

Lexington Medical Center
Student Requirements
 (To be completed by and submitted by school representative)
 Email to studentexperiences@lexhealth.org or fax to 803.936.7898

Student Name (First, Middle initial and Last)	
School Name	
A negative Tuberculosis Test (skin or blood test) within the preceding 12 months or a previously positive test with a clearance to work per the DHEC Form 1420 annually. A chest x-ray is only required if the medical provider suspects active TB due to the annual medical assessment.	Date Completed:
Documentation of verification of two MMR (Measles, Mumps, Rubella) vaccinations with the first one after the first birthday and two Varicella vaccinations or serologic immune status (titers) for Rubeola, Mumps, Rubella and Varicella.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Documentation of vaccination against Coronavirus Disease 2019 (COVID-19)	<input type="checkbox"/> Yes <input type="checkbox"/> No Date of 1 st vaccine dose: <input type="checkbox"/> Yes <input type="checkbox"/> No Date of 2 nd vaccine dose:
Documentation of vaccination against Diphtheria, pertussis and tetanus within the past ten years for participants in direct patient care experiences only	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (no direct patient care)
Documentation of three Hepatitis B vaccinations or positive serologic immune status for participants in direct patient care experiences only	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (no direct patient care)
Verification of completion of OSHA Blood Borne pathogen training for participants in direct patient care experiences only	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (no direct patient care)
Background Check as outlined in Student Affiliation Agreement	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Rotation date includes Influenza season (October through March). Status of vaccination for current year or signed declination.	<input type="checkbox"/> Yes (Vaccination) <input type="checkbox"/> No (Declination on file) <input type="checkbox"/> Not Applicable (rotation not during October to March timeframe)
Medical Professional Liability insurance on file \$300,000 per person/\$600,000 total per occurrence	<input type="checkbox"/> Yes <input type="checkbox"/> No
Documentation of negative 5 panel drug screen.	<input type="checkbox"/> Yes <input type="checkbox"/> No
School Representative Name (please print)	
School Representative Signature	
Date	