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 (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: September – April)

Flu Vaccine: 1. ____/____/_____

COVID-19 Vaccine

Manufacturer Name : _____ Lot Number 1:_____ Date Vaccinated Dose 1. ____/____/_____
Manufacturer Name : _____ Lot Number 2:_____ Date Vaccinated Dose 2. ____/____/_____
Manufacturer Name : _____ Lot Number 3: _____ Date Vaccinated Dose 3. ____/ ____/_____

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. ____/____/_____ **OR**
HEPLISAV-B Injection Dates: 1.____/ ____/ ___/ 2. ___/ ___/ ___/

☐ 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 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: _____