CHECK OFF LIST FOR CLEARANCE REQUIREMENT

***YOU MUST BRING YOUR IMMUNIZATION DOCUMENTATION***

IF YOU ARE UNABLE TO OBTAIN YOUR IMMUNIZATION RECORDS EHS WILL PROVIDE THE FOLLOWING TEST(S)

IMMUNIZATION DOCUMENTATION FOR INFECTION DISEASE CLEARANCE REQUIREMENT IS AS FOLLOWS:

(2) STEP TUBERCULIN INTERMEDIATE SKIN (PPD) TEST:

(2) _____ 1st EHS WILL ACCEPT 1 PPD WITHIN 365 DAYS & _____ 2nd PPD WITHIN 90 DAYS OF START DATE

OR

(1) QUANTIFERON TITER WITH RESULTS:

(1) _____ EHS WILL ACCEPT QUANTIFERON TEST WITHIN 90 DAYS OF START DATE.

**IF YOU HAVE A HISTORY OF POSITIVE PPD TEST OR QUANTIFERON THEN A CHEST X-RAY IS REQUIRED**

_____ CHEST X-RAY WITHIN 90 DAYS OF START DATE

HISTORY OF TREATMENT: □ YES □ NO IF YES, DATE________

HOW MANY MONTHS TAKEN________ WHAT PRESCRIPTION_________

(2) MMR – IMMUNIZATION DATES - MUST BE GIVEN 28 DAYS APART OR POSITIVE TITER:

(2) _____ 1st & _____ 2nd MMR (RUBEOLA/(MEASLES); MUMPS; RUBELLA): VACCINE DATE

IF IMMUNIZATION WERE GIVEN SEPARATELY - (2) VACCINES MUST BE GIVEN 28 DAYS APART:

(1) _____ RUBELLA: VACCINE DATE

(2) _____ 1st RUBEOLA/(MEASLES): VACCINE DATE & _____ 2nd RUBEOLA/(MEASLES): VACCINE DATE

(2) _____ 1st MUMPS: VACCINE DATE & _____ 2nd MUMPS: VACCINE DATES

OR

MMR - POSITIVE TITERS

(1)_____ RUBELLA POSITIVE TITER DATE

(1)_____ RUBEOLA/(MEASLES) POSITIVE TITER DATE

(1)_____ MUMPS POSITIVE TITER DATE

(2) VARICELLA - IMMUNIZATION DATES - MUST BE GIVEN 28 DAYS APART OR (1) POSITIVE TITER:

(2) _____ 1st VARICELLA: VACCINE DATE & _____ 2nd VARICELLA: VACCINE DATE

OR

(1)_____ POSITIVE VARICELLA TITER DATE

(1) TDAP - IMMUNIZATION DATE

(1) _____ TDAP: VACCINE DATE

ADDITIONAL REQUIRED TITERS FOR ALL BLOOD/BODY FLUID EXPOSURE RISK JOBS:

(1) _____ HEPATITIS B SURFACE ANTIBODY (HBSAB) TITER WITH NUMERIC VALUE RESULTS

(1) _____ HEPATITIS C ANTIBODY TITER BASELINE WITHIN 90 DAYS OF START DATE
# EHS NEW HIRE HEALTH HISTORY QUESTIONNAIRE

<table>
<thead>
<tr>
<th>Name:</th>
<th>DOB:</th>
<th>Department:</th>
</tr>
</thead>
</table>

If you answer “YES” to any of the following questions, Employee Health Services (EHS) may need to schedule an additional appointment (916) 734-3572. Please keep in mind times slots are limited so you must be flexible. Incomplete follow-ups will result in a delayed/denied clearance. Thank you.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you have any conditions or disabilities that may require accommodations or work restrictions in order for you to safely do the essential duties of your position (e.g. seizures, back or joint issues, etc.)? If YES, please explain:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Do you have any special requirements for your workstations? If YES, please explain:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Do you have any significant visual or hearing problems (including problems distinguishing colors) that could affect your ability to perform your essential job duties? If YES, please explain:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Do you have any severe allergies that could affect your work? If YES, please explain:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Is there any medical reason why you cannot wear an n-95 mask (similar to a painters mask?) If YES, please explain:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. TB information:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Country of Birth:            USA</td>
<td>Other:</td>
<td>Year Arrived in USA:</td>
</tr>
<tr>
<td>BCG:                        Yes No</td>
<td>If Yes, Date:</td>
<td>Previous Positive CXR: Never had CXR for TB</td>
</tr>
<tr>
<td>Previous Positive TB Test? If YES, Year: If YES, Year:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of Treatment:       Yes No</td>
<td>Duration:</td>
<td>Treatment:</td>
</tr>
<tr>
<td>7. For healthcare workers only:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7a. Do you have any allergic or irritant reactions to latex?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7b. Do you have any known communicable infectious conditions that could potentially place patients or co-workers at risk? Example: Active Hepatitis B or C, etc.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signature: Date:
# EHS New Hire Latex Allergy Screening Questionnaire

**Name:**

**DOB:**

**Department:**

---

**1.** Are you aware of having an allergy to latex?  
If YES, please circle your reaction(s) below:  
☐ Yes  ☐ No  
- Local Rash Within Minutes Of Latex Exposure / Local Rash Hours To Days After Exposure / Worsening Asthma / Nasal Congestion / Itching Eyes / Diffuse Rash / Urticaria / Facial Swelling / Sob / Chest Tightness / Hypotension / Fainting

**2.** Do any of the following cause you rashes, irritation or any of the above symptoms (even if mild)? If YES, please circle the item(s) below:  
☐ Yes  ☐ No  
- Balloons / Rubber Gloves / Hot Water Bottles / Rubber Bands, Balls, Grips / Foam Pillows / Diaphragms / Condoms / Latex Sexual Aids / Gyn Exams / Digital Rectal Exams / Dental Exams / Enemas / Erasers / Face Masks / Clothing Elastic / List Any Other Rubber Items: ____________________________

**3.** Do you ever use latex gloves?  
☐ Yes  ☐ No

**4.** Do your co-workers ever use latex gloves?  
☐ Yes  ☐ No

**5.** Have you ever had unexplained intraoperative, hypotension, shock or anaphylaxis?  
If YES, please explain:  
☐ Yes  ☐ No

**6.** Does frequent hand washing cause your hands to break out in a rash?  
If YES, please explain:  
☐ Yes  ☐ No

**7.** Have you ever required medical treatment for a latex reaction?  
If YES, please explain:  
☐ Yes  ☐ No

**8.** Do you have an EPI pen because of a latex allergy?  
☐ Yes  ☐ No

---

**Below Section EHS Staff Only**

☐ No Allergy  ☐ Irritant Derm  ☐ Type IV Latex Allergy

☐ Type I Latex Allergy  ☐ **Type 1 Accommodation Request Sent**  ☐ Latex Sticker Given

Medical Alert Bracelet Recommended  ☐ Yes  ☐ No

EPI Pen Thru Your PCP (Primary Care Physician) Recommended  ☐ Yes  ☐ No

Latex Surveillance Appointment Needed  ☐ Yes  ☐ No

Follow-Up:  ☐ Annually  ☐ Semiannually  ☐ None Needed
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.

<table>
<thead>
<tr>
<th>NAME:</th>
<th>DOB:</th>
<th>AGE:</th>
<th>DATE:</th>
</tr>
</thead>
</table>

| GENDER: ☐ MALE ☐ FEMALE | HEIGHT: _____ | WEIGHT: _____ |

| HOME/CELL PHONE: | DEPARTMENT: | JOB TITLE: |

**PART A SECTION 1. (MANDATORY) THE FOLLOWING INFORMATION MUST BE PROVIDED BY EVERY EMPLOYEE.**

1. Has your employer told you how to contact the health care professional who will review this questionnaire?  
   ☐ Yes ☐ No

2. Have you worn a respirator?  
   If YES, what type:  
   ☐ Yes ☐ No

**PART A SECTION 2 (MANDATORY) QUESTIONS 1 THROUGH 10 BELOW MUST BE ANSWERED BY EVERY EMPLOYEE. (please indicate “YES” OR “NO”) If any YES, please explain. (Please print)**

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?  
   ☐ Yes ☐ No

2. Have you ever had any of the following conditions?
   - 2a. Seizures (fits)  
     If YES, please explain:  
     ☐ Yes ☐ No
   - 2b. Diabetes (sugar disease)  
     If YES, please explain:  
     ☐ Yes ☐ No
   - 2c. Allergic reactions that interfere with your breathing  
     If YES, please explain:  
     ☐ Yes ☐ No
   - 2d. Claustrophobia (fear of closed-in places)  
     If YES, please explain:  
     ☐ Yes ☐ No
   - 2e. Trouble smelling odors  
     If YES, please explain:  
     ☐ Yes ☐ No

3. Have you ever had any of the following pulmonary or lung problems?
   - 3a. Asbestosis  
     If YES, please explain:  
     ☐ Yes ☐ No
   - 3b. Asthma  
     If YES, please explain:  
     ☐ Yes ☐ No
   - 3c. Chronic bronchitis  
     If YES, please explain:  
     ☐ Yes ☐ No
   - 3d. Emphysema  
     If YES, please explain:  
     ☐ Yes ☐ No
   - 3e. Pneumonia  
     If YES, please explain:  
     ☐ Yes ☐ No
   - 3f. Tuberculosis  
     If YES, please explain:  
     ☐ Yes ☐ No
**RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE - N95**  
(*RESPIRATORY ISOLATION MASK*)

APPENDIX C TO SEC.1910.134: OSHA RESPIRATORY MEDICAL EVALUATION QUESTIONNAIRE (MANDATORY)

### 3g. Silicosis
- **If YES, please explain:**
  
- **Options:**
  - ☐ Yes
  - ☐ No

### 3h. Pneumothorax (collapsed lung)
- **If YES, please explain:**
  
- **Options:**
  - ☐ Yes
  - ☐ No

### 3i. Lung cancer
- **If YES, please explain:**
  
- **Options:**
  - ☐ Yes
  - ☐ No

### 3j. Broken ribs
- **If YES, please explain:**
  
- **Options:**
  - ☐ Yes
  - ☐ No

### 3k. Any chest injuries or surgeries
- **If YES, please explain:**
  
- **Options:**
  - ☐ Yes
  - ☐ No

### 3l. Any chest lung problem that you’ve been told about
- **If YES, please explain:**
  
- **Options:**
  - ☐ Yes
  - ☐ No

### 4. Do you currently have any of the following symptoms of pulmonary or lung illness?

#### 4a. Shortness of breath
- **If YES, please explain:**
  
- **Options:**
  - ☐ Yes
  - ☐ No

#### 4b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline
- **If YES, please explain:**
  
- **Options:**
  - ☐ Yes
  - ☐ No

#### 4c. Shortness of breath when walking with other people at an ordinary pace on level ground
- **If YES, please explain:**
  
- **Options:**
  - ☐ Yes
  - ☐ No

#### 4d. Have to stop for breath when walking at your own pace on level ground
- **If YES, please explain:**
  
- **Options:**
  - ☐ Yes
  - ☐ No

#### 4e. Shortness of breath when washing or dressing yourself
- **If YES, please explain:**
  
- **Options:**
  - ☐ Yes
  - ☐ No

#### 4f. Shortness of breath that interferes with your job
- **If YES, please explain:**
  
- **Options:**
  - ☐ Yes
  - ☐ No

#### 4g. Coughing that produces phlegm (thick sputum)
- **If YES, please explain:**
  
- **Options:**
  - ☐ Yes
  - ☐ No

#### 4h. Coughing that wakes you early in the morning
- **If YES, please explain:**
  
- **Options:**
  - ☐ Yes
  - ☐ No

#### 4i. Coughing that occurs mostly when you are laying down
- **If YES, please explain:**
  
- **Options:**
  - ☐ Yes
  - ☐ No

#### 4j. Coughing up blood in the last month
- **If YES, please explain:**
  
- **Options:**
  - ☐ Yes
  - ☐ No

#### 4k. Wheezing
- **If YES, please explain:**
  
- **Options:**
  - ☐ Yes
  - ☐ No

#### 4l. Wheezing that interferes with your job
- **If YES, please explain:**
  
- **Options:**
  - ☐ Yes
  - ☐ No

#### 4m. Chest pain when you breathe deeply
- **If YES, please explain:**
  
- **Options:**
  - ☐ Yes
  - ☐ No

#### 4n. Any other symptoms that you think may be related to lung problems
- **If YES, please explain:**
  
- **Options:**
  - ☐ Yes
  - ☐ No

#### 4o. Do you have uncontrolled thyroid problems
- **If YES, please explain:**
  
- **Options:**
  - ☐ Yes
  - ☐ No

#### 4p. Do you have problems with temperature regulations
- **If YES, please explain:**
  
- **Options:**
  - ☐ Yes
  - ☐ No
4q. Have you ever had “heat” stroke
   If YES, please explain:
   ☐ Yes ☐ No

4r. Do you have history of heat intolerance
   If YES, please explain:
   ☐ Yes ☐ No

5. Have you ever had any of the following cardiovascular or heart problems?
   5a. Heart attack
       If YES, please explain:
       ☐ Yes ☐ No
   5b. Stroke
       If YES, please explain:
       ☐ Yes ☐ No
   5c. Angina
       If YES, please explain:
       ☐ Yes ☐ No
   5d. Heart failure
       If YES, please explain:
       ☐ Yes ☐ No
   5e. Swelling in your legs or feet (not caused by walking)
       If YES, please explain:
       ☐ Yes ☐ No
   5f. Heart arrhythmia (heart beating irregularly)
       If YES, please explain:
       ☐ Yes ☐ No
   5g. High blood pressure
       If YES, please explain:
       ☐ Yes ☐ No
   5h. Any other symptoms that you can think may be related to lung
       If YES, please explain:
       ☐ Yes ☐ No

6. Have you ever had any of the following cardiovascular or heart symptoms?
   6a. Frequent pain or tightness in your chest
       If YES, please explain:
       ☐ Yes ☐ No
   6b. Pain or tightness in your chest during physical activity
       If YES, please explain:
       ☐ Yes ☐ No
   6c. Pain or tightness in your chest that interferes with your job
       If YES, please explain:
       ☐ Yes ☐ No
   6d. In the past two years, have you noticed your heart skipping or missing a beat
       If YES, please explain:
       ☐ Yes ☐ No
   6e. Heartburn or indigestion that is not related to eating
       If YES, please explain:
       ☐ Yes ☐ No
   6f. Any other symptoms that you think may be related to heart or circulation problems
       If YES, please explain:
       ☐ Yes ☐ No

7. Do you currently take medication for any of the following problems?
   7a. Breathing or lung problems
       If YES, list medications:
       ☐ Yes ☐ No
   7b. Heart trouble
       If YES, list medications:
       ☐ Yes ☐ No
   7c. Blood pressure
       If YES, list medications:
       ☐ Yes ☐ No
   7d. Seizures
       If YES, list medications:
       ☐ Yes ☐ No
   7e. List any other medications:
**RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE - N95**  
**RESPIRATORY ISOLATION MASK**

**APPENDIX C TO SEC.1910.134: OSHA RESPIRATORY MEDICAL EVALUATION QUESTIONNAIRE (MANDATORY)**

<table>
<thead>
<tr>
<th>8.</th>
<th>(If you’ve never used a respirator, check never used and go to question #9) Have you ever had any of the following problems while using a respirator?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Never used</td>
</tr>
<tr>
<td>8a.</td>
<td>Eye irritation</td>
</tr>
<tr>
<td></td>
<td>If YES, please explain:</td>
</tr>
<tr>
<td></td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>8b.</td>
<td>Skin allergies or rashes</td>
</tr>
<tr>
<td></td>
<td>If YES, please explain:</td>
</tr>
<tr>
<td></td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>8c.</td>
<td>Anxiety</td>
</tr>
<tr>
<td></td>
<td>If YES, please explain:</td>
</tr>
<tr>
<td></td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>8d.</td>
<td>General weakness or fatigue</td>
</tr>
<tr>
<td></td>
<td>If YES, please explain:</td>
</tr>
<tr>
<td></td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>8e.</td>
<td>Seizures (fits)</td>
</tr>
<tr>
<td></td>
<td>If YES, please explain:</td>
</tr>
<tr>
<td></td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9.</th>
<th>Would you like to talk to the healthcare professional who will review this questionnaire about your answers to this questionnaire?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

*BELOW SECTION EHS STAFF ONLY*

- □ Employee is cleared to perform job duties with use of a respirator
- □ Employee needs an appointment with employee health service for further evaluation
- □ Other recommendations:

It should be noted that medical qualification for respirator use is dependent upon proper fit testing and instruction regarding use and maintenance of respiratory equipment.

Nurse OR Physician Signature:  
Date:
The purpose of this document is to outline the University of California, Davis Medical Center policy for pre-employment health screening and immunization.

I. SETTING: UC DAVIS MEDICAL CENTER

II. POLICY

It is the University of California, Davis Medical Center policy that all new employees, as a condition of employment, be required to pass a health clearance & infectious disease evaluation. All services are provided without charge to the individual.

A. PROCEDURES

The pre-employment screening of all new employees shall include:

1. WORK RELATED HEALTH ASSESSMENT

Work related health assessment forms will be completed and then reviewed with a provider/clinician in EHS. Additional evaluations or documentation may be required before an applicant is cleared for employment. This may be necessary to clarify the ability of a prospective employee to safely perform the essential functions of their job duties or determine reasonable accommodations.

2. TB SCREENING

TB screening will consist of one or more of the following:

a. TB PPD Skin Test (TST), primary testing method;
b. Quantiferon blood test, if meeting specific criteria;
c. Chest X-Ray;
d. TB Symptom Interview.

The screening selected will be determined at the time of your appointment.

In the event that you have had a BCG vaccine during your lifetime, or have had a positive PPD skin test, a Quantiferon test and/or a CXR may be used along with the TB symptom interview.

3. TB SKIN TESTING

The two step process for TST involves either the following

a. Placing an initial PPD skin test with a “read” 48 to 72 hours after placement, followed by a second test 1 to 4 weeks after the initial test reading. This method of testing is utilized for those individuals who have never had a TB skin test or the testing has lapse for 366 days or more.
b. One test within 365 days before the employment start date and one test within 90 days before the employment start date.

4. QUANTIFERON AND CHEST X-RAY (CXR), as determined by EHS as needed.

Quantiferon blood testing and/or a CXR needs to be completed within 90 days before the employment start date.
5. POSITIVE TB TESTS

Those who have a positive TB screening test or are known positive must have a one view PA CXR documenting no active TB. A recent negative CXR, within 90 days before the employment start date, will be accepted in lieu of a new CXR.

Applicants with a positive TST who have no active disease will be referred to their primary care providers (PCP) to discuss INH therapy for LTBI (Latent TB Infection). Those with evidence of possible active disease will be referred to their PCP for further evaluations. In such cases, clearance will not be granted until adequate evaluation and treatment is complete, as determined by the Employee Health Services Department.

6. IMMUNIZATION EVALUATION

All employees must have an evaluation of immunity to Measles, Mumps, Rubella, Varicella and Pertussis. Individuals with potential exposure to blood and body fluids will be evaluated for Hepatitis B.

If the evaluation, by review of records or blood tests (serologic immunity), reveals that you are not immune to any of the diseases listed above, a vaccine will be offered at no cost to you.

Hepatitis C testing will be provided to employees with potential contact with blood and body fluids. There is currently no vaccine for Hepatitis C.

7. PROOF OF IMMUNITY

It is a condition of employment that all new hires show proof of immunity unless otherwise specified.

MMR

Two documented doses of MMR vaccine, given after the age of 1 year old, OR documented serum immunity. (If administered doses are documented separately, only one dose of rubella is required)

VARICELLA

Documented serologic immunity or 2 documented vaccines given at least 4 weeks apart.

HEPATITIS B

Documentation of serum immunity with a numerical value is required to verify immunity. Simply having the 3 vaccine series is not adequate proof of immunity. Evidence of serum immunity as determined by the lab performing the test (UCDMC currently >12mIU/ml) at any one time during your life will be considered immune. A negative titer after receiving a Hep B series will be evaluated for additional injections and titers.

TETANUS/PERTUSSIS (Whooping Cough)

A Tdap vaccination will be offered to individuals without documentation of receiving this vaccine.

INFLUENZA VACCINATIONS

Influenza vaccine is offered to all employees during the influenza season. All employees are encouraged to have this immunization, yearly, to help protect themselves, their patients, coworkers and family from seasonal influenza. Those not wishing to receive this vaccine must sign a declination. Non-immunized persons may be required to wear a mask while on university property during flu season.
8. WORK ACCOMMODATION

If you have a disability, please inform the EHS department so that the disability may be evaluated for a reasonable work accommodation request to the hiring department.

9. DISCLOSURE

You may choose to have all of your necessary labs and x-rays completed elsewhere, at your own expense, and bring it to your EHS appointment or you may have any necessary lab work and x-rays done to complete the health screening, free of charge, through EHS. If done through EHS, EHS utilizes UCDMC lab and x-ray services. Therefore, any tests/results may be in the UCDMC EMR in your medical record as well as the EHS EMR.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND AGREE TO HAVE THE APPROPRIATE EVALUATION/TESTING AS OUTLINED ABOVE.

I AGREE TO BE TESTED FOR:

MEASLES
MUMPS
RUBELLA
VARICELLA
HEPATITIS B
HEPATITIS C
ACTIVE OR LATENT TB QUANTIFERON/ TB SKIN TEST/ CHEST X-RAY

PRINT NAME: __________________________ SIGNATURE: __________________________

DATE: _____ - _____ - ________
UCDMC Employee Health Services

Annual TB Symptom-Screening Questionnaire

If at any time you develop an unexplained cough >3 weeks, especially if associated with extreme fatigue, new
night sweats, fevers > 3 weeks, or significant ‘unexplained’ weight loss you should report this to EHS and your
PCP immediately.

Name: ________________________________  DOB: ______________  Date: ______________

New Employee □ Yes □ No  Employee or Volunteer Identification Number: ________________

In order to meet health compliance regulations, it is required that all employees and physicians participate in
annual tuberculosis surveillance. This testing is mandatory and is a condition of continued employment.

All questions must be answered.

Prior to PPD/Quantiferon testing this annual TB Symptom screening questionnaire must be completed.

□ Yes □ No Have you had a *BCG vaccination? (*BCG is a vaccine given to those born outside the United States.)
□ Yes □ No Have you ever had a Positive PPD skin test?
□ Yes □ No Have you ever had a Positive Quantiferon test?
□ Yes □ No Have you completed treatment for latent/active TB?

If “Yes” What Year _____; How Many Months______; What Prescription_________

□ Yes □ No Do you have any known immune problems?  If “Yes” What? __________________________

□ Yes □ No Have you had any known exposures to active TB?  If “Yes” when? ______________________

In the last year, have you had any of the following progressive symptoms?

□ Yes □ No Unexplained, Persistent cough lasting three weeks or more?
□ Yes □ No Unexplained, Persistent excessive fatigue?
□ Yes □ No Unexplained, Coughing up bloody sputum/phlegm?
□ Yes □ No Unexplained, Fevers lasting three weeks or more?
□ Yes □ No Unexplained, Night sweats?
□ Yes □ No Unexpected, Weight loss?

Employee Signature: _________________________

EHS Staff Signature: __________________________

Annual TB Questionnaire January 2015
DISCLOSURE NOTICE

DISCLOSURE: YOU MAY CHOOSE TO HAVE ALL OF YOUR NECESSARY LABS AND X-RAYS COMPLETED ELSEWHERE, AT YOUR OWN EXPENSE, AND BRING IT TO YOUR EHS APPOINTMENT OR, YOU CAN HAVE ANY NECESSARY LABS AND X-RAYS COMPLETED FREE OF CHARGE, THROUGH EHS. IF DONE THROUGH EHS THE RESULTS COULD BE PLACED INTO THE UC DAVIS MEDICAL CENTER (UCDMC) ELECTRONIC MEDICAL RECORDS (EMR) AND WOULD BE AVAILABLE TO BE VIEWED BY UCDMC.

I HAVE READ THE DISCLOSURE ABOVE AND AGREE FOR SERVICES RENDERED AT EHS.

PRINT NAME: __________________________ SIGNATURE: _____________________________

DATE: _______________________

PATRICK LASTOWSKI, RN
MANAGER, EHS

Shared drive/PE’s/Disclosure Notice January 2015
**NEW HIRE QUESTIONNAIRE FOR CLEARANCE**

*CONFIDENTIAL*

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name:</th>
<th>Middle name:</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

**Gender:**
- ☐ Male
- ☐ Female

**Date of birth:**

**Phone #**

**Address:**

**City:**

**State:**

**Zip:**

**Department:**

**Job Title:**

---

**I am aware of the essential job functions for the position for which I am applying.**

**Signature:** _______________________________  **Date:** ____________

---

**PLEASE NOTE: ANSWER THE QUESTIONS BELOW AS THEY RELATE TO THE ESSENTIAL FUNCTIONS OF THE JOB FOR WHICH YOU ARE APPLYING. ***YOUR RESPONSES WILL BE USED TO DETERMINE IF WORK ACCOMMODATIONS WILL NEED TO BE REQUESTED.**

**1.** Do you have any condition, illness, injury, or are taking any medication that affects any of the following job related abilities for your position as identified in the job description?  
- ☐ Yes  ☐ No

If YES, please explain:

---

**2.** Vision problems that would affect your ability to do the following?

<p>| | |</p>
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>2a. Distinguish colors</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>If YES, please explain:</td>
<td></td>
</tr>
<tr>
<td>2b. Read or see objects clearly</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>If YES, please explain:</td>
<td></td>
</tr>
<tr>
<td>2c. See at a distance</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>If YES, please explain:</td>
<td></td>
</tr>
<tr>
<td>2d. See in dim light</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>If YES, please explain:</td>
<td></td>
</tr>
<tr>
<td>2e. Work at a computer monitor</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>If YES, please explain:</td>
<td></td>
</tr>
<tr>
<td>2d. Work under fluorescent lighting</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>If YES, please explain:</td>
<td></td>
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</tbody>
</table>

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**3.** Hearing problems that would affect your ability to do the following?

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<table>
<thead>
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</thead>
<tbody>
<tr>
<td>3a. Hear normal speaking voice</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>If YES, please explain:</td>
<td></td>
</tr>
<tr>
<td>3b. Hear in noisy situations</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>If YES, please explain:</td>
<td></td>
</tr>
<tr>
<td>3c. Requires you to avoid exposure to excessive noise</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>If YES, please explain:</td>
<td></td>
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</tbody>
</table>

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**4.** Speech problems that would affect your ability to do the following?

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<table>
<thead>
<tr>
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<tbody>
<tr>
<td>4a. Communicate to others by speech</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>If YES, please explain:</td>
<td></td>
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</tbody>
</table>

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**5.** Shoulder/elbow problems that would affect your ability to do the following?

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<table>
<thead>
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</thead>
<tbody>
<tr>
<td>5a. Move either shoulder or fully extend either arm overhead</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>If YES, please explain:</td>
<td></td>
</tr>
</tbody>
</table>
5b. Lift with either arm
   If YES, please explain: ☐ Yes ☐ No

5c. Push or pull with either arm
   If YES, please explain: ☐ Yes ☐ No

5d. Twist or turn with either arm
   If YES, please explain: ☐ Yes ☐ No

6. **Hand/wrist problems that would affect your ability to do the following?**

   6a. Do repetitive grasping or gripping
       If YES, please explain: ☐ Yes ☐ No

   6b. Do forceful grasping or gripping
       If YES, please explain: ☐ Yes ☐ No

   6c. Do repetitive or rapid finger movements
       If YES, please explain: ☐ Yes ☐ No

7. **Foot/leg problems that would affect your ability to do the following?**

   7a. Walk
       If YES, please explain: ☐ Yes ☐ No

   7b. Squat
       If YES, please explain: ☐ Yes ☐ No

   7c. Kneel
       If YES, please explain: ☐ Yes ☐ No

   7d. Climb
       If YES, please explain: ☐ Yes ☐ No

   7e. Walk on uneven or slippery surfaces
       If YES, please explain: ☐ Yes ☐ No

8. **Neck problems that would affect your ability to do the following?**

   8a. Fully bend or rotate your neck
       If YES, please explain: ☐ Yes ☐ No

   8b. Hold your neck in a fixed position for a long prolonged period of time
       If YES, please explain: ☐ Yes ☐ No

9. **Back problems that would affect your ability to do the following?**

   9a. Sit for prolonged time
       If YES, please explain: ☐ Yes ☐ No

   9b. Stand for prolonged time
       If YES, please explain: ☐ Yes ☐ No

   9c. Walk for prolonged time
       If YES, please explain: ☐ Yes ☐ No

   9d. Bend your back frequently
       If YES, please explain: ☐ Yes ☐ No

   9e. Lift or carry 1-5 pounds
       If YES, please explain: ☐ Yes ☐ No

   9f. Lift or carry 6-10 pounds
       If YES, please explain: ☐ Yes ☐ No

   9g. Lift or carry 11-25 pounds
       If YES, please explain: ☐ Yes ☐ No

   9h. Lift or carry greater than 26 pounds
       If YES, please explain: ☐ Yes ☐ No
10. **Breathing problems that would affect your ability to do the following?**

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<table>
<thead>
<tr>
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<tbody>
<tr>
<td>10a.</td>
<td>Work outdoors in cold, hot or humid weather</td>
</tr>
<tr>
<td></td>
<td>If YES, please explain:</td>
</tr>
<tr>
<td></td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>10b.</td>
<td>Work around fumes or dust</td>
</tr>
<tr>
<td></td>
<td>If YES, please explain:</td>
</tr>
<tr>
<td></td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>10c.</td>
<td>Work around pollen, dust, mold</td>
</tr>
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<td></td>
<td>If YES, please explain:</td>
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<tr>
<td></td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>10d.</td>
<td>Walk rapidly</td>
</tr>
<tr>
<td></td>
<td>If YES, please explain:</td>
</tr>
<tr>
<td></td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>10e.</td>
<td>Walk for a prolonged time</td>
</tr>
<tr>
<td></td>
<td>If YES, please explain:</td>
</tr>
<tr>
<td></td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>10f.</td>
<td>Run</td>
</tr>
<tr>
<td></td>
<td>If YES, please explain:</td>
</tr>
<tr>
<td></td>
<td>□ Yes □ No</td>
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<tr>
<td>10g.</td>
<td>Climb stair or walk uphill</td>
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<tr>
<td></td>
<td>If YES, please explain:</td>
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<tr>
<td></td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>10h.</td>
<td>Walk while carrying 1-5 pounds</td>
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<td>If YES, please explain:</td>
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<td></td>
<td>□ Yes □ No</td>
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<tr>
<td>10i.</td>
<td>Walk while carrying 6-10 pounds</td>
</tr>
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<td></td>
<td>If YES, please explain:</td>
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<tr>
<td></td>
<td>□ Yes □ No</td>
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<tr>
<td>10j.</td>
<td>Walk while carrying 11-26 pounds</td>
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<td>If YES, please explain:</td>
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<td></td>
<td>□ Yes □ No</td>
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<tr>
<td>10k.</td>
<td>Walk while carrying greater than 26 pounds</td>
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<td>If YES, please explain:</td>
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<td>□ Yes □ No</td>
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11. **Cardiac/heart problems or take any medication which would limit your ability to?**

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<tbody>
<tr>
<td>11a.</td>
<td>Walk rapidly</td>
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<td></td>
<td>If YES, please explain:</td>
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<tr>
<td></td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>11b.</td>
<td>Walk for a prolonged time</td>
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<td></td>
<td>If YES, please explain:</td>
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<tr>
<td></td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>11c.</td>
<td>Run</td>
</tr>
<tr>
<td></td>
<td>If YES, please explain:</td>
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<tr>
<td></td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>11d.</td>
<td>Climb stair or walk uphill</td>
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<td></td>
<td>If YES, please explain:</td>
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<tr>
<td></td>
<td>□ Yes □ No</td>
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<tr>
<td>11e.</td>
<td>Walk while carrying 1-5 pounds</td>
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<td></td>
<td>If YES, please explain:</td>
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<tr>
<td></td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>11f.</td>
<td>Walk while carrying 6-10 pounds</td>
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<td></td>
<td>If YES, please explain:</td>
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<tr>
<td></td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>11g.</td>
<td>Walk while carrying 11-26 pounds</td>
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<tr>
<td></td>
<td>If YES, please explain:</td>
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<tr>
<td></td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>11h.</td>
<td>Walk while carrying greater than 26 pounds</td>
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<tr>
<td></td>
<td>If YES, please explain:</td>
</tr>
<tr>
<td></td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>11i.</td>
<td>Change positions rapidly</td>
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<td>If YES, please explain:</td>
</tr>
<tr>
<td></td>
<td>□ Yes □ No</td>
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</table>

12. **Balance and/or consciousness conditions or are taking any medication which could cause?**

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<table>
<thead>
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<tbody>
<tr>
<td>12a.</td>
<td>Dizziness or loss of balance</td>
</tr>
<tr>
<td></td>
<td>If YES, please explain:</td>
</tr>
<tr>
<td></td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>
12b. Fainting or loss of consciousness  
   If YES, please explain:  [ ] Yes  [ ] No

12c. Seizures or convulsions  
   If YES, please explain:  [ ] Yes  [ ] No

12d. Inability to do night shift or variable shift work  
   If YES, please explain:  [ ] Yes  [ ] No

13. Psychological and/or emotional disorder condition which would cause?  
13a. Inability to work closely with others  
   If YES, please explain:  [ ] Yes  [ ] No

13b. Inability to follow multiple directions or multitask  
   If YES, please explain:  [ ] Yes  [ ] No

13c. History of claustrophobia  
   If YES, please explain:  [ ] Yes  [ ] No

13d. Inability to be in confined spaces  
   If YES, please explain:  [ ] Yes  [ ] No

13e. Inability to wear a face mask  
   If YES, please explain:  [ ] Yes  [ ] No

14. Allergies to the following?  
14a. To medication you may be exposed to at work  
   If YES, please explain:  [ ] Yes  [ ] No

14b. Perfumes or smells  
   If YES, please explain and list:  [ ] Yes  [ ] No

14c. Animals  
   If YES, please explain and list:  [ ] Yes  [ ] No

14d. Foods  
   If YES, please explain and list:  [ ] Yes  [ ] No

15. Immune system?  
15a. Any condition that would limit your ability to work around infectious agents  
   If YES, please explain:  [ ] Yes  [ ] No

16. Any other condition that would limit your ability to do any of the essential job functions?  
   If YES, please explain:  [ ] Yes  [ ] No

17. TB Information  
17a. HAVE YOU EVER HAD A POSITIVE TB TEST?  [ ] Yes  [ ] No

17b. HAVE YOU EVER HAD A BCG VACCINATION?  [ ] Yes  [ ] No

17c. HAVE YOU EVER BEEN TREATED FOR LATENT TB?  [ ] Yes  [ ] No

I attest that the above is true to the best of my knowledge. I understand that knowingly answering any of the above questions falsely will lead to immediate dismissal.

Signature:  
Date: