Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES

NON-COUNTY HEALTH CLEARANCE INSTRUCTIONS

Welcome to Los Angeles County, Department of Health Services. You are required to obtain a health clearance by Employee Health Services (EHS) prior to beginning your work assignment. You must successfully complete the Human Resources in-processing and criminal background check prior to beginning the EHS health clearance process. This packet includes health screening forms and questionnaires that should be completed by you and your physician or a licensed health care professional prior to your visit to EHS for your health clearance. **Only return the E2 certificate** to EHS on the day of your appointment/visit. **Completed forms and questionnaires should be returned to your school/contract agency and kept in your personnel file.**

This packet contains the following forms/questionnaires:

- ✓ **E2** – This form is a certificate of health clearance certified by your physician or licensed health care professional (PLHCP) and school/contract agency that you have met DHS health screening requirements. This form is to be completed by your PLHCP (Section I), you (Section II) and your school/contract agency (Section III). Return this certificate only, unless specifically noted to submit form(s) to EHS.

- ✓ **B-NC** – This form contains Tuberculosis (TB) questionnaire and is used as a template to provide evidence of immunity to vaccine-preventable diseases. If you have documentation of a 2-step TB test record or chest x-ray (within the past 12 months) and immunization record, please bring them with you for review by your PLHCP. Your records may be acceptable to meet DHS health clearance requirement.

- ✓ **K-NC** – This form is a declination to receiving vaccines. If you decline to receive the recommended vaccine(s) as listed on form B-NC, you must provide a reason for the declination on this form. This form must be signed by you and your school/contract agency, and submitted with the E2 certificate to EHS.

- ✓ **N-NC** – This form is used for a N95 respirator fit test to be completed by your PLHCP. If your job assignment requires a N95 respirator, you must be fit tested for the N95 respirator. If your job assignment involves Airborne Infection Isolation Rooms (AIIR), you will need to be fit tested. If your job assignment does not involve AIIR, you will not need to complete this form or the questionnaire below (Form P-NC).
    - **P-NC** – This form is an Aerosol Transmissible Disease Respirator Medical Evaluation Questionnaire. You must complete this questionnaire and submit to your PLHCP **prior** to the respirator fit test.
      ****NOTE**:** N95 respirator is the most commonly used respirator in DHS facility, however, if you need a respirator greater than a N95 (such as full-face respirator), you must complete the Respirator Medical Evaluation Questionnaire (Form O-NC) and submit to your PLHCP prior to fit test. Form O-NC is available on EHS link at www.dhs.lacounty.gov .

Once you have been cleared by EHS, you may report to Human Resources to obtain an ID badge and begin your work assignment. If you have any questions, please contact the facility EHS.

Sincerely,

EMPLOYEE HEALTH SERVICES

E2

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES

HEALTH CLEARANCE CERTIFICATION

FOR NON-DHS/NON-COUNTY WFM

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	GENDER	HSN NO.

JOB TITLE	DHS FACILITY	ONSITE DEPT/DIVISION	ONSITE WORK AREA/UNIT

ONSITE WORK PHONE	ONSITE COORDINATOR NAME	YOUR E-MAIL ADDRESS	YOUR CELL/PAGER NO.

NAME OF SCHOOL/CONTRACT AGENCY/INDEPENDENT CONTRACTOR	PHONE NO.	CONTACT PERSON

Completion of this certificate certifies the individual identified above has met the Los Angeles County Department of Health Services (DHS) Pre-placement Health Screening **Section A**, **OR** Annual Health Screening **Section B**, requirements in accordance with DHS policy.

I. FOR COMPLETION BY THE PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL (PLHCP)

INSTRUCTIONS TO THE PLHCP: Please complete the following forms. All fields on the forms must be completed in order to meet DHS health clearance requirements to work in DHS health care facilities. Return completed forms to the patient. ***Only complete one section (Section A or B).***

Section A **FOR PRE-PLACEMENT HEALTH SCREENING** *(ONE TIME use for initial pre-placement only):*
(Must complete form B-NC. Complete forms K-NC, N-NC and P-NC, as applicable)

- ☐ **B-NC** Tuberculosis History and Evidence of Immunity Form
- ☐ **K-NC** Declination Form, if workforce member (WFM) declined any vaccination(s). ***(If applicable, complete and submit form K-NC to DHS-EHS)***
- ☐ **N-NC** FIT Test – *Only if N95 respirator is needed for job assignment (WFMs such as laboratory, clinicians, custodians and others who may be assigned work in airborne precaution areas or procedures.)*

  WFM must complete the following medical questionnaire form P-NC prior to Fit Test, then every 4 years thereafter or more frequently, as needed)

  - ☐ **P-NC** Appendix B – ATD Respirator Medical Evaluation Questionnaire ***(for N95 respirator only*)***
    ***NOTE**: If WFM requires a respirator *greater than N95 respirator*, please obtain and complete the Respirator Medical Questionnaire (Form O-NC) from EHS website link at www.dhs.lacounty.gov

Section B **FOR ANNUAL HEALTH SCREENING** *(Use annually):*
(Must complete form E-NC. Complete forms K-NC, N-NC and P-NC, as applicable)

- ☐ **E-NC** Annual Health Screening Form
  NOTE: For new TB Conversion, attach form E-NC and submit to DHS-EHS.
- ☐ **K-NC** Declination Form, if WFM declined any vaccination(s). ***(If applicable, submit form K-NC to DHS-EHS)***
- ☐ **N-NC** FIT Test *(Only if N95 respirator is needed for job assignment (WFMs such as laboratory, clinicians, custodians and others who work in airborne precaution areas or procedures.)*

  WFM must complete the following medical questionnaire form P-NC prior to Fit Test, then every 4 years thereafter or more frequently, as needed)

  - ☐ **P-NC** Appendix B – ATD Respirator Medical Evaluation Questionnaire ***(for N95 respirator only*)***
    ***NOTE**: If WFM requires a respirator *greater than N95 respirator*, please obtain and complete the Respirator Medical Questionnaire (Form O-NC) from EHS website link at www.dhs.lacounty.gov

I certify that the individual identified above has met the Los Angeles County Department of Health Services Pre-placement OR Annual health screening requirements AND verified completion of the forms.

DATE OF COMPLETED HEALTH CLEARANCE

PRINT NAME	PLHCP SIGNATURE	LICENSE NO.	TODAY'S DATE

FACILITY NAME/ADDRESS	PHONE NO.

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	HSN NO.

II. FOR COMPLETION BY THE WORKFORCE MEMBER

INSTRUCTION TO THE WORKFORCE MEMBER: You must provide authorization to release your health information to your School/Contract Agency/Independent Contractor (SCAIC) and to DHS-EHS by signing below. Return all completed forms to your SCAIC for verification of completion and to store source documents.

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

PRINT NAME	SIGNATURE	DATE

III. FOR COMPLETION BY THE SCHOOL/CONTRACT AGENCY/INDEPENDENT CONTRACTOR (SCAIC)

INSTRUCTION TO THE HOME SCHOOL/CONTRACT AGENCY/INDEPENDENT CONTRACTOR: You must verify all forms are accurately completed and ensure the workforce member (WFM) has met the DHS health clearance requirements. Sign below and **return this E2 certificate only** (original to be kept by SCAIC) **unless specifically noted to submit form(s)** in Section A or B to DHS-EHS.

E2 certificate ONLY must be presented to DHS-EHS for final health clearance.

In accordance with DHS policy, the WFM's SCAIC shall:

1. Maintain and file original E2, B-NC or E-NC and other forms as applicable at the WFM's Home SCAIC, and must ensure the confidentiality and privacy of WFM's health information.
2. Ensure the above WFM completes a health screening annually **by the end of the month of last health screening.** Failure to provide documentation of timely health screening/clearance will result in immediate termination of assignment and placement in a "Do Not Send" status until compliant.
3. Provide health surveillance/post-exposure services to WFM. If the WFM's SCAIC chooses to have DHS-EHS perform such surveillance/post-exposure services, the WFM's SCAIC will be billed, as appropriate.

As the WFM's SCAIC, I certify that I have verified DHS forms are complete to ensure the health clearance requirements are complete and, upon DHS request, will supply supporting document(s) within four (4) hours. WFM will comply with DHS policy and will complete health screening annually.

PRINT NAME	SIGNATURE		DATE
E-MAIL ADDRESS	NAME OF SCHOOL/CONTRACT AGENCY/SELF		PHONE NO.
SCHOOL/CONTRACT AGENCY/SELF ADDRESS		STATE	ZIP CODE

SAVE ORIGINAL FOR YOUR RECORDS
SUBMIT COPY OF E2 FORM INCLUDING K-NC or E-NC, AS NECESSARY

DHS-EHS STAFF ONLY

DATE CLEARED BY EHS	PRINT NAME	SIGNATURE

DHS-EHS is to provide Form A2 or E3 to WFM for Area/Unit File

B-NC

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES

TUBERCULOSIS HISTORY AND EVIDENCE OF IMMUNITY

FOR NON-DHS/NON-COUNTY WFM

GENERAL INSTRUCTIONS on last page

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	HSN NO.

JOB TITLE	DHS FACILITY	DEPT/DIVISION	WORK AREA/UNIT	SHIFT

E-MAIL ADDRESS	WORK PHONE	CELL/PAGER NO	SUPERVISOR NAME

NAME OF SCHOOL/EMPLOYER *(If applicable)*	PHONE NO.	CONTACT PERSON

FOR COMPLETION BY WORKFORCE MEMBER (WFM)

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)
			Note: Having immunodeficiency increases a person's risk for active TB infection/disease. If you think you may be immunocompromised you should consult with your physician or licensed health care professional. DHS-EHS does not test for HIV or related diseases.
			TUBERCULOSIS (TB) SCREENING
☐	☐	☐	11. Do you have a cough lasting longer than three (3) weeks?
☐	☐	☐	12. Do you cough up blood?
☐	☐	☐	13. Do you have unexplained or unintended weight loss?
☐	☐	☐	14. Do you have night sweats (not related to menopause)?
☐	☐	☐	15. Do you have a fever or chills?
☐	☐	☐	16. Do you have excessive sputum?
☐	☐	☐	17. Do you have excessive fatigue?
☐	☐	☐	18. Have you had recent close contact with a person with TB?

WORKFORCE MEMBER SIGNATURE	DATE

LAST NAME	FIRST NAME	BIRTHDATE	HSN NO.

FOR COMPLETION BY EMPLOYEE HEALTH STAFF – OR – DESIGNATED WFM AGENCY

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									Select One
	2nd									Select One

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

OR

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

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** Select One
	CXR (<12 months)	Date:	Results_____	☐ LA County ☐ Outside Document	

OR

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

OR

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

OR

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

CONTINUE ON NEXT PAGE

B-NC

CONFIDENTIAL
TUBERCULOSIS HISTORY AND EVIDENCE OF IMMUNITY

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	HSN NO.

G — IMMUNIZATION DOCUMENTATION HISTORY (THESE VACCINATIONS ARE MANDATORY)

	Date Received	Titer	If not immune, give Vaccination x 2, unless Rubella x 1		Date Received	Vaccine		Declined Vaccination
Measles		☐ Immune ☐ Non-Immune ☐ Equivocal ☐ Laboratory confirm of disease	**OR**	**X 2**			**OR**	☐ **If WFM declines, WFM must complete Form K-NC AND specify reason(s) for declination.**
Mumps		☐ Immune ☐ Non-Immune ☐ Equivocal ☐ Laboratory confirm of disease	**OR**	**X 2**			**OR**	☐ **If WFM declines, WFM must complete Form K-NC AND specify reason(s) for declination.**
Rubella		☐ Immune ☐ Non-Immune ☐ Equivocal ☐ Laboratory confirm of disease	**OR**	**X 1**			**OR**	☐ **If WFM declines, WFM must complete Form K-NC AND specify reason(s) for declination.**
Varicella		☐ Immune ☐ Non-Immune ☐ Equivocal ☐ Laboratory confirm of disease	**OR**	**X 2**			**OR**	☐ **If WFM declines, WFM must complete Form K-NC AND specify reason(s) for declination.**

AND

H

Vaccination	Date Received		Declined Vaccine
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 Received	Immunity	Declined Vaccine
Hepatitis B (HBsAb)		☐ Reactive ☐ Non reactive ☐ N/A	☐

AND

J

Vaccination (VOLUNTARY)	Date Received	Location Received		Declined Vaccine
Seasonal Influenza (Annually)			☐ Verbal ☐ Document	☐

ATTACH SUPPORTING DOCUMENTATION(S) WITH THIS FORM INCLUDING FORM K-NC IF WFM DECLINED VACCINATION(S)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. 29 C.F.R. Part 1635

GENERAL INSTRUCTIONS ON NEXT PAGE

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	HSN NO.

GENERAL INSTRUCTIONS FOR EACH SECTION

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, <u>DO NOT CLEAR</u> 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. **DHS-EHS must be notified if WFM does not demonstrate evidence of immunity.**
H	**<u>Td</u>** – 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. **<u>Tdap</u>** 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-DHS/non-County workforce member's School/Employer. The School/Employer shall verify completeness of DHS-Employee Health Services (EHS) form(s) and ensure confidentiality of non-DHS/non-County WFM health information.

Upon request by DHS-EHS, the non-DHS/non-County WFM School/Employer shall have this form and its attachment(s) readily available within four (4) hours.

All workforce member health records are confidential in accordance with federal, state and regulatory requirements.

K-NC

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES

DECLINATION FORM

FOR NON-DHS/NON-COUNTY WFM

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	HSN NO.

JOB CLASSIFICATION	DHS FACILITY	DEPT/DIVISION	WORK AREA/UNIT	SHIFT

E-MAIL ADDRESS	WORK PHONE	CELL/PAGER NO	SUPERVISOR NAME

NAME OF SCHOOL/EMPLOYER *(If applicable)*	PHONE NO.	CONTACT PERSON

Please check in the section(s) as apply AND indicate reason for the declination. Submit original to DHS-EHS.

I. ☐ 8 CCR §5199. Appendix C1 - Vaccination Declination Statement (Mandatory)*

Please check as apply: ☐ Measles ☐ Mumps ☐ Rubella ☐ Varicella ☐ Td/Tdap

I understand that due to my occupational exposure to aerosol transmissible diseases, I may be at risk of acquiring infection as indicated above. 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 the above infection, 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 from my School/Employer or DHS-Employee Health Services (EHS) at no charge to me.

Reason for declination: _____

_____

☐ Seasonal Influenza

Reason for declination *(check as apply):*

☐ I am allergic to vaccine components.
☐ I believe I can get the flu if I get the shot.
☐ I am concerned about vaccine side effects.
☐ It's against my personal belief.
☐ I don't believe I need it.
☐ I'm concerned about vaccine safety.
☐ I do not like needles.
☐ Other: _____

II. ☐ 8 CCR §5193. Appendix A-Hepatitis B Vaccine Declination (Mandatory)*

☐ Hepatitis B

I understand that due to my occupational exposure to blood or other potentially infectious material (OPIM) I may be at risk of acquiring Hepatitis B virus (HBV) infection. 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 OPIM and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series from my School/Employer or DHS-EHS at no charge to me.

Reason for declination: _____

_____

III. ☐ Specialty Surveillance Declination (Mandatory)**

Please check as apply: ☐ Asbestos ☐ Hazardous/Anti-Neoplastic Drugs ☐ Other:_____

PLEASE SIGN ON PAGE 2

K-NC

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	HSN NO.

I understand that due to my occupational exposure as indicated above, I am eligible and have been given the opportunity to enroll in the Medical Surveillance Program. This will enable me to receive specific initial, periodic and exit medical examinations for the hazard identified above, at no charge to me and at a reasonable time and place.

However, I decline to be enrolled in this program at this time. I understand that by declining this enrollment, I will not be medically monitored for occupational exposure to this hazard. I understand that it is strongly recommended that I complete a medical questionnaire or examination. I also understand that if in the future I continue to have occupational exposure to the hazard identified above and I want to be enrolled in the Medical Surveillance Program, I can do so at any time at no charge to me.

Reason for declination: _____

_____

SIGN BELOW

By signing this, I am declining as indicated on this form.

WORKFORCE MEMBER SIGNATURE		DATE
SCHOOL/EMPLOYER (PRINT NAME)	SIGNATURE	DATE

MAKE A COPY FOR YOUR RECORDS
SUBMIT ORIGINAL AND ANY SUPPORTING DOCUMENT(S)

*Vaccination(s) is available to all workforce members (WFM), and free of charge for County employees and volunteers. Non-County WFM should obtain the vaccinations from their physician or licensed health care professional. Services provided through DHS will be billed to the non-County WFM School/Employer, as appropriate.

**Non-County WFM who has potential exposure to occupational hazards will be included in the surveillance program, but will not have their assessments done through the County, unless specified in contract/agreement. Medical surveillance/post-exposure regulations are the responsibility of the school/contract agency. If the non-County WFM School/Employer chooses to have DHS-Employee Health Services (EHS) to perform such surveillance/post-exposure services, the non-County WFM School/Employer will be billed accordingly. Emergency services will be provided post-exposure within the allowable time frames, but will be billed to the contractor/agency, as appropriate.

Workforce member must complete this form if declining DHS recommended and mandatory vaccinations or medical surveillance program. The School/Employer must verify completeness and ensure declination form is submitted to DHS-EHS. **The School/Employer must notify DHS-EHS if workforce member does not provide evidence of immunity.**

This form and its attachment(s), if any, such as health records shall be maintained and kept in workforce member's EHS health file.

N-NC

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES

RESPIRATORY FIT TEST RECORD

FOR NON-DHS/NON-COUNTY WFM

☞ **GENERAL INFORMATION on last page**

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	HSN NO.

JOB TITLE	DHS FACILITY	DEPT/DIVISION	WORK AREA/UNIT	SHIFT

E-MAIL ADDRESS	WORK PHONE	CELL/PAGER NO	SUPERVISOR NAME

NAME OF SCHOOL/EMPLOYER *(If applicable)*	PHONE NO.	CONTACT PERSON

RESPIRATOR, QUESTIONNAIRE, MEDICAL EVALUATION

EQUIPMENT TYPE:	MANUFACTURER:	MODEL:	SIZE:
N95	Kimberly-Clark	☐ PFR95-174 ☐ PFR95-170	☐ Small ☐ Regular

Based on review of the respirator health questionnaire: ☐ 8 CCR §5144 (Form O-NC) ***OR*** ☐ 8 CCR §5199 (Form P-NC), this individual is:

☐ Medically approved for only the following types of respirator subject to satisfactory fit test:

- ☐ 1. Disposable Particulate Respirators
- ☐ 2. Replaceable Disposable Particulate Respirators: ☐ a. Half-Facepiece ☐ b. Full-Facepiece
- ☐ 3. Powered Air Purifying Respirators (PAPRs): ☐ a. Tight Fitting
- ☐ 4. Self-Contained Breathing Apparatus (SCBA)

Recommended time period for next questionnaire: ☐ 4 years ☐ Other _____ with justification _____

Date Completed: _____ Next Due Date: _____

List any facial fit problem conditions that apply to you (e.g., beard growth, sideburns, scars, deep wrinkles): _____

TASTE THRESHOLD SCREENING (NO food, drink, smoke, gum X 15 minutes before testing)

(Bitrex or Saccharin): ☐ X 10 ☐ X 20 ☐ X 30 ☐ Fail

RESPIRATOR FIT, PRESSURE FIT CHECK, COMFORT

	ATTEMPT #1	ATTEMPT #2	ATTEMPT #3
Fit Check: ☐ **POSITIVE** and/or	☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail
☐ **NEGATIVE** pressure	☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail
Overall Comfort Level	☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail
Ability to Wear Eyeglasses	☐ Pass ☐ Fail ☐ NA	☐ Pass ☐ Fail ☐ NA	☐ Pass ☐ Fail ☐ NA

FIT TEST

	ATTEMPT #1	ATTEMPT #2	ATTEMPT #3
Normal Breathing *(performed for one minute)*	☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail
Deep Breathing *(performed for one minute)*	☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail
Turning Head Side to Side *(performed for one minute)*	☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail
Moving Head Up and Down *(performed for one minute)*	☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail
Talking – Rainbow Passage *(performed for one minute)*	☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail
Bending Over *(performed for one minute)*	☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail
Normal Breathing *(performed for one minute)*	☐ Pass ☐ Fail	☐ Pass ☐ Fail	☐ Pass ☐ Fail

COMMENTS: _____

CONTINUE ON NEXT PAGE

N-NC

RESPIRATORY FIT TEST RECORD

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	HSN NO.

Workforce member failed fit testing. A powered air-purifying respirator (PAPR) must be provided to workforce member.
WFM trained on PAPR use. N/A

PASS Pre-Placement FIT Test on: _____ **PASS Annual FIT Test on:** _____

ACKNOWLEDGMENT OF TEST RESULTS

I have undergone fit testing on the above respirator. I have been instructed in and understand the proper fitting, use and care of the respirator.

Workforce Member Signature:_____Date:_____

FIT Test Trainer (Print Name):_____Signature:_____Date:_____

DHS-EHS OFFICE STAFF ONLY			
Completion of this form:	Reviewed By (Print)	Signature	Date

GENERAL INFORMATION

Pursuant to Title 8 of the California Code of Regulations, Sections 5144 and 5199 (8 CCR §5144 and §5199), all workforce member (WFM) who are required to use respiratory protection must be fit tested with the same make, model, style, and size of respirator to be used. Fit testing procedures for respirators must be conducted for the following:

- Initial fit test must be conducted after the WFM has passed medical evaluation and clearance.
- Newly hired/assigned workforce members who have passed medical evaluation and clearance.
- When new style of respirator face piece is to be worn by WFM.
- Annual fit test for all WFM required to wear a respirator.
- WFM reports, or the Physician or Licensed Health Care Professional (PLHCP), supervisor, or Program Administrator makes visual observations of changes in the workforce member's physical condition that could affect respirator fit. Such conditions include, but are not limited to, facial scarring, facial hair, dental changes, cosmetic surgery, or an obvious change in body weight.
- WFM must be given a reasonable opportunity to select a different respirator face piece and be re-fit tested, if required.
- If WFM is unable to be fit-tested or has failed the fit test, WFM must be provided with a powered air-purifying respirator (PAPR).

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

Upon request by DHS-EHS, the non-DHS/non-County WFM School/Employer shall have this form and its attachment(s) readily available within four (4) hours.

All workforce member health records are confidential in accordance with federal, state and regulatory requirements.

DHS-EHS will obtain the workforce member's written authorization before using or disclosing health 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.

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

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. 29 CFR Part 1635

P-NC

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES

CONFIDENTIAL
NON-DHS/NON-COUNTY WORKFORCE MEMBER
8 CCR SECTION 5199 – APPENDIX B
ATD RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

☞ **GENERAL INFORMATION on last page**

Questionnaire for N95 Respirator

COMPLETE ONCE EVERY FOUR (4) YEARS OR AS NEEDED

This Appendix is Mandatory if the Employer chooses to use a Respirator Medical Evaluation Questionnaire other than the Questionnaire in Section 5144 Appendix C (Form O-NC).

To the PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL: Answers to questions in Section 1, and to question 6 in Section 2 do not require a medical examination. Workforce member must be provided with a confidential means of contacting the health care professional who will review this questionnaire.

To the WORKFORCE MEMBER: Can you read and understand this questionnaire (check one): ☐ Yes ☐ No

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Please complete this questionnaire in PEN and present to the staff at the examination clinic. **To protect your confidentiality, it should not be given or shown to anyone else.** On the day of your appointment, you must bring a valid driver's license or other form of identification which has both your photograph and signature.

SECTION 1

The following information must be provided by every workforce member who has been selected to use any type of respirator.

PLEASE PRINT LEGIBLY

		TODAY'S DATE:	
LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	GENDER ☐ MALE ☐ FEMALE
HEIGHT FT IN	WEIGHT LBS	JOB TITLE	HSN NO.
PHONE NUMBER	Best Time to reach you?	Has your employer told you how to contact the health care professional who will review this questionnaire? ☐ Yes ☐ No	

Check type of respirator you will use (you can check more than one category): N, R, Or P disposal respirator (filter-mask, non-cartridge type only) Other type (specify): _____	
Have you worn a respirator? ☐ Yes ☐ No	If "yes", what type:

SECTION 2

Questions 1 through 6 below must be answered by every workforce member who has been selected to use any type of respirator (please check "YES", "NOT SURE" or "NO").

YES	NOT SURE	NO	
			1. Have you ever had the following conditions?
☐	☐	☐	a. Allergic reactions that interfere with your breathing?

CONTINUE ON NEXT PAGE

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	HSN NO.

YES	NOT SURE	NO	
			If "yes," what did you react to? _____
☐	☐	☐	b. Claustrophobia (fear of closed-in places)
			2. **Do you currently have any of the following symptoms of pulmonary or lung illness:**
☐	☐	☐	a Shortness of breath when walking fast on level ground or walking up a slight hill or incline
☐	☐	☐	b. Have to stop for breath when walking at your own pace on level ground
☐	☐	☐	c. Shortness of breath that interferes with your job
☐	☐	☐	d. Coughing that produces phlegm (thick sputum)
☐	☐	☐	e. Coughing up blood in the last month
☐	☐	☐	f. Wheezing that interferes with your job
☐	☐	☐	g. Chest pain when you breath deeply
☐	☐	☐	h. Any other symptoms that you think may be related to lung problems: _____
			3. **Do you currently have any of the following cardiovascular or heart symptoms?**
☐	☐	☐	a. Frequent pain or tightness in your chest
☐	☐	☐	b. Pain or tightness in your chest during physical activity
☐	☐	☐	c. Pain or tightness in your chest that interferes with your job
☐	☐	☐	d. Any other symptoms that you think may be related to heart problems: _____
			4. **Do you currently take medication for any of the following problems?**
☐	☐	☐	a. Breathing or lung problems
☐	☐	☐	b. Heart trouble
☐	☐	☐	c. Nose, throat or sinuses
☐	☐	☐	d. Are your problems under control with these medications?
			5. **If you've used a respirator, have you ever had any of the following problems while respirator is being used?** ***(If you've never used a respirator, check the following space and go to question 6).***
☐	☐	☐	a. Skin allergies or rashes
☐	☐	☐	b. Anxiety
☐	☐	☐	c. General weakness or fatigue
☐	☐	☐	d. Any other problem that interferes with your use of a respirator
☐	☐	☐	6. **Would you like to talk to the health care professional about your answers in this questionnaire?**

Workforce Member Signature	Date

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. 29 C.F.R. Part 1635

PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL TO COMPLETE NEXT PAGE

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	HSN NO.

FOR COMPLETION BY A PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL
PROVIDE A COPY OF THIS PAGE TO THE WORKFORCE MEMBER

Part 1: Fit Testing Recommendation – Based on Questionnaire

☐ Questionnaire above reviewed.
☐ Medical Approval to Receive Fit Test
1. ☐ Disposable Particulate Respirators (N95)
2. ☐ Replaceable Disposable Particulate Respirator ☐ a. Half-Facepiece ☐ b. Full Facepiece
3. ☐ Powered Air-Purifying Respirators (PAPRs) ☐ a. Tight Fitting
4. ☐ Self-Contained Breathing Apparatus (SCBA)

Recommended time period for next questionnaire: ☐ 4 years ☐ Other _____ with justification _____

Date Completed: _____ Next Due Date: _____

Any recommended limitations for respirator use on workforce member: _____

☐ The above workforce member has not been cleared to be fit tested for a respirator.
- ☐ Additional medical evaluation is needed. Physician or Licensed Health Care Professional to complete Part 2 below.
- ☐ Medically unable to use a respirator.

☐ Informed workforce member of the results of this examination.

Comments: _____

Part 2: Additional Medical Evaluations ☐ NOT APPLICABLE

☐ Medical evaluation completed.
☐ Medical Approval to Receive Fit Test
1. ☐ Disposable Particulate Respirators (N95)
2. ☐ Replaceable Disposable Particulate Respirator ☐ a. Half-Facepiece ☐ b. Full Facepiece
3. ☐ Powered Air-Purifying Respirators (PAPRs) ☐ a. Tight Fitting
4. ☐ Self-Contained Breathing Apparatus (SCBA)

Recommended time period for next questionnaire: ☐ 4 years ☐ Other _____ with justification _____

Date Completed: _____ Next Due Date: _____

Any recommended limitations for respirator use on workforce member: _____

☐ Medically unable to use a respirator.

☐ Informed workforce member of the results of this examination.

Comments: _____

Physician or Licensed Health Care Professional Signature	Print Name	License No.	Date

Facility Name/Address	Phone No.

Workforce Member Signature	Date

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	HSN NO.

DHS-EHS OFFICE STAFF ONLY			
Completion of this form:	Reviewed By (Print)	Signature	Date

GENERAL INFORMATION

THIS QUESTIONNAIRE IS TO BE REVIEWED BY A PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL.

8 CCR §5199
Medical evaluation: DHS-EHS or non-DHS/non-County workforce member (WFM) School/Employer shall provide a medical evaluation, in accordance with 8 CCR §5144(e) of these orders, to determine the workforce member's (WFM) ability to use the respirator before the WFM is fit tested or required to use the respirator. For WFM who use respirators solely for compliance with subsections (g)(3)(A) and subsections (g)(3)(B), this alternate questionnaire may be used.

8 CCR §5144(e)

1. General. DHS-EHS or non-DHS/non-county WFM School/Employer shall provide a medical evaluation to determine the WFM's ability to use a respirator, before the WFM is fit tested or required to use the respirator in the workplace. DHS-EHS may discontinue a WFM's medical evaluations when the WFM is no longer required to use a respirator.
2. Medical evaluation procedures.
   a. DHS-EHS or non-DHS/non-County WFM School/Employer shall identify a physician or other licensed health care professional (PLHCP) to perform medical evaluations using a medical questionnaire or an initial medical examination that obtains the same information as the medical questionnaire.
   b. The medical evaluation shall obtain the information requested by this questionnaire in Sections 1 and 2, Part A.
3. Follow-up medical examination.
   a. DHS-EHS or non-DHS/non-County WFM School/Employer shall ensure that a follow-up medical examination is provided for a WFM who gives a **positive response to any question among questions 1 through 8 in Section 2, Part A** of this questionnaire or whose initial medical examination demonstrates the need for a follow-up medical examination.
   b. The follow-up medical examination shall include any medical tests, consultations, or diagnostic procedures that the PLHCP deems necessary to make a final determination.

If WFM is unable to be fit-tested or has failed the fit test, WFM must be provided with a powered air-purifying respirator (PAPR).

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

Upon request by DHS-Employee Health Services (EHS), the non-DHS/non-County WFM School/Employer shall have this form and its attachment(s) readily available within four (4) hours.

All workforce member health records are confidential in accordance with federal, state and regulatory requirements.

Health records will be maintained by DHS-EHS or non-DHS/non-County WFM School/Employer and kept for thirty (30) years after the workforce member's employment/assignment ends, in accordance with State and Federal medical records standards and DHS policies and procedures.

DHS-EHS will obtain the workforce member's written authorization 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.

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

A copy of the respiratory protection regulation Title 8 CCR §5144 and §5199 can be found at http://www.dir.ca.gov/title8/5144.html and http://www.dir.ca.gov/Title8/5199.html