UCDAVIS MEDICAL CENTER

# 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. Two-step Tuberculin Intermediate Skin Test (PPD):**

Test 1 Date: ____/____/_____ Reading: ____/____/_____ Results: _____ MM Induration: ☐ Neg ☐ Pos**

Test 2 Date: ____/____/_____ Reading: ____/____/_____ Results: _____ MM Induration: ☐ Neg ☐ Pos**

**B. QuantiFERON:** Test Date: ____/____/_____ Results: _____

Date of Annual TB Symptoms Interview: _____/____/_____ ☐ Neg ☐ Pos**

History of BCG Vaccination: ☐ Yes ☐ No

(BCG is a vaccine given to those born outside the US.)

**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: September – April)

**FLU Vaccine:** 1. ____/_____/_____

### Direct Patient Care Contact Requires— Hepatitis B and C (Hep C is Recommended)

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

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

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

***Note to UCDH dept:** Hep B Vaccination Agreement must be included if a negative titer result is indicated above.

### Ishihara Color Screening

**A. Color Vision Test:** ☐ Normal ☐ Abnormal

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: