UCDAVIS HEALTH

Outside Clearance Form

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

Employee 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 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 (dated at least 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: September – April)
Flu Vaccine: 1. ____/____/______
COVID-19 Vaccine
Manufacturer Name : _______________ Lot Number 1:_____________ Date Vaccinated Dose 1. ____/____/______ Lot Number 2:_____________ Date Vaccinated Dose 2. ____/____/______
Direct Patient Care Contact Requires – Hepatitis B and C (Hep C is Recommended)
A. **Manufacturer Name** : ____________________________ **Hepatitis B*:** Surface Antibody Titer Date: ____/____/______ Numeric Value: ________mIU/ml ☐ Neg ☐ Pos **Hepatitis B Injection Dates**: 1. ____/____/______ 2. ____/____/______ 3. ____/____/______ ☐ 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 UCDH Dept: Hep B Vaccination agreement must be included if a negative titer result is indicated above.

X____
Signature

B. **Hepatitis C (Recommended):** Surface Antibody Titer Date: ____/____/______ Results: _________________

☐ Declination: EHS encourages new hires to know their status through blood titer; however, it is not required. I choose to decline the titer.

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: _______________________________