APPENDIX B - HEALTH SCREENING FORM FOR CONTRACTED WORKERS/VISITORS/VISITING STUDENTS

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.*

☐ Non-Clinical Contracted Worker ☐ Clinical Contracted Worker ☐ Visitor ☐ Student Worker

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

INITIAL <u>ONE</u> OPTION IN EACH SECTION & PROVIDE DATES WHERE INDICATED
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 or serologic proof of immunity (positive HB surface antibody) (Immunity testing is recommended 4 to 8 weeks following final dose.) ___ 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**: ___ 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) ___ One dose of Tdap vaccine (NOTE: DTP/DTaP and Td/TD vaccines do <u>not</u> meet this requirement.)

I attest that I have reviewed the <u>original documentation</u> for all vaccines, X-rays, and lab tests marked above and that the information is complete and accurate to the best of my knowledge:

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