

Please submit forms to the Department Manager hosting your observation experience.
Forms sent directly to Employee Health will be discarded.

IMMUNIZATION HISTORY CERTIFICATION

Name:	Today's Date:
Date of Birth:	Department to Shadow:
Hospital Campus/Location:	
OBSERVER Health History Requirements	

St. Luke's University Health Network follows CDC and Immunization Coalition Healthcare Personnel Vaccination Recommendations. Please provide vaccine records if available. If this form is completed by a Healthcare Provider, page 2 must be signed. Immunizations and lab tests must be completed BEFORE beginning work/experience. If non-immune, appropriate vaccinations must be administered prior to/on start date. Once all data is collected and reviewed, the certification form will be completed. St. Luke's does not grant exemptions to Observers for required immunizations.

REQUIRED IMMUNIZATIONS

Two documented doses of MMR vaccine or MMR titers (IgG) showing immunity to each of the 3 diseases:			
*Live virus vaccines (MMR) affect accuracy of Tuberculin Skin Test (TST/PPD); please complete at least one TST dose at the same time or prior to receiving the MMR vaccine.			
MEASLES	_____ Dose 1	_____ Dose 2	OR _____ Date & result of Measles Titer (provide copy of positive/immune IgG)
MUMPS	_____ Dose 1	_____ Dose 2	OR _____ Date & result of Mumps Titer (provide copy of positive/immune IgG)
RUBELLA	_____ Dose 1		OR _____ Date & result of Rubella Titer (provide copy of positive/immune IgG)

Two documented doses of Chickenpox vaccine or Varicella titer (IgG) showing immunity:			
*Live virus vaccines (Varicella) affect accuracy of Tuberculin Skin Test (TST/PPD); please complete at least one TST dose at the same time or prior to receiving the Varicella vaccine.			
History of Chickenpox			
*Having disease does NOT meet this requirement; please continue below...			
Chickenpox (Varicella)	_____ Dose 1	_____ Dose 2	OR _____ Date & result of Varicella Titer (provide copy of positive/immune IgG)

Up-to-date TDAP (Tetanus-Diphtheria-Pertussis) is required
*If last Tdap is ≥ 10 years and/or was a Td only; administer a Tdap vaccine now
Most recent TDAP administration DATE: _____

(Side 2) Name:
TB Questionnaire: Please complete and submit as part of the health history clearance
Employee Health TB Questionnaire received/reviewed <input type="checkbox"/>

Influenza (Flu shot): SLUHN requires mandatory influenza vaccination for anyone in the Network between Oct 1 to March 31 <i>or longer depending on influenza activity.</i>
Most recent flu shot administration date:

COVID19 Vaccination: Check box of which vaccine was administered and include dates
DATES: _____ VACCINE: <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> J&J

OPTIONAL IMMUNIZATIONS

Hepatitis B Vaccine Series: Documentation of 3 vaccine doses or titer showing immunity are strongly encouraged for those with risk of exposure to BBF. <i>Declination requires signature.</i>			
Hepatitis B Vaccine Series:			
_____	_____	_____	_____ / _____
Dose 1	Dose 2	Dose 3	HBsAb: Date/result (provide copy)
Declination of Hepatitis B vaccine at this time: _____			
Signature			Date

CLEARANCE: Must be completed & signed by a licensed Healthcare Professional
Incomplete forms will not be reviewed.

<i>I certify that the information contained in this document is true, accurate, and complete according to the medical records available to me.</i>		
_____	_____	_____
Signature of Health Care Professional	Printed Name	Date
Title of HC professional:	Name of Practice:	

Review and clearance completed by SLUHN Network Employee Health Services:

Immunizations/Titers up-to-date: YES, Cleared NO, Need:		
Reviewed by:	Title:	Date:
Follow up (when indicated) by SLUHN Network Employee Health Services:		
F/U review completed by:	Title:	Date:
Records complete upon final review: YES NO Need:		

ImmunizationhistorycertificationVOLN2016.doc; last revision: 3/9/22

TUBERCULOSIS EDUCATION - ONBOARDING

The following information is based on the TB Guidelines from the Centers for Disease Control and Prevention (CDC) for healthcare personnel (HCP) MMWR 5/17/19

ONBOARDING: New hires are screened for TB at the time of the pre-employment physical, including a symptom evaluation, TB blood test for those without documented prior TB disease or infection, and individual TB risk assessment.

ONGOING SCREENING: Annual TB education is recommended for all HCP including information on TB exposure risk. **For volunteers:** leave of absence >3months, complete TBQ, if answer yes to one or both of last 2 risk assessment questions, exclude from volunteering and evaluate by PCP.

POSITIVE TEST: Treatment is encouraged for all HCP with untreated latent TB infection (LTBI) unless medically contraindicated.

EXPOSURES: After a known exposure to potentially infectious TB disease, HCP should have a timely symptom evaluation, TB testing (if no prior positive result), and additional testing if indicated. Those with initial negative tests should be retested 8–10 weeks after exposure. HCP with documented prior TB infection or disease are not retested but should have further evaluation if a concern for TB disease exists.

RISKS: HCP might have risks for TB exposure that are not related to their work in the U.S., or they might have risks for TB progression after baseline testing that necessitate special consideration, when these risks are unrecognized, HCP might experience TB disease and then transmit TB to others. Therefore, health care facilities should educate all HCP annually about TB, including risk factors, signs, and symptoms; in addition to encouraging HCP to discuss any potential occupational or non-occupational TB exposure with their primary care provider, employee health, or occupational medicine clinician. Certain groups might be at increased occupational risk for TB exposure such as pulmonologists and respiratory therapists. Some work settings might have a higher risk such as emergency departments and bronchoscopy units. Factors influencing risk of exposure include the number of patients with infectious pulmonary TB who are examined in these areas and delays in initiating airborne isolation precautions.

TB FACTS: TB is a disease which usually affects the lungs, typically spread from person to person through the airborne route when the person with active pulmonary TB disease coughs, sneezes, or speaks. It is caused by a bacterium called Mycobacterium Tuberculosis (MTB).

SYMPTOMS: Include a feeling of weakness, weight loss, fever, night sweats, chest pain, and coughing up blood.

PPE: HCP caring for patients with TB need to use appropriate respiratory protection (N95 particulate respirator) which requires annual fit testing; including when caring for patients placed on airborne precautions and during a cough-inducing procedure like a bronchoscopy. Patients with suspected or confirmed TB need to be placed in private rooms with negative airflow or HEPA filter units, on Airborne Precautions, with the door closed...no one enters without wearing the appropriate mask.

Not everyone infected with TB becomes sick; there are 2 different TB related conditions; Latent TB infection (LTBI) and active TB disease...

LTBI: Latent TB infection is when the TB germs are in the body but the person is not sick or exhibiting TB symptoms because the germs are not active and can not spread to others; however, there is a risk they can develop active TB disease in the future – those with untreated LTBI should be encouraged to be treated.

TB DISEASE: Active pulmonary TB disease is when TB germs are actively multiplying and the person is sick with some or all symptoms of TB, they are capable of spreading the germs to others – those with active MTB disease need to be treated with medication, isolated until proven non-contagious, and take medication exactly as instructed to prevent becoming sick again or developing resistance.

RISK GROUPS: People who are most likely to get sick from TB are those with HIV, people who inject illegal drugs, babies and young children, elderly, people who were not treated correctly for MTB in the past, and people with chronic medical conditions.

TUBERCULOSIS SCREENING QUESTIONNAIRE - ONBOARDING

Name (print): _____
Department: _____
Campus/Location: _____
Phone number: _____ DOB: _____

- Please check **Yes** or **No** to any **NEW** onset of the following symptoms
- Additional testing may be necessary depending on your responses and QFT result
- This form is to remain with the Pre-Employment Physical Exam packet

YES*	NO	History Review
		Positive TB skin test (PPD or TST)
		Positive TB blood test (QFT or T-spot)
		Diagnosis of LTBI or TB disease
		Treatment for LTBI or TB disease
YES*	NO	Symptom Description
		Fatigue, malaise, extreme tiredness
		Unexplained weight loss
		Anorexia or loss of appetite
		Fever of <i>unknown etiology</i>
		Night Sweats <i>unrelated to menopause</i>
		Productive cough lasting more than 2 weeks and <i>not from a cold</i>
		Spitting or coughing up blood
		Chest pain <i>unrelated to cardiac history</i>
YES*	NO	Risk Assessment
		Current or planned immunosuppression
		Temporary or permanent residence (≥ 1 month) in a country with high TB rate
		Close contact with someone who has had infectious TB disease

*Additional explanation: _____

☐ *I read the attached education on TB and responded to all symptoms honestly and truthfully and I understand that if I have questions, develop any of these symptoms, or believe I was in contact with or exposed to a patient with active TB disease, I should contact Network Employee Health Services*

Signature: _____ Date: _____

Employee Health: Complete this section if YES is checked above or QFT result is positive/indeterminant

Reviewed by: _____ Date: _____
Chest X-ray: _____
QFT: _____ Repeat QFT: _____
Comments: _____