Mass General Brigham

Infection Control Standards for Health Clearance

- **Tuberculosis (TB) Screening Required**
  One of the following is required:
  a. Documentation of TB skin test within 3 months of screening date
     OR
  b. Documentation of a negative IGRA (QFT or T-Spot) within 3 months of screening date
     OR
  c. For individuals known to be TB skin test positive or who have positive IGRA, documentation of a chest x-ray report which rules out active tuberculosis is required and a completed TB symptom survey

- **Measles, Mumps, and Rubella Immunity Required**
  One of the following is required:
  a. Documentation of two MMR vaccines **OR** two measles vaccines, two mumps vaccine, and one rubella vaccine
     OR
  b. Proof of immunity to measles, mumps, and rubella by IgG antibody titer (blood test).

- **Chicken Pox (Varicella) Recommended**
  One of the following is required:
  a. History of Varicella
  OR
  b. Proof of immunity to chicken pox by IgG antibody titer (blood test)
  OR
  c. Documentation of two varicella vaccinations

- **Influenza Vaccination Required**
  Mass General Brigham requires all health care workers to receive a **seasonal** flu vaccine.

- **COVID Vaccination Required**
  Mass General Brigham requires all health care workers to be up to date with COVID-19 vaccinations.

Mass General Brigham

Health Screening Requirements

Observer Name:_____ **Date of Birth:**_____

Must be Completed by Personal Health Care Provider or School Health Office:

All personnel who will work, volunteer, or observe at a Mass General Brigham healthcare facility are required to meet the minimal infection control standards on page 1.

Tuberculosis (TB):

BAMT within 3 mos. of screening date	QFT Date: _____ Result: _____	OR	T-Spot Date: _____ Result: _____	
For history of +TST or +BAMT a Chest X-Ray (CXR) is required	CXR Date: _____		Chest X-Ray Result_____	
LTBI TX	Dated of Completion: _____	OR	LTBI TX Not Completed_____	
Symptom Review *(Only for applicants who have a history of a positive PPD)*	Loss of appetite ❒ Yes ❒ No Unexplained weight loss ❒ Yes ❒ No Night Sweats ❒ Yes ❒ No		Fever ❒ Yes ❒ No Fatigue ❒ Yes ❒ No Productive Cough ❒ Yes ❒ No	

TB SCREENING:
Have you lived for more than one month in a country with a high rate of TB? (Any country other than the United States, Canada, Australia, New Zealand, and those in Northern Europe or Western Europe) YES _____ NO _____
Are you immunosuppressed? YES _____NO _____
Have you had close contact with someone who had infectious TB disease since your last TB screening? YES____ NO ____

Other Requirements

		Date		Date	Titer Result (circle)	Date
MMR	MMR #1	_____	MMR #2	_____		
Measles	Measles #1	_____	Measles #2	_____	POS / NEG	_____
Mumps	Mumps #1	_____	Mumps #2	_____	POS / NEG	_____
Rubella	Rubella #1	_____			POS / NEG	_____
Hx of Varicella	Yes___		No____			
Varicella	Varicella #1	_____	Varicella #2	_____	POS / NEG	_____
COVID 19	COVID 19 #1	_____	COVID19 #2	_____	Booster:	_____
	Manufacturer:	_____	Manufacturer:	_____	Manufacturer:	_____
Influenza (Seasonal)	Influenza	_____				

Provider Name (Print): _____ **Phone:** _____

Provider Signature: _____ **Date** _____