

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

Name: _____ Date of Birth: ____/____/____
 SSN: _____
 Start Date: ____/____/____ End Date: ____/____/____
 Sponsor *: _____ Sponsor 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
<p>MEASLES, MUMPS AND RUBELLA</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>VARICELLA</p> <p>___ Documented serologic immunity to varicella (positive IgG antibody date: _____)</p> <p>___ Two (2) doses of varicella vaccine (vaccine dates: _____, _____)</p>
<p>HEPATITIS 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.) ___ Wishes to decline vaccine.</p>
<p>TUBERCULOSIS</p> <p>If TB skin test or IGRA positive:</p> <p>___ 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</p> <p>TB skin test or IGRA negative:</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>INFLUENZA (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 & Mar 31 of current flu season): _____</p>
<p>PERTUSSIS (required in pediatric, emergency, and women's health departments)</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 _____