

#### 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

# **Sponsored Staff Health Screening Requirements**

	Spons	oreu Sta	all n	leaili	1 30	reen	ing Require	ements				
To be completed by Health Care Provider of School Health Department												
All personnel who will w infection control standar	ds on page 2.		_				•		me	et the mi	inima	
	For questions o	n form cor	nplet	tion, c	all 61	7-732						
TB Skin Test (TST) within 3 months	Date Planted:						n mm: chest x-ray is					
OR												
Blood Test Within 3 months	QFT date/result: _ If positive, chest x-ray is required							ate/ resul		uired		
Symptom Review (Only for applicants who	Loss of appetite Unexplained weigl	nt loss		Yes Yes		No No	Fever Fatigue			Yes Yes		No No
have a history of a	Night Sweats			Yes		No	Productive Cou Coughing up B	•		Yes		No
Documentation of Chest X-ray is required	1 TD1 T ( ) ( )						_ Chest X-Ra _					
Please include separate documentation if there is a history treatment for Latent TB	LTBI Completion t	Jale _					_					
	Da	te				Dat	e	er Resul	t	Date		
MMR	MMR #1		MM	R #2			(•	,				
Measles	Measles #1	Measles #2				PC	OS / NEG					
Mumps	Mumps#1	Mumps #2				POS / NEG						
Rubella	Rubella #1	#1				PC	S / NEG					
Varicella	Varivax #1		Vari	vax #	2		PC	OS / NEG				
Hepatitis B*	Hep B #1		Ant	ibody	Hep	atitis	B PC	S / NEG				
*(Strongly recommended if with working with blood or body fluids)	Hep B #2		Tda	p			CC	OVID #1				
ilulus)	Hep B #3		Td				CC	OVID #2				
Influenza Vaccine	Seasonal Flu						Ma	ınufactureı	†			
Print Name Health Care F	Provider	Signature						Da	ate			
Location							Te	lephone				

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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 a TST (skin test) within 3 months

OR

b. Documentation of a negative IGRA (QFT or T-Spot) within 3 months

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.
- d. Please provide documentation of any treatment for Latent TB.

#### Measles, Mumps, and Rubella Immunity Required

One of the following is required:

 Documentation of <u>two</u> measles vaccines, <u>two</u> mumps vaccine, and <u>one</u> rubella vaccine or documentation or <u>two</u> MMR vaccines

OR

b. Proof of immunity to measles, mumps and rubella by IgG antibody titer (blood test).

#### • Chicken Pox Immunity One of the following:

a. Proof of immunity to chicken pox by IgG antibody titer (blood test)

OR

b. Documentation of two varicella vaccinations

OR

c. Reliable history of chicken pox disease

### • Hepatitis B Vaccine (Strongly recommended for those working with blood or body fluids)

Strongly recommended for individuals who may be exposed to blood or body fluids during their experience at BWH. Please discuss with your health care provider).

a. Documentation of the hepatitis B series

AND

b. Positive antibody test for hepatitis B.

#### Tdap/Td (Recommended)

Up to date Tdap/Td is **recommended**.

#### Influenza

Brigham and Women's Hospital requires all staff all individuals working at a BWH site to receive a <u>seasonal</u> flu vaccine. BWH has a mandatory mask policy for those not vaccinated against seasonal influenza due to a medical or religious exemption.

 COVID Vaccine: At this time, the COVID 19 Vaccine is not required, but is <u>highly recommended</u> prior to beginning employment at BWH. BWH will provide updates on the availability and process for obtaining COVID Vaccine.



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Sponsored Staff Questionnaire: Please complete

If YES, provide date: NO
COVID Symptoms  If you have fever, cough (not related to a chronic condition), shortness of breath, sore throat, runny nose (not related to allergies), muscle aches, loss of smell/taste you may not come to any BWH site. Stay home and notify your sponsor.
TB Risk 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
Additional Questions: Will you be working with Animals? Yes No
Will you perform direct patient care? Yes No  Sponsored staff (Print name)
Sponsored Staff (Sign Name)
Date of Birth:/
Today's Date:/