EMPLOYEE HEALTH SERVICES
PRE-PLACEMENT TUBERCULOSIS HISTORY AND EVIDENCE OF IMMUNITY

See GENERAL INSTRUCTIONS on last page.

FOR NON-DHS/NON-COUNTY WFM

<table>
<thead>
<tr>
<th>LAST NAME:</th>
<th>FIRST, MIDDLE NAME:</th>
<th>BIRTHDATE:</th>
<th>E or C#:</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-MAIL ADDRESS:</td>
<td>HOME/CELL PHONE #:</td>
<td>DHS FACILITY:</td>
<td>DEPT/WORK AREA/UNIT:</td>
</tr>
<tr>
<td>JOB CLASSIFICATION:</td>
<td>NAME OF SCHOOL/EMPLOYER/AGENCY/SELF:</td>
<td>AGENCY CONTACT PERSON:</td>
<td>AGENCY PHONE #:</td>
</tr>
</tbody>
</table>

In accordance with Los Angeles County, Department of Health Services policy 705.001, Title 22, and CDC guidelines all contactors/students/volunteers working at the health facilities must be screened for communicable diseases prior to assignment. This form must be signed by a healthcare provider attesting all information is true and accurate OR workforce member may supply all required source documents to DHS Employee Health Services to verify.

SECTION 1: FOR WORKFORCE MEMBER TO COMPLETE

TUBERCULOSIS SYMPTOM REVIEW – Check all appropriate boxes

- [ ] No [ ] Yes Cough lasting more than 3 weeks
- [ ] No [ ] Yes Coughing up blood
- [ ] No [ ] Yes Unexplained/unintended weight loss (> 5 LBS)
- [ ] No [ ] Yes Night sweats (not related to menopause)
- [ ] No [ ] Yes Fever/chills
- [ ] No [ ] Yes Excessive sputum

If you have any of the above symptoms, you should meet with your provider to determine whether a chest x-ray is indicated.

SECTION 2: FOR HEALTHCARE PROVIDER TO COMPLETE OR MUST PROVIDE SOURCE DOCUMENTS

TUBERCULIN SKIN TEST RECORD

<table>
<thead>
<tr>
<th>DATE PLACED</th>
<th>STEP</th>
<th>MANUFACTURER</th>
<th>LOT #</th>
<th>EXP</th>
<th>SITE</th>
<th>*ADM BY (INITIALS)</th>
<th>DATE READ</th>
<th>*READ BY (INITIALS)</th>
<th>RESULT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>mm</td>
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<tr>
<td>2nd</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>mm</td>
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</tbody>
</table>

If either result is positive, send for CXR and complete Section C below.

OR

B Negative IGRA: QuantiFERON or Tspot (<12 months)

Date: Results

LA County [ ]
Outside Document [ ]

STATUS

If CXR is positive for active TB, DO NOT CLEAR for hire/assignment.
Refer Workforce Member for immediate medical care.

C Positive TST (no date requirement)

Date: Results mm

LA County [ ]
Outside Document [ ]

STATUS

OR

CXR (at or after date of +TST)

Date: Results ______________

LA County [ ]
Outside Document [ ]

STATUS

CONTINUE ON NEXT PAGE
### PRE-PLACEMENT TUBERCULOSIS HISTORY AND EVIDENCE OF IMMUNITY

**CONFIDENTIAL**

**PAGE 2 OF 4**

<table>
<thead>
<tr>
<th>LAST NAME</th>
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<th>BIRTHDATE</th>
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</table>

<table>
<thead>
<tr>
<th>D</th>
<th>Positive IGRA: QuantiFERON or Tspot (no date requirement)</th>
<th>Date:</th>
<th>Results</th>
<th>LA County</th>
<th>Outside Document</th>
</tr>
</thead>
<tbody>
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<table>
<thead>
<tr>
<th>D</th>
<th>CXR (at or after date of +IGRA)</th>
<th>Date:</th>
<th>Results</th>
<th>LA County</th>
<th>Outside Document</th>
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</table>

**OR**

<table>
<thead>
<tr>
<th>E</th>
<th>History of Active TB with Treatment</th>
<th>Date:</th>
<th>__months with ___</th>
<th>LA County</th>
<th>Outside Document</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>E</th>
<th>CXR (after date of completed Tx)</th>
<th>Date:</th>
<th>Results</th>
<th>LA County</th>
<th>Outside Document</th>
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<tbody>
<tr>
<td></td>
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</table>

**OR**

<table>
<thead>
<tr>
<th>F</th>
<th>History of LTBI Treatment</th>
<th>Date:</th>
<th>__months with ___</th>
<th>LA County</th>
<th>Outside Document</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>F</th>
<th>CXR (at or after date of Tx)</th>
<th>Date:</th>
<th>Results</th>
<th>LA County</th>
<th>Outside Document</th>
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</thead>
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</tbody>
</table>

**AND**

### IMMUNIZATION DOCUMENTATION HISTORY (MANDATORY)

<table>
<thead>
<tr>
<th>Titer</th>
<th>Titer Result Date</th>
<th>Titer Result</th>
<th>If not immune, give Vaccination x 2, unless Rubella x 1</th>
<th>Date Received</th>
<th>Vaccine Received</th>
<th>Declined Vaccination (may be restricted from hospital/patient care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>☐ Decline only for true medical contraindication, must include medical documentation</td>
</tr>
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<td></td>
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<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>☐ Decline only for true medical contraindication, must include medical documentation</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubella</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>☐ Decline only for true medical contraindication, must include medical documentation</td>
</tr>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>☐ Decline only for true medical contraindication, must include medical documentation</td>
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</tr>
</tbody>
</table>

**AND**

<table>
<thead>
<tr>
<th>Vaccination</th>
<th>Date Received</th>
<th>Date of Declination Signed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus-diphtheria (Td) every 10 years</td>
<td></td>
<td>OR</td>
</tr>
<tr>
<td>Acellular Pertussis (Tdap) X 1</td>
<td></td>
<td>OR</td>
</tr>
</tbody>
</table>

**AND**

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### Vaccination (MANDATORY to offer to WFM who have potential to be exposed to blood or body fluid)

<table>
<thead>
<tr>
<th>Date</th>
<th>Titer</th>
<th>AND</th>
<th>Date</th>
<th>Vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(Engerix-B or Recombivax)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(HepB series)</td>
</tr>
</tbody>
</table>

- **Reactive**
- **Non-reactive**

If not reactive, vaccinate with HepB series

**OR**

**Date**

**Declination signed**

**Date**

**HbcAb/anti-HBc**

- **Non-reactive**
- **Reactive**

**Date**

**HbsAg**

- **Non-reactive**
- **Reactive**

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### Seasonal Influenza (one dose for current season)

**Note:** Must wear mask during influenza season.

**OR**

**Date Declination Signed**

**OR**

**Date of future appointment**

**OR**

**Not Vaccinated**

### Respiratory Fit Testing (Must be < 12 months from annual date)

<table>
<thead>
<tr>
<th>Date</th>
<th>Passed on</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N95 Honeywell DF300 Standard</td>
</tr>
<tr>
<td></td>
<td>Maxair PAPR 700</td>
</tr>
<tr>
<td></td>
<td>Maxair CAPR DLC36</td>
</tr>
<tr>
<td></td>
<td>Halyard 46827/76827 Small</td>
</tr>
<tr>
<td></td>
<td>N95 Halyard 46727/76727 Regular</td>
</tr>
<tr>
<td></td>
<td>N/A (Job duty does not involve airborne precautions or require a respirator)</td>
</tr>
</tbody>
</table>

### Color Vision (MANDATORY for WFM working with point of care testing)

<table>
<thead>
<tr>
<th>Date</th>
<th>Pass</th>
<th>Fail</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

- **Pass**
- **Fail**
- **N/A** (Job duty does not involve POC testing or electrical)

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### For Healthcare Provider:

- I attest that all dates and immunizations listed above are correct and accurate.

**Date:**

**Physician or Licensed Healthcare Professional Signature:**

**Print Name:**

**Facility Name/Address:**

**Phone #:**

- **OR**

### For Workforce Member:

- Required source documents attached.

**Workforce Member Signature:**

**Date:**

### DHS-EHS Staff Only

- WFM completed pre-placement health evaluation.

**Signature:**

**Print Name:**

**Today’s Date:**

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## GENERAL INSTRUCTIONS FOR EACH SECTION

### TUBERCULOSIS DOCUMENTATION HISTORY

**ALL WORKFORCE MEMBER (WFM) SHALL BE SCREENED FOR TB UPON HIRE/ASSIGNMENT**

#### A
- WFM shall receive a baseline TB screening using two-step Tuberculin Skin Test (TST).
  - **Step 1:** Administer TST test, with reading in seven days.
  - **Step 2:** After Step 1 reading is negative, administer TST test, with reading within 48-72 hours. If both readings are negative, WFM is cleared to work. WFM shall receive either TST or IGRA and symptom screening annually.
    - a. Documentation of negative TST within 12 months prior to placement will be accepted. WFM shall receive a one-step TST with reading within 48-72 hours. If result is negative, WFM is cleared to work.
    - b. Documentation of negative two-step TST within 12 months prior to placement will be accepted. WFM is cleared to work.

If TST is positive, record results and continue to Section C.

#### B
- WFM shall receive a baseline TB screening using a single blood assay for M. tuberculosis (IGRA). If negative result, WFM is cleared to work. WFM shall receive either TST or IGRA and symptom screening annually.
  - a. Documentation of negative IGRA within 12 months will be accepted. WFM is cleared to work.

If IGRA is positive, record results and continue to Section D.

#### C
- **TST POSITIVE RESULTS**
  - If CHEST X-RAY IS POSITIVE, DO NOT CLEAR FOR HIRE/ASSIGNMENT, AND REFER WORKFORCE MEMBER FOR IMMEDIATE MEDICAL CARE

  - **Section A:** if TST is positive during testing in Section A or C above, send for a chest x-ray (CXR). If CXR is negative, WFM is cleared to work. Documentation of negative CXR at or after first positive TST will be accepted for clearance to work as long as TB symptom screening is negative.
  - **Section B:** if IGRA is positive during testing in Section B above, send for an IGRA. If IGRA is negative, WFM is cleared to work. Documentation of negative IGRA at or after first positive TST will be accepted for clearance to work as long as TB symptom screening is negative.

#### D
- If WFM have a documented history of active TB, send for a chest x-ray (CXR). If CXR is negative, WFM is cleared to work. Documentation of negative CXR < 12 months of start date will be accepted for clearance to work as long as TB symptom screening is negative. If documentation is supported, WFM is cleared to work.

#### E
- If WFM have a documented history of latent tuberculosis infection (LTBI) treatment TB, send for a chest x-ray (CXR). If CXR is negative, WFM is cleared to work. Documentation of negative CXR after LTBI treatment will be accepted for clearance to work as long as TB symptom screening is negative.

#### F
- If WFM have a documented history of latent tuberculosis infection (LTBI) treatment TB, send for a chest x-ray (CXR). If CXR is negative, WFM is cleared to work. Documentation of negative CXR after LTBI treatment will be accepted for clearance to work as long as TB symptom screening is negative.

### IMMUNIZATION DOCUMENTATION HISTORY

Documentation of immunization or adequate titers will be accepted. If WFM is not immune against communicable diseases as listed in this section, WFM shall be immunized (unless medically contraindicated). WFM who declines the vaccination(s) must sign the mandatory declination form. WFM who declines the vaccination(s) may be restricted from patient contact.

#### A
- **IMMUNIZATION DOCUMENTATION HISTORY**
  - **Step 1:** Administer TST test, with reading in seven days.
  - **Step 2:** After Step 1 reading is negative, administer TST test, with reading within 48-72 hours. If both readings are negative, WFM is cleared to work. WFM shall receive either TST or IGRA and symptom screening annually.
    - a. Documentation of negative TST within 12 months prior to placement will be accepted. WFM shall receive a one-step TST with reading within 48-72 hours. If result is negative, WFM is cleared to work.
    - b. Documentation of negative two-step TST within 12 months prior to placement will be accepted. WFM is cleared to work.

If TST is positive, record results and continue to Section C.

#### B
- WFM shall receive a baseline TB screening using a single blood assay for M. tuberculosis (IGRA). If negative result, WFM is cleared to work. WFM shall receive either TST or IGRA and symptom screening annually.
  - a. Documentation of negative IGRA within 12 months will be accepted. WFM is cleared to work.

If IGRA is positive, record results and continue to Section D.

#### C
- If TST is positive during testing in Section A or C above, send for a chest x-ray (CXR). If CXR is negative, WFM is cleared to work. Documentation of negative CXR at or after first positive TST will be accepted for clearance to work as long as TB symptom screening is negative.

#### D
- If IGRA is positive during testing in Section B above, send for a CGA. If CGA is negative, WFM is cleared to work. Documentation of negative IGRA at or after first positive TST will be accepted for clearance to work as long as TB symptom screening is negative.

#### E
- If WFM have a documented history of active TB, send for a chest x-ray (CXR). If CXR is negative, WFM is cleared to work. Documentation of negative CXR < 12 months of start date will be accepted for clearance to work as long as TB symptom screening is negative. If documentation is supported, WFM is cleared to work.

#### F
- If WFM have a documented history of latent tuberculosis infection (LTBI) treatment TB, send for a chest x-ray (CXR). If CXR is negative, WFM is cleared to work. Documentation of negative CXR after LTBI treatment will be accepted for clearance to work as long as TB symptom screening is negative.

### RESPIRATORY FIT TEST

If WFM job assignment requires a N95 respirator, WFM must be fit tested for the N95 respirator. If WFM job assignment involves Airborne Infection Isolation Rooms (AIIR), WFM will need to be fit tested. Include manufacture, model and size of N95 WFM passed fit testing on.

### COLOR VISION

If WFM job assignment involves Point-of-Care testing or electrical duties, WFM will need to be tested for Color Vision (Mandatory for WFM working with Point-of-Care testing).

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This form and its attachment(s), if any, such as medical records shall be maintained and filed at non-DHS/non-County workforce member’s School/Employer. The School/Employer shall verify completeness of DHS-Employee Health Services (EHS) form(s) and ensure confidentiality of non-DHS/non-County WFM health information.

Upon request by DHS-EHS, the non-DHS/non-County WFM School/Employer shall have this form and its attachment(s) readily available within four (4) hours.

All workforce member health records are confidential in accordance with federal, state and regulatory requirements.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual’s family member’s genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. 29 C.F.R. Part 1635

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