APPENDIX B - HEALTH SCREENING FORM FOR VISITING RESEARCH INTERNS/OBSERVERS

Name: _____Date of Birth: _____/_____/_____ SSN: _____

Start Date: _____/_____/_____ End Date: _____/_____/_____

Sponsor*: _____ Sponsor's email: _____

**The sponsor is the contact person in the host department who is accountable to ensure the visitor's compliance.*

☐ Visiting Research Intern (HR record) ☐ Observer

THIS SECTION TO BE COMPLETED BY HEALTHCARE PROVIDER (NOT WORKER/VISITOR/VISITING STUDENT)

INITIAL ONE OPTION IN EACH SECTION & PROVIDE DATES WHERE INDICATED ("See attached" not accepted)
***Approved exemptions from home institutions will be honored with submission of proper documentation.**

MEASLES, MUMPS AND RUBELLA

___ Two (2) doses of MMR vaccine after first birthday (vaccine dates: _____ _____)

___ Serologic proof of immunity to measles, mumps and rubella (positive IgG antibody)

(Lab dates: Measles_____ Mumps _____ Rubella _____)

___ Pt born prior to 1957 and has positive immunity to rubella (lab date: _____)

VARICELLA

___ Documented serologic immunity to varicella (positive IgG antibody date: _____)

___ Two (2) doses of varicella vaccine (vaccine dates: _____ _____)

HEPATITIS B

___ Three (3) doses of hepatitis B vaccines* _____ _____ _____

___ Serologic Proof of Immunity (positive Hep B surface Antibody) _____ (*lab 4-8 weeks after vaccination is recommended)

___ Wishes to decline vaccine.

TUBERCULOSIS

If TB skin test or IGRA **positive**:

___ Chest X-ray has no evidence of active TB **AND** Treatment for latent TB infection was offered

X-ray date (must be more recent than 6 months before Start Date): _____

If TB skin test or IGRA **negative**: (*note: if stay will be < 2 weeks, only 1 TST within 3 months of start date is required).

___ Two step TB testing completed

Date of 1st TBST (must be within 1 year of start date): _____

Date of 2nd TBST (must be more recent than 3 months before start date): _____

___ IGRA completed more recently than 3 months before start date. IGRA date: _____

INFLUENZA (only applicable if individual will be on VUMC campus for any day between Oct 1 and Mar 31)

___ Date of annual influenza vaccine (must be between Jul 1 & Mar 31 of current flu season): _____

PERTUSSIS (required in pediatric, emergency, and women's health departments or "assignment pending/uncertain" status)

___ One dose of Tdap vaccine (NOTE: DTP/DTaP and Td/TD vaccines do not meet this requirement.) Date: _____

COVID-19 (Full primary series of an FDA/WHO-approved/emergency authorized COVID-19 vaccine. Booster not required)

___ Brand: _____ Vaccine dates: _____ _____ _____ _____

I attest that I have reviewed official documentation for all vaccines, X-rays, and lab tests marked above and that the information is complete and accurate to the best of my knowledge: (note: VUMC may, at its discretion, request additional/clarifying information if needed)

Healthcare Provider Printed Name _____Date _____

Healthcare Provider Signature _____

Office Address: _____Phone Number (_____)_____

THIS SECTION TO BE COMPLETED BY CONTRACTED WORKER/VISITOR/VISITING STUDENT:

I have received and reviewed the educational materials related to blood borne pathogens as required by OSHA.

_____ _____

Contract Worker/Visitor/Visiting Student Date