UCLA Health

VOLUNTEER SERVICES

MEDICAL CLEARANCE FORM

Name _____ Date of Birth _____/_____/_____

To ensure the safety of volunteers, patients, clients and staff, all individuals providing service for UCLA Health must be screened for potentially infectious diseases and conditions, as recommended by the Centers for Disease Control and Prevention.

Individual must obtain medical clearance, as delineated on this form, by a licensed healthcare provider prior to volunteering on UCLA Health premises. Once complete, forms must be uploaded to your dashboard for Volunteer Office for review and approval.

1. Immunity to Measles, Mumps, Rubella and Varicella - Individual must have proof of immunity, (e.g. blood titers) to the following conditions or vaccination records for 2 MMR and 2 Varicella Vaccines.
   Measles Mumps Rubella Varicella
2. Evidence of COVID Vaccine(s) - Proof of having received the mandated COVID vaccine(s).

   Type of vaccine: _____ Date of Vaccine #1: _____ Date of Vaccine #2: _____

   Type of booster (if eligible): _____ Date of booster: _____
3. Tuberculosis Testing - Individual must be tested for Tuberculosis by Quantiferon (QFT) blood test or TSpot AND be free of active tuberculosis. TB Skin tests are not acceptable. If individual has history of positive TB test, a negative chest X-ray is required in lieu of a TB blood test. TB blood test/X-ray must be completed within the last 3 months.

   TB Test Type (Blood test or X-ray): _____TB Result: _____ Date of TB Test: _____
4. Tetanus-diphtheria-pertussis Vaccine - Individual must either have documentation of Tdap (Tetanus, Diphtheria, and Pertussis) vaccine or sign a declination for the Tdap vaccine (Addendum I).
5. Hepatitis B Vaccination- Individual must either demonstrate immunity to Hepatitis B (blood titers), or sign a declination for Hepatitis B vaccine (Addendum II).
6. Flu Vaccine - Required annually during flu season (November-April) only.
   Date of Flu Vaccine: _____

Licensed Healthcare Provider Statement:

I certify that this individual has met the above-described health clearance criteria and does not represent a communicable disease safety risk or risk in a hospital environment.

Licensed Healthcare Provider Name _____

Office Phone (_____) _____

Address_____

License # _____

Signature _____Date _____/_____/_____

Revised 1/27/2022

Addendum I

Hepatitis B Vaccine Declination

I understand that as a volunteer at UCLA Health I may be exposed to to blood or other potentially infectious materials, I may be at risk of acquiring hepatitis B virus (HBV) infection.

(Please check appropriate box)

☐ **I would like to receive the Hepatitis B Vaccine.**

Hepatitis B Vaccine Declination (mandatory)

☐ I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to me; 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, I can receive the vaccination series.**

I decline the Hepatitis B Vaccination Series due to the following reason(s):

(Please mark at least one choice)

- ☐ I have previously completed a hepatitis B 3-vaccine series with written documentation and choose not to repeat the vaccine series at this time.
- ☐ I have previously completed a hepatitis B 3-vaccine series, but I do not have written documentation and choose not to repeat the vaccine series at this time.
- ☐ I have been diagnosed with hepatitis B in the past.
- ☐ Other_____

_____ _____

Signature Date Date of Birth

_____

Print Name

Addendum II

Tdap Vaccine Declination

I understand that as a volunteer at UCLA Health I may be exposed to aerosol transmissible diseases, I may be at risk of acquiring infection with Pertussis.

(Please check appropriate box)

☐ **I would like to receive the Tdap vaccine.**

Tdap Vaccine Declination (mandatory)

☐ I have been given the opportunity to be vaccinated against this disease or pathogen at no charge to me. However, I decline this vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Pertussis, a serious disease. **If in the future I continue to have occupational exposure to aerosol transmissible diseases and want to be vaccinated, I can receive the vaccination.**

☐ I am declining because I choose not to have the Tdap vaccination. I am aware that I may change my mind at a later date.

☐ I have already received a Tdap vaccination. I have a record or know the date and location of that vaccination.

☐ I have already received a Tdap vaccination. I do not have a record or cannot recall when I received the vaccination.

☐ Other _____

_____ _____

Signature Date Date of Birth

_____

Print Name