UCDAVIS HEALTH

Outside Clearance Form

Services must be done by your PCP (Primary Care Physician), not Occupational and Employee Health Clinic (OEHC).

Name:_____ Phone Number:_____

UCDH Dept. Name:_____ Dept. Contact Name & Phone_____

Required Immunization Documentation for Infectious Diseases Clearance

TB Screening

Requirement: 1st PPD within the last 365 days and 2nd PPD within 90 days prior to start date **OR** Quantiferon within 90 days prior to start date.

**For positive PPD or QuantiFERON test, a chest x-ray is required within 90 days prior to start date (step C)

A. QuantiFERON **(Preferred)** : Test DATE: ____/____/_____ Results: _____
Date of Annual TB Symptoms Interview: ____/____/_____ ☐ Neg ☐ Pos**
History if BCG Vaccination: ☐ Yes ☐ No (BCG is a vaccine given to those born outside the US.)

B. Two-step Tuberculin Intermediate Skin Test (PPD)
Test 1 Date: ____/____/_____ Reading: ____/____/_____ Results: _____ MM Induration: ☐ Neg ☐ Pos**
Test 2 Date: ____/____/_____ Reading: ____/____/_____ Results: _____ MM Induration: ☐ Neg ☐ Pos**

C. Chest x-ray: Date: ____/____/_____ Results: _____ TB Symptoms: ☐ Neg ☐ Pos
History of Treatment: ☐ Yes ☐ No If yes, Date: ____/____/_____ How many months?:_____

MMR or Individual Measles, Mumps, and Rubella

Requirement: Two immunization dates (dated at least 28 days apart OR positive titer)

A. MMR Vaccines: 1. ____/____/_____ 2. ____/____/_____
OR
B. Individual Measles, Mumps and Rubella Vaccines:
Measles: 1. ____/____/_____ 2. ____/____/_____ **OR** Titer Date: ____/____/_____ ☐ Neg ☐ Pos
Mumps: 1. ____/____/_____ 2. ____/____/_____ **OR** Titer Date: ____/____/_____ ☐ Neg ☐ Pos
Rubella: 1. ____/____/_____ **OR** Titer Date: ____/____/_____ ☐ Neg ☐ Pos

Varicella Vaccine (Chicken Pox)

Requirement: Two vaccination dates (28 days apart) OR positive titer

Varicella Vaccines: 1. ____/____/_____ 2. ____/____/_____ **OR** Titer Date: ____/____/_____ ☐ Neg ☐ Pos

Tdap Vaccine (Tetanus, Diphtheria, Pertussis) * From June of 2005 or more recent

Tdap vaccine: 1. ____/____/_____

Flu Vaccine (Required only during flu season per CDPH)

Flu Vaccine: 1. ____/____/_____

☐ I am choosing to decline the influenza (flu) vaccine and I am attesting and agreeing to:

*Wear a mask everywhere on campus until the end of the flu season (May/June of next year), regardless of any change in COVID-19 requirements,

* Any additional NPIs (Non-Pharmaceutical Interventions), social distancing, or other requirements or restrictions specified by my campus or local public health authorities.

* I understand that as long as I refuse to accept the flu vaccine, I may be required to take extra precautions against transmission while at work, consistent with local policies.

* I understand that I can change my mind at any time and accept the flu vaccine

X_____
Signature

Direct Patient Care Contact Requires – Hepatitis B

A. **Manufacturer Name** : _____

Hepatitis B*: Surface Antibody Titer Date: ____/____/_____ *Numeric Value: _____mlU/ml ☐ Neg ☐ Pos
Hepatitis B Injection Dates: 1. ____/____/_____ 2. ____/____/_____ 3. ____/____/_____ **OR**
HEPLISAV-B Injection Dates: 1.____/ ____/ ___/ 2. ___/ ___/ ___/
***NUMERIC VALUE REQUIRED**

☐ Hep B Declination: I understand that due to my potential occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. However, I decline hepatitis B vaccination at this time, but understand a baseline titer will be drawn. I understand that by declining this vaccine I continue to be at risk of acquiring hepatitis B, a serious disease. If, in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I will follow up with OEHC, my primary care physician (PCP), or school. If exposed to the Hepatitis B virus at work, I know that I need to report this exposure to OEHC as soon as possible.
*Note to UCDH Dept: Hep B Vaccination declination must be included if a negative titer result is indicated above.

X_____
Signature

Fit Test (To be completed by the Unit)

☐ N95 Respirator:_____ ☐ PAPR Date Tested: ____/____/_____

I HAVE EVALUATED THIS INDIVIDUAL AND HAVE FOUND THEM TO BE FREE FROM INFECTIOUS DISEASE

Primary care physician's name: _____ Date: _____

PCP signature: _____ PCP Business Stamp: _____