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 dashboard for Volunteer Office 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.
   MMR Vaccine #1: _____ MMR Vaccine #2: _____ OR Positive Titer Date: _____

   Varicella Vaccine #1: _____ Varicella Vaccine #2: _____ OR Positive Titer Date: _____

   Comments: _____
2. COVID Vaccine – Individuals must either have the most recent COVID vaccine or complete a declination in volunteer portal.

   Date of Vaccine: _____
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 received after age 12 and within the past 10 years or complete a declination in volunteer portal.

   Has individual been vaccinated for Tdap? If yes (add date here): _____
5. Hepatitis B Vaccination - Individual must either demonstrate immunity to Hepatitis B (blood titers) or complete a declination in volunteer portal.
6. Flu Vaccine - Required annually during flu season (November-April) only. Individuals must either have the most recent flu vaccine or complete the declination in volunteer portal.

   Date of Flu Vaccine: _____

General Comments: _____

_____

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 _____ License # _____

Office Phone (_____) _____ Address_____

Signature _____ Date _____/_____/_____

Revised 9/11/2024