

Outside Clearance Form

Services must be done by your PCP (Primary Care Physician), not employee health services.

Employee name: _____ Phone Number: _____

UCDH Dept. Name: _____ Dept. Contact Name & Phone _____

Required Immunization Documentation for Infectious Diseases Clearance

TB Screening

Requirement: 1st PPD within the last 365 days and 2nd PPD or QuantiFERON within 90 days prior to start date.
****For positive PPD or QuantiFERON test, a chest x-ray is required within 90 days prior to start date (step C)**

- A. QuantiFERON (**Preferred**) : Test DATE: ___/___/___ Results: _____
Date of Annual TB Symptoms Interview: ___/___/___ Neg Pos**
History if BCG Vaccination: Yes No (BCG is a vaccine given to those born outside the US.)
- B. Two-step Tuberculin Intermediate Skin Test (PPD)
Test 1 Date: ___/___/___ Reading: ___/___/___ Results: _____ MM Induration: Neg Pos**
Test 2 Date: ___/___/___ Reading: ___/___/___ Results: _____ MM Induration: Neg Pos**
- C. Chest x-ray: Date: ___/___/___ Results: _____ TB Symptoms: Neg Pos
History of Treatment: Yes No If yes, Date: ___/___/___ How many months?: _____

MMR or Individual Measles, Mumps, and Rubella

Requirement: Two immunization dates (dated at least 28 days apart OR positive titer)

- A. MMR Vaccines: 1. ___/___/___ 2. ___/___/___
OR
- B. Individual Measles, Mumps and Rubella Vaccines:
Measles: 1. ___/___/___ 2. ___/___/___ OR Titer Date: ___/___/___ Neg Pos
Mumps: 1. ___/___/___ 2. ___/___/___ OR Titer Date: ___/___/___ Neg Pos
Rubella: 1. ___/___/___ OR Titer Date: ___/___/___ Neg Pos

Varicella Vaccine (Chicken Pox)

Requirement: Two vaccination dates (28 days apart) OR positive titer

Varicella Vaccines: 1. ___/___/___ 2. ___/___/___ OR Titer Date: ___/___/___ Neg Pos

Tdap Vaccine (Tetanus, Diphtheria, Pertussis) * From June of 2005 or more recent

Tdap vaccine: 1. ___/___/___

Flu Vaccine (Required only during flu season: September – April)

Flu Vaccine: 1. ___/___/___

COVID-19 Vaccine

Manufacturer Name : _____ Lot Number 1: _____ Date Vaccinated Dose 1. ___/___/___

Manufacturer Name : _____ Lot Number 2: _____ Date Vaccinated Dose 2. ___/___/___

Manufacturer Name : _____ Lot Number 3: _____ Date Vaccinated Dose 3. ___/___/___

Direct Patient Care Contact Requires – Hepatitis B and C (Hep C is Recommended)

- A. **Manufacturer Name** : _____
Hepatitis B*: Surface Antibody Titer Date: ___/___/___ Numeric Value: _____ mIU/ml Neg Pos
Hepatitis B Injection Dates: 1. ___/___/___ 2. ___/___/___ 3. ___/___/___ **OR**
HEPLISAV-B Injection Dates: 1. ___/___/___ 2. ___/___/___

Declination: I understand that due to my potential occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. However, I decline hepatitis B vaccination at this time, but understand a baseline titer will be drawn. 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 will follow up with my primary care physician (PCP) or school. If exposed to the Hepatitis B virus at work, I know that I need to report this exposure to EHS as soon as possible.

*Note to UCDH Dept: Hep B Vaccination agreement must be included if a negative titer result is indicated above.

X _____

Signature

B. **Hepatitis C (Recommended):** Surface Antibody Titer Date: ___/___/___ Results: _____

Declination: EHS encourages new hires to know their status through blood titer however, it is not required. I choose to decline the titer.

X _____

Signature

Ishihara Color Screening

Color Vision Test: Normal Abnormal

Fit Test

N95 Respirator: _____ PAPR Date Tested: ___/___/___

I HAVE EVALUATED THIS EMPLOYEE AND HAVE FOUND THEM TO BE FREE FROM INFECTIOUS DISEASE

Primary care physician's name: _____ Date: _____

PCP signature: _____ PCP Business Stamp: _____