

Outside Clearance Form

Services must be done by your PCP (Primary Care Physician), not Occupational and Employee Health Clinic (OEHC).

Name: _____ Phone Number: _____

UC Davis Health Dept. Name: _____ Dept. Contact Name and Phone _____

Required Immunization Documentation for Infectious Diseases Clearance

TB Screening

Requirement: 1st PPD within the last 365 days and 2nd PPD within 90 days prior to start date **OR** Quantiferon within 90 days prior to start date.

For positive PPD or QuantiFERON test, a chest x-ray is required within 90 days prior to start date (step C)

A. QuantiFERON (**Preferred**) : Test Date: ____/____/____ Results: ____

Date of Annual TB Symptoms Interview: ____/____/____ ☐ Neg ☐ Pos

History if BCG Vaccination: ☐ Yes ☐ No (BCG is a vaccine given to those born outside the US.)

B. Two-step Tuberculin Intermediate Skin Test (PPD)

Test 1 Date: ____/____/____ Reading: ____/____/____ Results: ____ MM Induration: ☐ Neg ☐ Pos

Test 2 Date: ____/____/____ Reading: ____/____/____ Results: ____ MM Induration: ☐ Neg ☐ Pos

C. Chest x-ray: Date: ____/____/____ Results: ____ TB Symptoms: ☐ Neg ☐ Pos

History of Treatment: ☐ Yes ☐ No If yes, Date: ____/____/____ How many months: _____

MMR or Individual Measles, Mumps, and Rubella

Requirement: Two immunization dates (dated at least 28 days apart or positive titer)

A. MMR Vaccines: 1. ____/____/____ 2. ____/____/____

OR

B. Individual Measles, Mumps and Rubella Vaccines:

Measles: 1. ____/____/____ 2. ____/____/____ **OR** Titer Date: ____/____/____ ☐ Neg ☐ Pos

Mumps: 1. ____/____/____ 2. ____/____/____ **OR** Titer Date: ____/____/____ ☐ Neg ☐ Pos

Rubella: 1. ____/____/____ **OR** Titer Date: ____/____/____ ☐ Neg ☐ Pos

Varicella Vaccine (Chicken Pox)

Requirement: Two vaccination dates (28 days apart) OR positive titer

Varicella Vaccines: 1. ____/____/____ 2. ____/____/____ **OR** Titer Date: ____/____/____ ☐ Neg ☐ Pos

Tdap Vaccine (Tetanus, Diphtheria, Pertussis) from June of 2005 or more recent

Tdap vaccine: 1. ____/____/____

Flu Vaccine (Required only during flu season per CDPH)

Flu Vaccine: 1. ____/____/____

☐ I am choosing to decline the influenza (flu) vaccine and I am attesting and agreeing to:

- Wear a mask everywhere on campus until the end of the flu season (May/June of next year), regardless of any change in COVID-19 requirements,
- Any additional NPIs (Non-Pharmaceutical Interventions), social distancing, or other requirements or restrictions specified by my campus or local public health authorities.
- I understand that as long as I refuse to accept the flu vaccine, I may be required to take extra precautions against transmission while at work, consistent with local policies.
- I understand that I can change my mind at any time and accept the flu vaccine

X _____

Signature

Up to date COVID-19 Vaccine

Manufacturer Name : _____ Lot Number 1: _____ Date Vaccinated Dose 1. ____/____/____

☐ COVID-19 Declination: The University of California recommends that all members of the community, except those who have had a severe allergic reaction to a previous dose of the COVID-19 vaccine or to any of its components, receive a vaccination to protect against COVID-19 disease and get boosters as needed to stay up to date. I am voluntarily choosing to decline the most recent COVID-19 booster.

X _____
Signature**Direct Patient Care Contact Requires – Hepatitis B**A. **Manufacturer Name :** _____**Hepatitis B:** Surface Antibody Titer Date: ____/____/____ *Numeric Value: _____ mIU/ml ☐ Neg ☐ Pos**Hepatitis B Injection Dates:** 1. ____/____/____ 2. ____/____/____ 3. ____/____/____ **OR****HEPLISAV-B Injection Dates:** 1. ____/____/____ 2. ____/____/____***Numeric value required**

☐ **Hep B Declination:** I understand that due to my potential occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. However, I decline hepatitis B vaccination at this time, but understand a baseline titer will be drawn. 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 other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I will follow up with OEHC, my primary care physician (PCP), or school. If exposed to the Hepatitis B virus at work, I know that I need to report this exposure to OEHC as soon as possible.

Note to UC Davis Health Dept: Hep B Vaccination declination must be included if a negative titer result is indicated above.

X _____
Signature**Fit Test (To be completed by the Unit)**☐ N95 Respirator: _____ ☐ PAPR Date Tested: ____/____/____

I have evaluated this individual and have found them to be free from infectious disease.

Primary care physician's name: _____ Date: _____

PCP signature: _____ PCP Business Stamp: _____