BRIGHAM HEALTH

BRIGHAM AND WOMEN'S HOSPITAL

OCCUPATIONAL HEALTH SERVICES
75 Francis Street
Boston, MA 02115
Neville House Clinic *tel. 617-732-6034*
fax 1.617. 975-0808

Last Name	First Name	Date of Birth

Health Screening Requirements

For Personal Health Care Provider or School Health Completion:

All personnel who will work, volunteer, or observe at the Brigham and Women's Hospital are required to meet the minimal infection control standards on page 2.

For questions on form completion, call 617-732-6034. Thank You.

TB Skin Test (TST) **#1 within 1 year of screening date**	Date Planted: ______	Date Read: _______	Result in mm: _______
#2 TST within 3mos of screening date	Date Planted: ______	Date Read: _______	Result in mm: _______
Within 3mos of start date (see p.2)	QFT date/result:______ If positive, chest xray is required		T-spot date/ result_______ If positive, chest xray is required

Symptom Review *(Only for applicants who have a history of a positive PPD)* **Chest X-ray is required**	Loss of appetite	❒ Yes	❒ No	Fever	❒ Yes	❒ No
	Unexplained weight loss	❒ Yes	❒ No	Fatigue	❒ Yes	❒ No
	Night Sweats	❒ Yes	❒ No	Productive Cough	❒ Yes	❒ No
	Chest X-Ray Date	__________		Chest X-Ray Result__________		
	LTBI Treatment Length	__________				
	INH Completion Date	__________				

		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	______		______	POS / NEG	______
Varicella	Varivax #1	______	Varivax #2	______	POS / NEG	______
Hepatitis B	Hep B #1	______	**Antibody Hepatitis B**		POS / NEG	______
	Hep B #2	______				
	Hep B #3	______				
Td/Tdap	Td	______	Tdap	______		
Influenza Vaccine	Seasonal	______	**Color Vision Screen date**	______	Normal/Abn	

Print Name Health Care Provider	Signature	Date

Location ____________________________ **Telephone** __________

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Infection Control Standards for Health Clearance

- **Tuberculosis Screening and Chest X-Rays**

One of the following is required:

a. Documentation of 2 step TB testing; #1 within 1 year of start date, #2 within 3 months of start date.
b. For individuals known to be TB skin test positive, documentation of a chest x-ray report is required which rules out active tuberculosis.
c. Documentation of a negative QFT or Tspot within 3 months of start date; if positive QFT or Tspot, then documentation of a chest xray report is required which rules out active tuberculosis.
d. ***For clinical staff who need to be screened annually, QFT or Tspot test accepted only if new hire is from TB endemic country or who have history of BCG vaccine.***

- **Measles, Mumps, and Rubella Immunity Required**

One of the following is required:

a. Documentation of two measles vaccines, two mumps vaccine, and one rubella vaccine or documentation of two MMR vaccines ***or,***
b. Proof of immunity to measles, mumps and rubella by IgG antibody titer (blood test).

- **Hepatitis B Vaccine**

For individuals who may be exposed to blood or body fluids during their experience at BWH:

a. Documentation of the hepatitis B series and/ or
b. Positive antibody test for hepatitis B.

*BWH will provide this vaccine free of charge to individuals who may be exposed to blood or body fluid during their work.

- **Chicken Pox Immunity Required**

One of the following is required:

a. Proof of immunity to chicken pox by IgG antibody titer (blood test).
b. Documentation of two varicella vaccinations

- **Tetanus**

All staff should have documentation of up to date tetanus vaccine (Td/Tdap).

- **Influenza**

Massachusetts Department of Public Health requires all health care workers to receive flu vaccine.