UNIVERSITY OF UTAH HEALTH CARE
EMPLOYEE HEALTH CLINIC

Employee Health REQUIREMENTS Documentation

PLEASE PRINT LEGIBLY

Employee Name:____ DOB:__________ Orientation Date: ____________
Last, First Middle

Employee UID#:______________________ Job Title: ____________________________ Supervisor's Name: ____________________

Department ID #: _______________ Department Name: ___________________________________ Facility: ________________________

Please read and sign: University of Utah Health Care may verify all of the information listed on this form. I understand that being hired, and my continued employment, may depend on the truthfulness of the information provided.

Employee Signature: __________________________________ **Cell/Home Phone #:**____________________ Today's Date:______________

Requirement	Documentation	Clinic Use Only
Two Step TB Skin Testing (TST): **Must provide documentation** of one negative TST completed within 12 months of hire date, **AND** one TST completed within 2 months of hire date that was evaluated by a qualified reader and documented in MM. If prior TST positive, **must provide documentation** of a negative chest x-ray completed within 12 months prior to hire date. **TST #1:** (**self evaluate**) Employee evaluates 1st TST 48-72 hours after placement and signs off IF there is no swelling or hard raised area present. **TST #2:** (placed no sooner than 7 days after TST #1 was placed) Must be evaluated 48-72 hours after placement by a qualified reader and documented in MM. *Call the Employee Health Clinic at 801-581-2227 to locate a qualified reader if needed.	**TST #1** Date Placed: __________ Placed by: __________________________ Please self evaluate 48-72 hours after placement. **IF swollen, hard or raised do not sign off, RETURN to Employee Health Clinic.** If okay sign below. Date Evaluated: __________ Employee Signature:______________________ **AND** **TST #2** to be placed no sooner than __________ and **NOT on a Thursday** Date Placed: __________ Placed by: __________________________ Date Evaluated: __________ Evaluated by: ______________________ Result of TST #2 MUST be documented in millimeters: _________ MM OR **If Previous TST+** DATE TST+:__________ Result in MM: __________ **Quantiferon TB Gold** Date drawn______________ Negative: ☐ Positive: ☐ Chest X-ray Date:__________ Chest X-ray Results:___________________	
MMR (Measles/Mumps/Rubella): ***If born 1957 or later***, **<u>must provide documentation</u>** of two MMR immunizations OR of a titer that proves immunity OR documentation from a health care provider of confirmed disease. ***If born before 1957***, laboratory evidence of immunity status is required: must receive MMRs if there is a measles, mumps, or rubella outbreak.	MMR #1: __________ ☐ MMR #2: __________ ☐ OR Measles (Rubeola) Titer Date: __________ Result: __________ Mumps Titer Date: __________ Result:__________ Rubella Titer Date: __________ Result: __________	
Varicella (Chickenpox): Must provide documentation of 2 varicella vaccinations OR of a varicella titer that proves immunity OR documentation from the MD who treated/ evaluated you **when you had chicken pox.**	Varicella #1: __________ ☐ Varicella #2: __________ ☐ OR Varicella Titer Date: __________ Result: __________ OR Date of MD documented disase: __________	
Hepatitis B: Employees who may come in contact with blood or body substances, soiled equipment, or specimens from patients **must provide documentation** of three appropriately spaced Hepatitis B immunizations AND a Hepatitis B titer that proves immunity.	Hepatitis B #1: __________ ☐ Hepatitis B #2: __________ ☐ Hepatitis B #3: __________ ☐ AND Hepatitis B Antibody Titer Date: __________ Result:__________ *Hepatitis B #4: ____________ ☐ (*If needed) *Hepatitis B Antibody Titer Date: __________ Result:__________	
Tetanus-Diphtheria-Pertussis (Tdap): Must provide documentation of Tdap immunization within the past 10 years regardless of time since last tetanus-diphtheria (Td) vaccine.	Date of last Tetanus-Diphtheria-Pertussis (Tdap): __________ ☐	
Influenza: ANNUALLY during influenza season (Oct-May), ALL EMPLOYEES **must provide documentation** of a current influenza vaccination OR a current **official** influenza exemption for an **accepted valid** reason.	Date of CURRENT influenza vaccination: __________	

You MUST provide supporting documentation for each of these requirements, dates alone are not sufficient.

*Please call the Employee Health Clinic for any questions at **(801) 581-2227***
*You may fax records as needed to the Employee Health Clinic's confidential **fax at (801) 585-2222***

June 2014