HEALTH
UNIVERSITY OF UTAH

Employee Health REQUIREMENTS Documentation

PLEASE PRINT LEGIBLY

ONLY fill out what you know on the first page. Employee Health will complete the second page.

Employee Name: _____
Last First Middle Initial

Employee UID#:_____

Date of Birth:_____ Cell or personal number: _____

Email (personal or work): _____

Orientation Date: _____ Job Title:_____

Supervisors Name: _____ Department Name:_____

Facility: Main Hospital, Huntsman, Neilsen Rehab Hospital, Ortho, Moran, Neuro Sciences, HMHI
Community Clinic: _____ Other: _____

Have you ever previously worked for University of Utah Health? (circle one) yes no

Check box if you consent:

☐ **If I have any immunization records documented in the Utah Statewide Immunization Information System (USIIS), I agree to allowing Work Wellness to access those records for the purpose of verifying and documenting my work-related immunizations.**

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: _____ Date:_____

Page 2 is for internal clinic use only.

This page for clinic use only **Name and UID** _____

Two Step TB Skin Testing (TST) or QFG: **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. **TB Blood Test (QFG, T-Spot):** Within the 12 months before date of hire	**TST #1** Date Placed:_____ Date read (if read in clinic): _____ Result in mm: _____ **AND** **TST #2 (**to be placed no sooner than 7 days after previous placement) Date placed: _____ Date read: _____ Results in mm: _____ Interpretation: _____ ****Quantiferon Gold or T spot within 1 yr of start may substitute for two skin tests:** **QFG date**_____ Results_____ **If previously treated for TB or latent TB, CXR within a year of start:** Chest X-ray DATE: _____ Chest X-ray RESULT: ___	**Clinic Use Only**
MMR (Measles/Mumps/Rubella): **Must provide documentation** of two MMR immunizations OR of a titer that proves immunity. Healthcare workers born before 1957 were likely exposed and immune.	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.	Varicella #1:_____☐ Varicella #2:_____☐ OR Varicella Titer Date:_____ Result:_____	
Hepatitis B: Employees who may come into contact with blood or body substances, soiled equipment, or specimens from patients **must provide documentation** of a Hepatitis B titer that proves immunity.	Hepatitis B #1:_____☐ Hepatitis B #2:_____☐ Hepatitis B #3:_____☐ AND/OR Hepatitis B Antibody Titer Date:_____ Result:_____ Hepatitis B #4:_____☐ Hepatitis B #5:_____☐ Hepatitis B #6:_____☐ Repeat Hepatitis B Draw Date: _____ Antibody :_____ Core: _____ Antigen: _____	
Tetanus-Diphtheria-Pertussis (Tdap): Must provide documentation of Tdap immunization once as an adult, and Td or Tdap within 10 years.	Date of last Tetanus-Diphtheria-Pertussis (Tdap): _____ ☐ Last Td_____	
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: _____ OR Date of CURRENT accepted valid influenza exemption:_____	
COVID vaccine required by policy ALL EMPLOYEES **must provide documentation** of a current COVID vaccination OR a current **official** COVID exemption for an **accepted valid** reason.	Date of #1_____ Moderna Pfizer J&J Other Date of #2_____ Moderna Pfizer J&J Other Date of #3_____ Moderna Pfizer J&J Other Date of #4_____ Moderna Pfizer J&J Other Date of #5_____ Moderna Pfizer J&J Other	

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***

February 2023