Outside Clearance Form

Services must be done by your PCP (Primary Care Physician), not employee health services.

Employee name:_____ Phone Number:_____

Department Name:_____ Department 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 of 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 1 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)

Tdap vaccine: 1. ____/____/_____

Flu Vaccine (Required only during flu season per CDPH)

Flu Vaccine: 1. ____/____/_____

COVID-19 Vaccine

Manufacturer Name : _____ Lot Number 1:_____ Date Vaccinated Dose 1. ____/____/_____

Lot Number 2:_____ Date Vaccinated Dose 2. ____/____/_____

Lot Number 3:_____Date Vaccinated Dose 3. __/_____/_____

Direct Patient Care Contact Requires – Hepatitis B and Hepatitis C

A. **Manufacturer Name** : _____

Hepatitis B*: Surface Antibody Titer Date: ____/____/_____ * Numeric Value: _____mIU/ml ☐ Neg ☐ Pos

Hepatitis B Injection Dates: 1. ____/____/_____ 2. ____/____/_____ 3. ____/____/_____

*** NUMERIC VALUE REQUIRED**

☐ 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. 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 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 EHS as soon as possible.
*Note to UC Davis Health Department: Hep B Vaccination agreement must be included if a negative titer result is indicated above.

X_____
Signature

B. **Hepatitis C:** Surface Antibody Titer **(Must be within 90 days of start date)**
Date:_____/_____/_____ Results: _____

X_____
Signature

Ishihara Color Screening

Color Vision Test: ☐ Normal ☐ Abnormal

Fit Test

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

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

Primary care physician's name:_____ Date: _____

PCP signature:_____ PCP Business Stamp: _____