King’s Bay Naval Hospital (St. Marys, GA)

- SGHS Criminal Background Check
- Security Clearance Form
- Civilian Trainee Agreement Addendum
- READ – Immunization/Screening Requirements
- Immunization Screening Form
- Statement of Varicella Immune Status
- HEP B Declination Form
- PPD Reactor Document
- Latex Allergy Screening Questionnaire
- Medical Exemption from Influenza Vaccination (request)
- MACS Student Base Access Form
NAVAL HOSPITAL JACKSONVILLE
STUDENT INFORMATION FOR SECURITY CLEARANCE

Last Name ___________________________ First ___________________________ Middle ___________________________

Students Social Security Number ___________________________ Date of Birth ___________________________

Place of Birth _______________________ City _______________________ County _______________________ State ___________________

Citizenship

_____ I am a U.S. citizen or national by birth in the U.S. territor/commonwealth

_____ I am a U.S. citizen or national by birth, born to U.S. parent(s) in a foreign country

_____ I am a naturalized U.S. citizen

_____ I am not a U.S. Citizen

MILITARY STATUS: __________________BRANCH OF SERVICE ________ACTIVE DUTY _______ RESERVIST

Previous Military – Please indicate date of service: ____________  Branch of Service_____________________

Email Address ___________________________________________________________________________________

Cell Number ___________________________ Home Number ___________________________

Start Date ___________________________ End Date ___________________________

Department ___________________________ Preceptor Name ___________________________

Clinical Study _________________________________________________________________________________

Affiliating Institution ___________________________________________________________________________

Point of Contact Name ___________________________ Phone Number ___________________________

Email Address ___________________________________________________________________________________

PRIVACY ACT STATEMENT

Public Law 104-134 (April 26, 1996) requires that any person doing business with the Federal Government furnish a social security number or tax identification number. This is an amendment to Title 31, Section 7701. Furnishing the social security number, as well as other data, is voluntary, but failure to do so may delay or prevent action on the application. If your agency uses the information furnished on this form for purposes other than those indicated above, it may provide you with an additional statement reflecting those purposes.

SECURITY MANAGER (To be completed by the Naval Hospital Student Coordinator)

DELIVERED BY______________________________________ DATE_______________________________

RECEIVED BY___________________________________________ DATE___________________________________

CAC CARD REQUIRED _____YES _____NO
CIVILIAN TRAINEE AGREEMENT ADDENDUM

In consideration of being allowed to use the facilities of the Naval Hospital Jacksonville per the Memorandum of Understanding Agreement between Naval Hospital, Jacksonville, Florida, and (INSERT NAME COLLEGE/UNIVERSITY), I agree to abide by the rules and instructions listed in the agreement. I am aware of the rules concerning automobile liability insurance, and, if I drive my private automobile on base, I will register it with base authorities and maintain the required liability insurance. I specifically agree and understand that I will receive no monetary compensation whatsoever from the United States for this training.

______________________________________________________
Student Signature                         Date

Enclosure (1)
HEALTHCARE STUDENTS
IMMUNIZATION/SCREENING REQUIREMENTS

(Students who have direct/face to face contact with patients will be required to submit all required immunizations. Students that have no contact with patients will require to submit (e) and (h).)

a. **Varicella** – Reliable history of disease (as a child) or 2 dose vaccine series, or positive IgG titer to include quantitative. If a titer doesn’t show a positive reading then the student will be required to have the 2 dose vaccine.

b. **Measles/Mumps/Rubella** – Two lifetime doses of MMR or positive serologic test results. Persons born in 1957 or earlier are presumed to be immune through infection. Unless there is reason to suspect otherwise (example, childhood in a developing country, childhood immunizations not administered), a childhood dose of MMR vaccine may be assumed. It is reasonable to obtain rubella antibody titer for females of childbearing age.

c. **Hepatitis B** – HBV 3-dose vaccine **AND** HBsAB positive titer. HBV 3-dose vaccine series with negative titer **AND** repeat 3-dose HBV series with repeat titer **AND** in the case of persistent negative titer, counseling by licensed practitioner regarding implications of non-response.

d. **Tetanus/Diphtheria/Pertussis (Tdap)** within the preceding 10 years.

e. **Tuberculosis (PPD)** – Documentation of 2 previous Tuberculosis Skin Test (TST) is required to ensure Annual PPD testing has not lapsed. If a period between documented PPDs is more than 12 months, then the 2-step PPD testing method is required prior to student’s rotation.

   1st -step: Need Clearly Stated on Documentation:
   - Date of test
   - Results read within 48-72 hours
   - Date read and results
   - Provider Signature

   **The second test can be done one week from the date the first test was read.**

   2nd –step: Need Clearly Stated on Documentation:
   - Date of test
   - Results read within 48-72 hours
   - Date read and results
   - Provider Signature

   Note: A chest x-ray will not be accepted in place of a TB Skin Test, when the first test was negative. The student may provide QuantiFERON test documentation in place of a TB Skin Test.

f. **PPD Reactor (or a converter)** – Student will need to provide documentation of original TB Skin test showing positive reading results along with a chest x-ray within 1 year and a statement from their physician clearing them to work at the Naval Hospital.

g. **Latex** – Must complete Latex Screening Questionnaire for Student Clinical Training

h. **Influenza** – Must provide documentation of annual influenza vaccine from June of current year until August of the following year.
PRIMARY DOCUMENTATION OF IMMUNIZATION AND TITIER LABORATORY RESULTS MUST BE PROVIDED.
STATEMENT OF VARICELLA IMMUNE STATUS

Have you had chicken pox?  _______ yes

________ no

If you answered no, you will be required to receive a Varicella immunization prior to employment.

Signature:______________________________  Date:______________
HEPATITIS B DECLINATION
FOR
CONTRACT HEALTHCARE WORKERS

In accordance with Naval Hospital Instruction, contract healthcare workers are strongly recommended to obtain the Hepatitis B Antibody testing and provide Naval Hospital Jacksonville with this documentation. The statement can only be signed by the contract worker who elects to complete a declination statement. The contract worker will be notified of the efficacy safety and benefits of the vaccination. The statement is not a waiver. The statement must be signed, dated, witnessed and retained in the healthcare workers file.

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series. This is a recognizable risk to individuals working in a health care facility.

_________________________   ______________________
SIGNATURE OF CONTRACT WORKER                          DATE

_________________________   ______________________
WITNESS                  DATE
DATE: ____________________

To Whom It May Concern:

This is to certify that Mr. /Mrs. _____________________________ is a positive Tuberculin test reactor. Her lung fields are clear. This person is not infectious to others. The work capacity is not diminished as far as the test is concerned.

___________________________________________
Physician/ Nurse Signature

___________________________________________
Address:

___________________________________________
Phone Number
# LATEX ALLERGY SCREENING QUESTIONNAIRE

**FOR OFFICIAL USE ONLY (WHEN FILLED)**

## SECTION I - EMPLOYEE INFORMATION

<table>
<thead>
<tr>
<th>1. Last Name:</th>
<th>2. First Name:</th>
<th>3. Ml:</th>
<th>4. DOD ID#:</th>
<th>5. Rank/Rate:</th>
<th>6. Email:</th>
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</thead>
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<tr>
<th>10. Dept/Div/Work Center:</th>
<th>11. Duty Telephone:</th>
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<th>12. Sex:</th>
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<tr>
<td>Female [ ] Male [ ]</td>
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## SECTION II - LATEX SCREENING

***Note: Allergic symptoms may include sneezing, runny nose, hand rash, wheezing, eczema, hives, hypotension, anaphylaxis, etc.***

1. Do you have regular contact with latex gloves or other rubber products? [ ] Yes [ ] No

2. Indicate whether you have a history of any symptom or side effects after eating any of the following:
   - Avocado, banana, potato, tomato, chestnut, kiwi, papaya, peach, bell pepper, turnip, mango, fig, melon, pineapple, or zucchini? [ ] Yes [ ] No
   - Any other plants? (Note them below) [ ] Yes [ ] No

3. Have you ever had any side effects associated with exposure to latex gloves or any other product containing rubber or latex (e.g. balloons, condoms, etc.)? [ ] Yes [ ] No

4. Have you ever had frequent dental procedures or any medical condition or problem that resulted in multiple operations or chronic medical instrumentation, such as urinary catheterization? [ ] Yes [ ] No

5. Have you ever experienced hay fever, eczema, anaphylaxis, hives, or symptoms of asthma? [ ] Yes [ ] No

6. Have you ever experienced any allergic reaction to anything not included in any of the questions above? [ ] Yes [ ] No

7. If Yes to any allergic reaction, specify the cause(s), if known.
   - Enter unknown if not known:
   - Enter none if entire allergy history is negative:

## SECTION III - MEDICAL STAFF ASSESSMENT

[ ] Needs referral to Occupational Medicine (OM) provider for further assessment.

[ ] Does not need referral to OM provider for further assessment.

* If in doubt discuss with OM provider.

Staff Signature: ____________________________ Date: ____________

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Last Name: ____________________________ First Name: ____________________________ Ml: ______ Command UIC: ______ DOD ID#: ______

**FOR OFFICIAL USE ONLY - PRIVACY ACT SENSITIVE: Any misuse or unauthorized disclosure of this information may result in both criminal and civil penalties.**
Medical Exemption From Influenza Vaccination Request

It is the policy of the Naval Hospital, that all health care personnel working in the hospital are immunized against influenza on an annual basis. Health care personnel include, active duty staff, emergency service personnel, medical professionals, students, residents, contract personnel consistent with the terms of their contract and persons not directly involved in patient care but potentially exposed to infectious agents (housekeeping, dietary and volunteer personnel).

Medical exemption from the influenza vaccine is allowed for recognized contraindications. Please complete the form below to request medical exemption for your patient

Name of patient _____________________________________________________

My patient should not be vaccinated against influenza for the following reason(s):

□ Severe allergic reactions to eggs (defined as developing hives, swelling of the lips or tongue or difficulty breathing; does not include gastrointestinal symptoms) NOTE: The amount of eggs protein in influenza vaccine is extremely small. People who can tolerate eating food prepared with eggs, such as baked goods, can generally tolerate the influenza vaccine.

□ History of previous severe allergic reaction to the influenza vaccine or component of the vaccine (defined as developing hives, swelling of the lips or tongue, or difficulty breathing; does not include sore arm, local reaction, or subsequent upper respiratory tract infection).

□ History of Guillan-Barre syndrome within six weeks of receiving a previous vaccine.

□ Other (please, describe in the space below).

____________________________________________________________________

□ Temporary Medical Condition

□ Permanent Medical Condition

I certify that my patient has the above contraindications and request medical exemption from the influenza vaccine. I understand that I could be contacted for additional clarification.

Name of Medical Practitioner (MD, DO, NP, PA): __________________________

Signature: ________________________________DATE: _____________________
STUDENT INFORMATION:

LAST NAME: ____________________________________________________________

FIRST NAME: __________________________________________________________

SOCIAL SECURITY NUMBER: _______________________________ (Last 6 only)

AFFILIATING INSTITUTION: ______________________________________________

DRIVER’S LICENSE NUMBER: ____________________________________________

HOME ADDRESS: _______________________________________________________

CITY: _________________________________________________________________

STATE: _______________________________________________________________

ZIP CODE: ____________________________________________________________

START DATE: ___________________________ ENDING DATE: __________________

VEHICLE TYPE: _______________________________________________________

VEHICLE MAKE: ___________________________ VEHICLE MODEL: _____________

VEHICLE COLOR: ___________________________ VEHICLE YEAR: ______________

VEHICLE LICENSE PLATE NUMBER: ______________ LICENSING STATE: __________

PRIVATE ACT STATEMENT:

Requests for this information is authorized by 5 U.S.C. 302, 10 U.S.C. 5031, NASJAXINST 5451.1 (series). The information will be primarily be used for personnel accountability onboard NAS Jacksonville and generally, to allow compliance with applicable regulations and instructions. Disclosure of this information is voluntary; however, failure to provide the information may result in your inability to comply with administrative requirements outlined in the applicable regulations and instructions.

Need to bring original documents for base access
  Valid Drivers License
  Social Security Card
  Registration
  Proof of Insurance

If you do not have a base sticker on their car, stop by Bldg. 9 at the front gate to obtain a visitors pass.