<p><b>HEPATITIS C</b></p>	<p><b>Hepatitis C Antibody (within six months of program start date)</b></p> <p><b>Hepatitis C IgG titer</b> (<i>Lab report required</i>)</p> <p>Titer date ____/____/____ Result: _____ <input type="checkbox"/> Copy Attached</p> <p><b>Hepatitis C Quantitative RNA (only if IgG positive):</b></p> <p>Date ____/____/____ Result: _____ <input type="checkbox"/> Copy Attached</p>
<p><b>TB SCREEN</b> <b>(No prior positive test)</b></p> <ul style="list-style-type: none"> <li>• Please submit data for <b>either A or B</b>. Either of the options will meet the requirement.</li> <li>• <b>Testing is required regardless of BCG status</b></li> <li>• <b>TST reading must not exceed 72 hours following placement</b></li> <li>• <b>NOTE:</b> A TST skin test may NOT be placed in the 30 days after administration of a live virus vaccine to be considered valid. Live virus vaccines include measles, mumps, rubella, and varicella.</li> </ul>	<p><b>A. Two-step Tuberculin Skin Test (TST):</b> Two TSTs administered one to two weeks apart within six months of program start date</p> <p>TST test 1 placement ____/____/____ Reading ____/____/____ reading ____ mm</p> <p><input type="checkbox"/> Result Interpretation Negative <input type="checkbox"/> Result Interpretation Positive</p> <p>TST test 2 placement ____/____/____ Reading ____/____/____ reading ____ mm</p> <p><input type="checkbox"/> Result Interpretation Negative <input type="checkbox"/> Result Interpretation Positive</p> <p style="text-align: center;"><b>OR</b></p> <p><b>B. IGRA Blood Test (QuantIFERON or T-SPOT testing):</b> Documentation of a negative test reported within six months of program start date (<i>lab report required</i>).</p> <p>Test date ____/____/____ (only a negative test meets requirement)</p> <p>Result _____ <input type="checkbox"/> Copy Attached</p>
<p><b>TB SCREEN</b> <b>(History of prior positive test)</b></p> <p>(Recent or past)</p> <ul style="list-style-type: none"> <li>• History of latent TB, positive skin test or positive blood test <b>complete C</b>.</li> <li>• Chest x-ray should be dated after the date of the positive test.</li> </ul>	<p><b>C. POSITIVE skin test (reading &gt; 10 mm):</b></p> <p>PPD read date ____/____/____ Reading ____ mm</p> <p style="text-align: center;"><b>OR</b></p> <p><b>Positive IGRA Blood Test (QuantIFERON or T-SPOT testing):</b></p> <p>Test date ____/____/____ Reading ____ mm <input type="checkbox"/> Copy Attached</p> <p style="text-align: center;"><b>AND</b></p> <p><b>Chest X-ray Report (required):</b></p> <p>X-ray results: <input type="checkbox"/> normal <input type="checkbox"/> abnormal Date: ____/____/____ <input type="checkbox"/> Copy Attached</p> <p style="text-align: center;"><b>AND</b></p> <p><b>Prophylactic Medications for Latent TB Taken:</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Date started ____/____/____ Date ended ____/____/____</p> <p>Medications taken: _____</p> <p>Length of treatment: _____ months</p>

**HISTORY OF ACTIVE TB**

*(Recent or past)*

**D. History of Active TB:**

Date of diagnosis: \_\_\_\_/\_\_\_\_/\_\_\_\_      Date treatment completed: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Chest X-ray Report (required):**

X-ray results:  normal  abnormal      Date: \_\_\_\_/\_\_\_\_/\_\_\_\_       Copy Attached

**I attest that all dates, results, and immunizations listed on this form are correct and accurate.**

Provider's Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Physician, Nurse Practitioner, or Physician's Assistant

Provider's Signature \_\_\_\_\_ License Number \_\_\_\_\_

Clinician/Practice Stamp



# PHYSICAL EXAM FORM

*This form must be completed by an MD/DO, NP, or PA who is not a relative.*

**This section to be completed by the student:**

**Name:** \_\_\_\_\_ **UNI:** \_\_\_\_\_  
Last First Middle Initial

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **CUIMC School:** \_\_\_\_\_  **Full-time**  **Part-time**  
mm/dd/yyyy

**Contact Telephone:** (\_\_\_\_) - \_\_\_\_\_

**This section to be completed by a medical provider:**

Visual Acuity: OD \_\_\_\_\_ OS \_\_\_\_\_ Correction?  yes  no  
 (with correction, if any)

Height (inches) \_\_\_\_\_ Weight (pounds) \_\_\_\_\_ BP \_\_\_\_\_ Pulse \_\_\_\_\_

	<b>Normal</b>	<b>Abnormal</b>	<b>Not Done</b>	<b>If abnormal, please explain</b>
General appearance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears, Nose, Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lymph Nodes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breasts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pelvic Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
GU Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rectal Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

This student is in good health and is free of contagious disease. To the best of my knowledge, the student is free from any health impairment which is of potential risk to patients or which might interfere with the performance of assigned duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol, or other drugs or substances which may alter the individual's behavior.  yes  no

Does this student require ongoing medical care?.  yes  no

Specify \_\_\_\_\_

Provider's Printed Name: \_\_\_\_\_ License Number: \_\_\_\_\_ Date of Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Physician, Nurse Practitioner, or Physician's Assistant

Provider's Signature: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Clinician/Practice Stamp: