

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				

Infection Control Standards for Health Clearance

Tuberculosis Screening and Chest X-Rays

One of the following is required:

- Documentation of 2 step TB testing; #1 TST within 1 year of screening date, #2 TST within 3 months of start date
 OR
- b. Documentation of a negative IGRA (QFT or T-Spot) within 3 months of screening start date
- 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. Complete Symptom Review on page 1.

Measles, Mumps, and Rubella Immunity Required

One of the following is required:

a. Documentation of <u>two</u> measles vaccines, <u>two</u> mumps vaccine, and <u>one</u> rubella vaccine or documentation of <u>two</u> 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 MGB:

a. Documentation of the hepatitis B series

AND

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)

<u>OR</u>

b. Documentation of $\underline{\text{two}}$ varicella vaccinations after your first birthday

<u>OR</u>

c. Reliable history of Varicella Disease

Tdap/Td

All Residents/Clinical Fellows are required to have a documented Tdap. Up to date Tdap/Td is recommended.

Influenza

MGB requires all staff to receive a **seasonal** flu vaccine.

• **COVID Vaccine**: Completion of COVID Vaccination and a Booster is required for all staff.

The original vaccine must be a WHO approved vaccination.

Pfizer, Moderna and Johnson and Johnson are the only accepted Booster

Employees who request a religious or medical exemption must meet MGB standards for these exemptions. These exemptions must be approved prior to start.



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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:/