

**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

**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 ("See attached" not accepted)
<p><b>MEASLES, MUMPS AND RUBELLA</b></p> <p>___ Two (2) doses of MMR vaccine after first birthday (vaccine dates: _____, _____)</p> <p>___ Serologic proof of immunity to measles, mumps and rubella (positive IgG antibody) (Lab dates: Measles _____ Mumps _____ Rubella _____)</p> <p>___ Pt born prior to 1957 and has positive immunity to rubella (lab date: _____)</p>
<p><b>VARICELLA</b></p> <p>___ Documented serologic immunity to varicella (positive IgG antibody date: _____)</p> <p>___ Two (2) doses of varicella vaccine (vaccine dates: _____, _____)</p>
<p><b>HEPATITIS B</b></p> <p>___ 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.)</p> <p>___ Wishes to decline vaccine.</p>
<p><b>TUBERCULOSIS</b></p> <p>If TB skin test or IGRA <b>positive</b>:</p> <p>___ Chest X-ray has no evidence of active TB <b>AND</b> Treatment for latent TB infection was offered X-ray date (must be more recent than 6 months before Start Date): _____</p> <p>If TB skin test or IGRA <b>negative</b>: (*note: if stay will be &lt; 2 weeks, only 1 TST within 3 months of start date is required).</p> <p>___ 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): _____</p> <p>___ IGRA completed more recently than 3 months before start date. IGRA date: _____</p>
<p><b>INFLUENZA</b> (only applicable if individual will be on VUMC campus for any day between Oct 1 and Mar 31)</p> <p>___ Date of annual influenza vaccine (must be between Jul 1 &amp; Mar 31 of current flu season): _____</p>
<p><b>PERTUSSIS</b>(required in pediatric, emergency, and women's health departments or "assignment pending/uncertain" status)</p> <p>___ One dose of Tdap vaccine (NOTE: DTP/DTaP and Td/TD vaccines do <u>not</u> meet this requirement.)</p>

**I attest that I have reviewed the original 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:**

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