B-NC

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES

CONFIDENTIAL
NON-DHS/NON-COUNTY WORKFORCE MEMBER TUBERCULOSIS HISTORY AND EVIDENCE OF IMMUNITY

☞ See General Instructions on Last Page

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:

HOME ADDRESS:	CITY	STATE:	ZIP CODE:

E-MAIL ADDRESS:	HOME PHONE NO.:	CELL PHONE NO.:

JOB CLASSIFICATION:	WORK FACILITY:	DEPARTMENT:	WORK AREA/UNIT:	SHIFT:

NAME OF SCHOOL/EMPLOYER *(If applicable)*:	PHONE NO.:	CONTACT PERSON:
Santa Monica College	310-434-3453	Dr. Ida Maria Danzey

NON-DHS/NON-COUNTY WORKFORCE MEMBER (WFM) TO COMPLETE

TUBERCULOSIS QUESTIONNAIRE

YES	NOT SURE	NO	
			TUBERCULOSIS (TB) HISTORY
☐	☐	☐	1. Do you have history of a negative TB skin test?
☐	☐	☐	2. Do you have documentation of your negative test from the last 12 months?
☐	☐	☐	3. Do you have a history of a positive TB skin test?
☐	☐	☐	4. Do you have documentation of your positive skin test in millimeters?
☐	☐	☐	5. Do you have documentation of a chest X-ray within the last year?
☐	☐	☐	6. Have you received treatment for TB (INH)?
☐	☐	☐	If "yes", how many months?_____
☐	☐	☐	7. Do you have treatment documentation?
☐	☐	☐	8. Have you ever been diagnosed as having active or infectious TB?
☐	☐	☐	9. Have you received a TB vaccine called BCG?
☐	☐	☐	10. Have you had a weakened immune system due to (check all that applies):
☐	☐	☐	☐ Chemotherapy ☐ HIV ☐ Organ transplant ☐ Leukemia ☐ Cancer or medications ☐ Hodgkin's Disease ☐ Steroids (e.g., prednisone)
☐	☐	☐	11. Would you like to be tested for HIV?
			TUBERCULOSIS (TB) SCREENING
☐	☐	☐	12. Do you have a cough lasting longer than three (3) weeks?
☐	☐	☐	13. Do you cough up blood?
☐	☐	☐	14. Do you have unexplained or unintended weight loss?
☐	☐	☐	15. Do you have night sweats (not related to menopause)?
☐	☐	☐	16. Do you have a fever or chills?
☐	☐	☐	17. Do you have excessive sputum?
☐	☐	☐	18. Do you have excessive fatigue?
☐	☐	☐	19. Have you had recent close contact with a person with TB?

NON-DHS/NON-COUNTY WORKFORCE MEMBER SIGNATURE	DATE

LAST NAME	FIRST NAME	BIRTHDATE	IDENTIFICATION NO.

EMPLOYEE HEALTH STAFF – OR – DESIGNATED WFM AGENCY TO COMPLETE

TUBERCULOSIS DOCUMENTATION HISTORY

A

TUBERCULIN SKIN TEST RECORD
0.1 ml of 5 tuberculin units (TU) purified protein derivative (PPD) antigen intradermal

DATED PLACED	STEP	MANUFACTURER	LOT #	EXP	SITE	*ADM BY (INITIALS)	DATE READ	*READ BY (INITIALS)	RESULT	STATUS Indicate: Reactor Non-Reactor Converter
	1st									
	2nd									

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

OR

B	Negative BAMT (<12 months)	Date:	Results	☐ LA County ☐ Outside Document	**STATUS**

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

C	Positive TST	Date:	Results _____mm	☐ LA County ☐ Outside Document	**STATUS**
	CXR (<12 months)	Date:	Results_____	☐ LA County ☐ Outside Document	

OR

D	Positive BAMT	Date:	Results_____	☐ LA County ☐ Outside Document	**STATUS**
	CXR (<12 months)	Date:	Results_____	☐ LA County ☐ Outside Document	

OR

E	History of Active TB with Treatment	Date:	_____months with_____	☐ Outside Document	**STATUS**
	CXR (<12 months)	Date:	Results_____	☐ Outside Document	

OR

F	History of LTBI Treatment	Date:	_____months with_____	☐ Outside Document	**STATUS**
	CXR (<12 months)	Date:	Results_____	☐ Outside Document	

CONTINUE ON NEXT PAGE

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	IDENTIFICATION NO.

G — IMMUNIZATION DOCUMENTATION HISTORY

	Date	Titer	If not immune give Vaccination x 2, unless Rubella x 1	Date	Vaccine		Declination Signed
Measles		☐ Immune ☐ Non-Immune ☐ Equivocal ☐ Laboratory confirm of disease	OR			OR	☐ May be restricted from patient care areas
Mumps		☐ Immune ☐ Non-Immune ☐ Equivocal ☐ Laboratory confirm of disease	OR			OR	☐ May be restricted from patient care areas
Rubella		☐ Immune ☐ Non-Immune ☐ Equivocal ☐ Laboratory confirm of disease	OR			OR	☐ May be restricted from patient care areas
Varicella		☐ Immune ☐ Non-Immune ☐ Equivocal ☐ Laboratory confirm of disease	OR			OR	☐ May be restricted from patient care areas

AND

H

Vaccination	Date		Declination Signed
Tetanus-diphtheria (Td) Every 10 years		☐ Verbal ☐ Document	☐
Arcellular Pertussis (Tdap) X 1		☐ Verbal ☐ Document	☐

AND

I

Vaccination (MANDATORY for WFM who have potential to be exposed to blood or body fluid)	Date	Immunity	Declination Signed
Hepatitis B (HBsAb)		☐ Reactive ☐ Non reactive ☐ N/A	☐

AND

J

Vaccination (VOLUNTARY)	Date	Location		Declination Signed
Seasonal Influenza (annually)		PMD, employment, school, flu clinic, other	☐ Verbal ☐ Document	☐

STOP PLEASE ATTACH SUPPORTING DOCUMENTATION(S) WITH THIS FORM

DHS-EHS STAFF ONLY

K	Fit Test (Complete Form N-NC)	Date:	☐ **Pass** ☐ **Fail** ☐ **N/A**
L	FINAL RESOLUTION EHS Health Clearance	Date:	☐ **Pass** ☐ **Restricted** ☐ **Fail**

Completion of this form:	**Reviewed By (Print):**	**Signature:**	**Date:**

GENERAL INSTRUCTION ON NEXT PAGE

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	IDENTIFICATION NO.

GENERAL INSTRUCTIONS

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 BAMT 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 (BAMT). If negative result, WFM is cleared to work. WFM shall receive either TST or BAMT and symptom screening annually. a. Documentation of negative BAMT within 12 months will be accepted. WFM is cleared to work. If BAMT is positive, record results and continue to Section D.
TST POSITIVE RESULTS **If CHEST X-RAY IS POSITIVE, DO NOT CLEAR FOR HIRE/ASSIGNMENT, AND** **REFER WORKFORCE MEMBER FOR IMMEDIATE MEDICAL CARE**	
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 within 12 months prior to placement will be accepted for clearance to work. WFM shall be symptom screened for TB annually.
D	If BAMT is positive during testing in Section D above, send for a CXR. If CXR is negative, WMF is cleared to work. Documentation of negative CXR within 12 months prior to placement will be accepted for clearance to work. WFM shall be symptom screened for TB annually.
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 within 12 months prior to placement will be accepted for clearance to work. If documentation is supported, WFM is cleared to work. WFM shall be symptom screened for TB annually. Record documentation result in this section.
F	If WFM have a documented history of latent tuberculosis infection (LTBI) treatment, send for a chest x-ray (CXR). If CXR is negative, WFM is cleared to work. Documentation of negative CXR within 12 months prior to placement will be accepted for clearance to work. If documentation is supported, WFM is cleared to work. WFM shall be symptom screened for TB annually. Record documentation result in this section.
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 care areas of the hospital or facility. If WFM is non-immune or decides at a later date to accept the vaccination, DHS or WFM contract agency will make the vaccination available.	
G	Documentation of laboratory evidence of immunity or laboratory confirmation of disease will be accepted **OR** documentation of two doses (live measles, mumps and varicella) and one dose of live rubella virus vaccine. Measles vaccine shall be administered no earlier than one month (minimum 28 days) after the first dose. Mumps second dose vaccine vary depending on state or local requirements. Varicella doses shall be at least 4 week between doses for WFM. If Equivocal, WFM needs either vaccination or re-draw with positive titer.
H	**Td** – After primary vaccination, Td booster is recommended every 10 years. If unvaccinated WFM, primary vaccination consists of 3 doses of Td; 4-6 weeks should separate the first and second doses; the third dose should be administered 6-12 months after the second dose. **Tdap** should replace a one time dose of Td for HCP aged 19 though 64 years who have not received a dose of Tdap previously. An interval as short as 2 years or less from the last dose of Td is recommended for the Tdap dose.
I	All WFM who have occupational exposure to blood or other potentially infectious materials shall have a documented post vaccination antibody to Hepatitis B surface antigen HBsAb (anti-HBs). Hepatitis B vaccine series is available to WFM. Non-responders should be considered susceptible to HBV and should be counseled regarding precautions to prevent HBV infection and the need to obtain HBIG prophylaxis for any known or probable parenteral exposure to HBsAg positive blood.
J	Seasonal influenza is offered annually to WFM when the vaccine becomes available.

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

Upon request by DHS-Employee Health Services (EHS), the non-County WFM School/Employer shall have this form and its attachment(s) readily available within four (4) hours at request for review by DHS-EHS. All medical records of non-County workforce member submitted to DHS-EHS are confidential in accordance with federal, state and regulatory requirements.

E2

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES

NON-DHS/NON-COUNTY WORKFORCE MEMBER HEALTH CLEARANCE CERTIFICATION

Instructions:

- **Section A** shall be completed by the Non-County workforce member's physician or licensed health care professional including Department of Health Services (DHS) forms. Once complete, return this certificate along with DHS forms to the Non-County workforce member.
- **Section B** shall be completed by the Non-County workforce member (WFM) authorizing the release of medical information contained on DHS forms as listed in Section A to his/her School/Employer and DHS, Employee Health Services (EHS). Non-County WFM shall return this certificate and DHS forms to his/her School/Employer.
- **Section C** shall be completed by the Non-County WFM's School/Employer. School/Employer shall verify completion of DHS forms in Section A, sign and return this certificate only (Form E2) to DHS-EHS. DHS forms shall be kept at Non-County WFM's School/Employer.

A. TO BE COMPLETED BY A PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	DATE OF HEALTH CLEARANCE:

I certify that the individual identified above have met the Los Angeles County Department of Health Services Pre-placement/Annual health screening requirements AND verified completion of the following DHS forms*:

- ☐ B-NC Tuberculosis History and Evidence of Immunity
- ☐ E-NC Annual Health Screening**
- ☐ K-NC Declination Form, as applicable
- ☐ N-NC FIT Test
- ☐ O-NC Respirator Medical Questionnaire *(for respirators greater than N-95 respirator)*
- ☐ P-NC Appendix B – ATD Respirator Medical Evaluation Questionnaire *(for N-95 respirator)*

PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL SIGNATURE:	DATE:
PRINT NAME:	LICENSE NO.:
FACILITY NAME/ADDRESS:	PHONE NO.:

B. TO BE COMPLETED BY THE NON-COUNTY WORKFORCE MEMBER

I authorize the release of my medical information as listed above in Section A to my School/Employer, and to DHS-EHS upon request for regulatory requirements and auditing purposes. The purpose of releasing my medical information is to meet DHS pre-placement/annual health evaluation requirements. DHS forms shall be maintained and filed at my School/Employer. I understand that my School/Employer and DHS-EHS may not use or disclose my medical information unless another authorization is obtained from me or unless such use or disclosure is specially required or permitted by law.

PRINT NAME:	SIGNATURE:	DATE:

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:

C. TO BE COMPLETED BY THE SCHOOL/EMPLOYER

*DHS forms of Non-County workforce member's medical information shall be maintained and filed at Non-County workforce member's School/Employer. The School/Employer shall ensure confidentiality and meet all privacy regulations of Non-County WFM's medical information.

Annual health screening is a requirement in accordance to DHS policy No. 705.001, Medical Screening, Non-Workforce Member. School/Employer shall ensure the above workforce member completes health screening annually **on or before date of last health screening.

Medical surveillance/post-exposure regulations are the responsibility of WFM's School/Employer. If the school/employer chooses to have DHS-EHS to perform such surveillance/post-exposure services, the WFM's school/employer will be billed accordingly.

The School/Employer have verified completion of DHS forms and have ensure the health clearance requirements are accurate, and upon DHS request, supply supporting documents within four (4) hours to DHS-EHS.

PRINT NAME:	SIGNATURE:		DATE:
E-MAIL ADDRESS:	NAME OF SCHOOL/EMPLOYER:		PHONE NO.:
ADDRESS:		STATE:	ZIP CODE:

PLEASE MAKE A COPY FOR YOUR RECORDS

All medical records of Non-County workforce member submitted to DHS-Employee Health Services are confidential in accordance with federal, state and regulatory requirements.

DHS-EHS STAFF ONLY	
PRINT NAME:	SIGNATURE:
DATE RECEIVED:	DATE NOTIFIED HR:

Distribution:

Original DHS-EHS
Copy Workforce Member or Designee (To submit to area/unit supervisor)

E-NC

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES

CONFIDENTIAL
NON-DHS/NON-COUNTY WORKFORCE MEMBER ANNUAL HEALTH QUESTIONNAIRE & SCREENING

See GENERAL INSTRUCTIONS on Page 3

NON-COUNTY WORKFORCE MEMBER TO COMPLETE

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:

JOB CLASSIFICATION:	WORK FACILITY:	DEPARTMENT:	WORK AREA/UNIT:	SHIFT:

EMAIL ADDRESS:	WORK PHONE:	CELL/PAGER NO.:	SUPERVISOR NAME:

NAME OF SCHOOL/EMPLOYER *(If applicable)*:	PHONE NO.:	CONTACT PERSON:
Santa Monica College	310-434-3453	Dr. Ida Danzey

☐ Home Address Changed Since Last Visit ☐ Job Assignment Change Since Last Visit

Specialty Exam: ☐ Asbestos ☐ Antineoplastic ☐ DOT ☐ Hearing ☐ Color Vision ☐ RFT ☐ HazMat ☐ High Hazard Procedure ☐ Other:_____

MEDICAL HISTORY UPDATE - Check any of the following conditions you have had since your last health evaluation

☐ Chest Pains
☐ Elevated Blood Pressure
☐ Dizziness or Fainting Spells
☐ Any Surgery:_____
☐ Allergies (List):_____

☐ Problems with Mobility
☐ Backache
☐ Bone or Joint Injury
☐ Tingling ,Numbness, Pain in Hands, Wrists, Elbows, or Shoulders
☐ Skin Problem/Rash

☐ Exposure to Communicable Disease: _____
☐ Other:_____

FOOD HANDLERS ONLY:
☐ Change in Bowel Habits
☐ Stomach or Abdominal Pain

TUBERCULOSIS SYMPTOM REVIEW - Check any of the following conditions you have had since your last health evaluation

☐ Cough lasting more than 3 weeks
☐ Coughing up blood
☐ Unexplained/Unintended weight loss (> 5 LBS)
☐ Night sweats(not related to menopause)
☐ Fever/Chills
☐ Excessive sputum
☐ Excessive fatigue/Malaise
☐ Recent close contact with a person with TB
☐ A history of immune dysfunction or are you receiving chemotherapeutic or immunosuppressant agents

COMMENTS: _____

The answers to the questions contained in this questionnaire are to the best of my knowledge. I understand that this annual health questionnaire does not take the place of regular visits to a personal, primary care physician.

Non-DHS/Non-County Workforce Member Signature:_____ Date:_____

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:

EMPLOYEE HEALTH STAFF – OR – WFM'S HEALTHCARE PROVIDER USE ONLY

WT: _____ lbs.	HT: _____ ft _____ in	BMI:

TUBERCULOSIS SCREENING

☐ Positive TB Symptom Review with Clinical Evaluation
☐ Sent for CXR:_____ Results:_____
☐ Remove from Duty

TUBERCULIN SKIN TEST RECORD
0.1 ml of 5 tuberculin units (TU) purified protein derivative (PPD) antigen intradermal

DATED PLACED	STEP	MANUFACTURER	LOT #	EXP	SITE	*ADM BY (INITIALS)	DATE READ	*READ BY (INITIALS)	RESULT	STATUS Indicate: Reactor Non-Reactor Converter
	ANNUAL									
	ANNUAL									

RESPIRATORY FIT TESTING

Is WFM required to use a respirator during duty?
☐ Yes (if yes, FIT Testing and Questionnaire is required – Forms N and O or P)
☐ No

ANNUAL HEALTH SCREENING IS INCOMPLETE UNTIL REQUIRED FIT TEST IS DONE

EDUCATION/REFERRAL INFORMATION

☐ Referred to Smoking Cessation Classes
☐ Recommended Annual Exam with Primary Care Provider
☐ Referred to Primary Care Provider for treatment:_____
☐ Referred to EHS Provider for Positive Findings:_____
☐ Reviewed immunization history and declination status
☐ Recommend annual influenza vaccinations

COMMENTS

_____
_____
_____
_____

Physician or Licensed Health Care Professional Signature:	Print Name:	License No.:	Date:
Facility Name/Address:		**Phone No.:**	

DHS-EHS STAFF ONLY

☐ Workforce member completed annual health evaluation:_____

Signature:	Print Name:	Date:

GENERAL INSTRUCTIONS

Workforce member (WFM) shall complete annual health screening within or on the anniversary of their hire/start date of employment/assignment. Annual health surveillance shall be performed to ascertain that WFM is free from infectious disease and is able to perform their assigned duties. Due to the nature of some health care positions, a medical screening may be required more frequently.

The health screening consists of:

1. Annual health questionnaire
2. Tuberculosis surveillance
3. Respiratory Fit Testing

GENERAL INSTRUCTION ON NEXT PAGE

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION

4. Review of immunizations and provide recommended immunizations as needed, or obtain declination forms for declined immunizations
5. Limited physical assessment
6. Specialty exam surveillance for potential hazardous exposure

Annual medical screening will be provided to County workforce members and volunteers at no charge. Non-County WFM and students must obtain medical screening from their physician or school, as applicable; and provide DHS Employee Health Services (EHS) a health screening clearance certificate (**DHS-EHS Form E2**). Consent must be obtained from minor's parent or guardian to obtain medical records. Health screening for contract staff will be provided in accordance with the terms of the contract. Fees and costs for these services shall be billed to the contractor as appropriate.

No person will be allowed to work inside County medical facility without documentation of medical clearance or required medical screening.

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

Upon request by DHS-EHS, the non-County WFM School/Employer shall have this form and its attachment(s) readily available within (four) 4 hours at request for review by DHS-EHS. All medical records of non-County WFM submitted to DHS-EHS are confidential in accordance with federal, state and regulatory requirements.

DHS-EHS will obtain the workforce member's written consent before using or disclosing medical information, include to self, unless the disclosure is required by State or Federal law such as to a public health authority or governmental regulatory agency. An agency such as Cal/OSHA will need to provide a written order to access medical records with personally identifiable information. That written order will need to be posted at the facility upon such request. 8CCR §3204(e)(3)

Workforce members have the right to access their medical records and obtain a copy, thereof, within fifteen (15) days after the request.