PRE-EMPLOYMENT SCREENING AND IMMUNIZATION DOCUMENTATION

In order to protect the health of all residents/fellows, employees and patients, and in order to comply with CDC guidelines and immunization requirements mandated by state and federal agencies, all new residents/fellows must undergo pre-immunization/Tuberculosis screening performed by Employee Health Services (EHS) staff before beginning training, payroll or benefits.

The following are required:

1. History of measles, mumps, rubella immunization AND positive antibody titer**.
2. History of chicken pox or varicella vaccination AND positive antibody titer**.
3. History of Hepatitis B vaccination AND positive Hepatitis B surface antibody titer**.
4. Proof of two PPD skin tests at least 2 weeks apart or Quantiferon TB Gold test within the past 12 months. If there is a history of positive PPD or Quantiferon test in the past, a chest x-ray report less than 1 year old is required.
5. All residents/fellows will be screened for verbal or documented history of Tetanus Diphtheria vaccination and if needed, vaccination will be provided at no cost.

In order to facilitate the screening process:

Complete the required immunizations/TB skin tests and have your healthcare provider complete and sign the immunization documentation form. Do not sign the form yourself. Complete the Patient Questionnaire/Medical History screening form. Bring these documents to your appointment, do not fax or mail them. If you have your vaccination records and/or titers, bring them to your appointment.

If the immunization/TB test records and antibody titers are not available, we will obtain blood for antibody titers and provide TB skin test/Chest x-ray at no charge, but this may delay your clearance. If needed, the required vaccinations will also be provided at no charge. If required, you must return to EHS as scheduled for subsequent PPD skin tests, vaccinations and/or titers, otherwise the Graduate Medical Education (GME) will be notified that you are no longer fit for duty.

It is very important that you schedule an appointment early! When you call, it is important that you identify yourself as a resident/fellow.

Our contact information:

Employee Health Service/Division of Occupational and Environmental Medicine
270 Farmington Avenue, Suite 262
Telephone: 860-679-2893; Fax: 860-679-4587
Email for residents/fellows only: **EHS-Residents@uchc.edu**
General e-mail: occmedehs@uchc.edu

Keep a copy of your immunization documentation and bring it with you to your appointment.

Immunization Documentation Requirements

Measles (Rubeola), **Mumps, Rubella**

Laboratory report/documentation of immune serum antibody titer

Varicella

Laboratory report/documentation of immune serum antibody titer

Hepatitis B

Immunity for those with potential exposure to blood and bodily fluids by:

a) Three doses of Hepatitis B vaccine in the past **AND** a positive titer after at least one month from the third vaccine dose **OR**
b) Laboratory report/documentation of positive Hepatitis B antibody titer in the past

Tuberculosis (TB) Screening

a) Two Tuberculin Skin Tests with negative results, by the Mantoux technique (with purified protein derivative, PPD, 5TU intradermally applied), within the past 12 months **OR**
b) Results of radiography of the chest for those with a history a **positive Tuberculin Skin Test or treated TB** in the past (written report acceptable for an x-ray obtained in the US, otherwise copy film from a radiography obtained abroad will be necessary)

Tetanus-diphtheria toxoid is highly recommended by the CDC to be given every 10 years. **Tetanus-diphtheria acellular pertussis (Tdap)** is recommended for HCW once in the adult life, 2 years from the last Td.

Residents/fellows and students who cannot obtain the documentation form signed by their provider but have other immunization records with their provider signature (i.e., MD, APRN, RN) must complete the enclosed form and attach a copy of their previous record. Residents/fellows and students cannot sign for themselves.

DIRECTIONS

Division of Occupational & Environmental Medicine, UConn Health
270 Farmington Ave, The Exchange, Suite 262, Farmington, CT 06032-6210, (860) 679-4096

From I-84

- ❒ Take Exit 39 (Farmington Exit).
- ❒ Turn right at first traffic light onto Route 4 East (Farmington Avenue).
- ❒ Stay in the left lane for 0.6 miles through two sets of lights. At the third light, turn left to enter **The Exchange** office complex, located directly across the street from the UConn Health main campus entrance.
- ❒ After turning left into the Exchange, turn left at second stop sign and proceed to a large parking area. Enter through **Building 3** Main Entrance, take elevator to second floor and turn left. Suite 262 is on the left near the end of the hallway.

From Northbound Rte. 9 (From the New Haven area, take I-91 to Route 9 North)

- ❒ From Route 9, take Exit 32 (left exit) onto I-84 West and stay in the right lane (if you go on to Route 72 in New Britain, you will instead get on I-84 East).
- ❒ Take Exit 39 (first exit).
- ❒ Turn right at first traffic light onto Route 4 East (Farmington Avenue).
- ❒ Stay in the left lane for 0.6 miles through two sets of lights. At the third light, turn left to enter **The Exchange** office complex, located directly across the street from the UConn Health main campus entrance.
- ❒ After turning left into the Exchange, turn left at second stop sign and proceed to a large parking area. Enter through **Building 3** Main Entrance, take elevator to second floor and turn left. Suite 262 is on the left near the end of the hallway.

From Route 8 (From the Bridgeport area; from New York, take I-95 or the Merritt Parkway to Route 8 North in Bridgeport)

- ❒ From Route 8, take the exit for I-84 East in Waterbury.
- ❒ Take Exit 39 (first exit).
- ❒ Turn right at first traffic light onto Route 4 East (Farmington Avenue).
- ❒ Stay in the left lane for 0.6 miles through two sets of lights. At the third light, turn left to enter **The Exchange** office complex, located directly across the street from the UConn Health main campus entrance.
- ❒ After turning left into the Exchange, turn left at second stop sign and proceed to a large parking area. Enter through **Building 3** Main Entrance, take elevator to second floor and turn left. Suite 262 is on the left near the end of the hallway.

From Bradley International Airport

- ❒ Follow Route 20 to I-91 South to I-84 West in Hartford.
- ❒ Follow I-84 West about 7 miles to Exit 39.
- ❒ Turn right at first traffic light onto Route 4 East (Farmington Avenue).
- ❒ Stay in the left lane for 0.6 miles through two sets of lights. At the third light, turn left to enter **The Exchange** office complex, located directly across the street from the UConn Health main campus entrance.
- ❒ After turning left into the Exchange, turn left at second stop sign and proceed to a large parking area. Enter through **Building 3** Main Entrance, take elevator to second floor and turn left. Suite 262 is on the left near the end of the hallway.

University of Connecticut
Health Center
UCONN Medical Group
Occupational Medicine Clinic
Employee Health Service

(Patient Identification)

IMMUNIZATION DOCUMENTATION FORM

First Name_____Last Name_____Date of Birth _____

Employee	**Resident**	**Student**	**Grad Student**	**Volunteer**
Department:	Medical	Medical	MPH	Adult
_____	Dental	Dental	PhD	Youth
Job Title:	Start Yr._____	Start Yr._____	**Post-Doctorate**	Summer
_____				

MMR TITERS ARE REQUIRED
Date of Measles titer _____/_____/_____ Immune Not immune
Date of Mumps titer _____/_____/_____ Immune Not immune
Date of Rubella titer _____/_____/_____ Immune Not immune

MMR VACCINATIONS
1st vaccination _____/_____/_____
2nd vaccination _____/_____/_____

VARICELLA TITER REQUIRED
Date of Varicella titer _____/_____/_____ Immune Not immune
Verbal History of illness: (*circle*) YES NO

VARICELLA VACCINATIONS
1st vaccination _____/_____/_____
2nd vaccination _____/_____/_____

Tetanus diphtheria (Td)
Date of last booster dose _____/_____/_____

Tetanus diphtheria accellular pertussis (Tdap)
Date of vaccine _____/_____/_____

TUBERCULOSIS: 2 TUBERCULIN SKIN TESTS WITHIN PAST 12 MONTHS REQUIRED
Type PPD 1st _____/_____/_____
Result *(circle)* Positive (mm) Negative
If positive PPD, Chest x-ray must be within 12 months.
Chest x-ray date _____/_____/_____
Results (*circle*) Negative Positive
BCG History: (*circle*) YES NO

PPD 2nd _____/_____/_____
Positive (mm) Negative
Quantiferon TB Gold -Date _____/_____/_____
Results _____

HEPATITIS B VACCINATIONS Titer Post Vaccination Required (Not required for Volunteers**)**
Naturally Immune? *(circle)* Yes No
1st Dose _____/_____/_____
2nd Dose _____/_____/_____
3rd Dose _____/_____/_____
Titer Date _____/_____/_____
Titer Result *(circle)* Positive Negative

Previously vaccinated *(circle)* Yes No Unknown
4th Dose _____/_____/_____
5th Dose _____/_____/_____
6th Dose _____/_____/_____
Titer Date _____/_____/_____
Titer Result *(circle)* Positive Negative

The documentation above was completed by:

_____ _____ _____
Name of Health Care Provider *(print)* Telephone Number Address

_____ _____
Signature of Health Care Provider Date/Time

PLEASE BRING COMPLETED FORM WITH YOU TO YOUR APPOINTMENT, OR SEND OR FAX TO: UCONN HEALTH CENTER, SECTION OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE, MEDICAL RECORDS, 263 FARMINGTON AVENUE, FARMINGTON, CT 06030-6210
Fax# 860-679-4587 ***Telephone#*** 860-679-2893

HCH1544

University of Connecticut
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IMMUNIZATION CONSENT / DECLINATION

Type of Vaccine: (circle) **MMR Varicella Tdap Td**

CONSENT

I have read or have had explained to me the information on the Vaccine Information Sheet. I have had a chance to ask questions which were answered to my satisfaction. I understand that due to my occupational exposure, whether by employment, residency, clerkship or volunteering, I may be at risk of acquiring infection. I believe I understand the benefits and risks of the vaccine and request that the vaccine checked above be given to me or to the person named below for whom I am authorized to make this request.

_____ _____ _____
Patient or Legal Guardian Signature Relationship Date/Time

Type of Vaccine: MMR (0.5ml subcutaneous)

#1 Date/Time_____ Manufacturer: _____Lot#_____ Exp_____Site _____

Provider _____ VIS Edition Date_____

#2 Date/Time_____ Manufacturer: _____Lot#_____ Exp_____Site _____

Provider _____ VIS Edition Date_____

Type of Vaccine: Tdap / Td (0.5ml intramuscular)

Date/Time_____ Manufacturer: _____Lot#_____ Exp_____Site _____

Provider _____ VIS Edition Date_____

Type of Vaccine: Varicella (0.5ml subcutaneous)

#1 Date/Time_____ Manufacturer: _____Lot#_____ Exp_____Site _____

Provider _____ VIS Edition Date_____

#2 Date/Time_____ Manufacturer: _____Lot#_____ Exp_____Site _____

Provider _____ VIS Edition Date_____

DECLINATION

I understand the information provided and explained to me on the vaccine. I understand that due to my employment, residency, clerkship or volunteering, I may be at risk of acquiring infection. I have been given the opportunity to be vaccinated with the vaccine. However, I decline vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring a serious disease. If in the future I continue to have exposure to this infectious disease and want to be vaccinated, I can receive the vaccine at that time.

Type of Vaccine: ***(circle)*** **MMR Varicella Tdap Td**

_____ _____ _____
Patient or Legal Guardian Signature Relationship Date/Time

Reason for Declination:_____

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PATIENT QUESTIONNAIRE – PRE-PLACEMENT EXAMINATIONS

Appointment Date: _____
Please call Registration at 860-679-1600 at least 2 days prior to your appointment.

PLEASE COMPLETE THIS FORM PRIOR TO APPOINTMENT

Name: _____ Date: _____ Date of Birth: _____

Address: _____

Social Security #: _____ Telephone #: _____ Sex M F

Job Title: _____ Department: _____ Ext: _____ Starting Date Years in Position: _____

Describe Duties: _____

Will you be, or are you exposed to any known hazard (i.e. toxic chemicals, asbestos, heavy lifting, etc)? What type(s)?

_____

Do you have any work related health concerns? _____

WORK AND EXPOSURE HISTORY: Briefly describe previous jobs, titles, duties and dates:

Start Date	End Date	Employer	Job Title/Duties	Exposure

Have you ever had a work related injury, changed jobs, assignments or lost work time because of an injury or other health problem(s): received Worker's Compensation, or disability insurance? Please describe:

_____

Have you ever been directly exposed (touching, breathing, etc.) to any of the following? Please check all the appropriate boxes. Indicate in the comment section below if this was at work, home, doing a hobby or a part time job.

- ☐ Acids
- ☐ Ammonia
- ☐ Anesthetic Agents
- ☐ Antineoplastic Drugs
- ☐ Asbestos
- ☐ Carbon tetrachloride
- ☐ Carcinogens
- ☐ Ethylene Oxide
- ☐ Formaldehyde (Formalin)
- ☐ Gluteraldehyde
- ☐ Ketones
- ☐ Lead
- ☐ Mercury
- ☐ Noise (loud)
- ☐ Organic Solvents
- ☐ Pesticides
- ☐ Phenol
- ☐ Radiation
- ☐ Radionuclides
- ☐ X-Rays
- ☐ Other: _____

Comments: _____

Are there any other hazards which you are exposed to at home or doing hobbies or current part-time jobs? _____

Please List: _____

Have you ever changed your residence or home because of health problems? Describe. _____

_____

Do you live near an industrial plant or hazardous waste site? Describe. _____

_____

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PATIENT QUESTIONNAIRE – PRE-PLACEMENT EXAMINATIONS

MEDICAL HISTORY – Check if you have any of the following and give the year.

Illness	Year	Illness	Year	Illness	Year
Blackouts or Epilepsy		Ear Infection/Ruptured Drum		Liver Disease	
Heart Trouble		Bone or Joint Problems		Cancer	
High Blood Pressure		Varicose Veins		Neurological Disorder	
Tuberculosis		Hernia		Carpal Tunnel	
Diabetes, High Blood Sugar		Anemia/Other Blood Disorder		Neck/Shoulder Injury	
Asthma, Bronchitis, Pneumonia Other Lung Disease		High Cholesterol or Triglycerides		Tendonitis/Repetitive Strain Injury	
Spleen Absent		Vision Problems		Knee/Foot Problems	
Dermatitis/Skin Disease/Rash		Urinary or Kidney Problems		Other:	

Comments: _____

Have you ever had back pain or injury which disrupted your usual activities □ Yes □ No If yes, please describe all episodes which resulted in absence from work or school (include dates): _____

Any other illness? Please describe and give dates: _____

Please list current medications: _____

Do you have any concerns related to your current work or previous jobs and your reproductive history? (i.e. infertility, miscarriages, still births, or birth defects) _____

Have you ever been in the hospital? □ Yes □ No

Please list any hospitalizations and/or surgeries for major medical illnesses, injury, or procedures: _____

FAMILY HISTORY: _____

ALLERGY HISTORY - Allergy to Medications: _____

Allergy to Animals: _____

To Other Agents? Specify: _____

To Protective Gloves or Latex Allergy (glove dermatitis) _____

I certify to the best of my knowledge that the above information is true.

I understand that this evaluation (history review and physical exam) is related to my job and does not replace routine health care and physical examinations, by my own doctor.

The object of this form is to gather relevant information about occupational history, untoward effects of chemicals and other exposures from workplace, allergy history, current medications and current health problems. It serves as a baseline for when an employee seeks medical evaluation at the Division of Occupational and Environmental Medicine. This is not a preemployment, it is a preplacement questionnaire, and it will not have any power in terms of deterring employment. Furthermore, newly hired employees are free to omit information one may feel is not relevant to the scope of one's job or to the care one may receive from the Division of Occupational and Environmental Medicine.

Patient Signature: _____ Date _____

Reviewed By: _____ Date _____