Employee Health

HEALTH REQUIREMENTS FOR CONTINGENT STAFF
Information

Contingent staff are non Kaiser Permanente (KP) staff (individuals not on KP payroll) who provide services on behalf of KP. This includes non-UH residents, medical students, nursing, radiology and other clinical students or contract workers and volunteers.

The health requirements listed below will help us reduce the spread of infectious disease to our members, patients and staff. In addition, it will assure we have compliance with our regional policies and regulatory agencies such as the Department of Health.

Ask your health care provider to complete the back side of this form or provide the necessary documentation and submit to your assigned/field supervisor before you begin.

MANDATORY (providing services at the hospital or clinics)

1. Tuberculosis Clearance

A. TB Skin Test

- Documentation of 2-step TB skin test within past 12 months (2 separate skin tests; if initial is negative, a second test is given 1-3 weeks later)
- Or, documentation of last two annual skin tests (see other side for criteria), **OR**

B. Chest X-ray (if skin test positive in past)

- Documentation of chest x-ray results after date of positive skin test
- If chest x-ray greater than 12 months, TB symptom assessment by provider (see page 2)

C. TB Respirator Fit Test (for direct care providers only):

- You may not work with patients known or suspected to have TB unless you have evidence of being fit tested for the TB respirator (3M 1860). If you need more information or need to be fitted, contact Infection Control at 432-8688.

2. Rubella (german measles)

Documentation of immunity by blood test or one of the following vaccines: Rubella, MMR, MR

3. Rubeola (measles)

Documentation of immunity by blood test or two of either of the following: MMR, MR

4. Varicella (chicken pox)

History of disease, documentation of immunity by blood test or two chickenpox vaccines

5. If you have an infectious disease, do not come in to work (signs and symptoms below).

(diarrhea, skin rash, lesions, discharge from eyes, flu symptoms, fever > over 100 degrees F.)
If any of these occur, contact your supervisor that you will not be at work. Prior to your return, you will be required to submit documentation from your physician that you are free from an infectious disease.

HIGHLY RECOMMENDED (not required)

6. Hepatitis B Vaccine (if exposed to blood and body fluids during your work):

- Hepatitis B vaccine series (3 shots) or immunity by blood test

7. Tetanus Vaccine: within the past 10 years

8. Flu vaccine: annually during flu season (Sept-May)

HEALTH REQUIREMENTS FORM. FOR CONTINGENT STAFF

Documentation

❒ Resident/Medical Student ❒ Nursing, Radiology/Other Clinical Student/Contract ❒ Volunteer ❒ Other

Name_______________________________ Birth Date__________ Phone#________________

This portion to be completed by health care provider or attach required documentation.

HEALTH REQUIREMENT	DOCUMENTED DATE	RESULTS
1. Tuberculosis Screen (A or B)		
A. TB Skin Test (2- step) **or** Last 2 annual skin tests • Current: within past 12 months • Prior year: within 12 months of current	#1 ___________ #2____________ **or** Current Year: ______________________ Prior Year: ________________________	____________________ ____________________ ____________________
B. Chest X-ray (only if skin test is positive)	Last Chest X-ray: _________________ (If CXR over 12 months, need TB assessment from physician) TB Symptom Assessment:___________	____________________ ____________________
2. Immunity to Rubella		
Rubella Screen **or** One Vaccine (Rubella, MMR or MR)	Screen: ________________________ **or** #1 Vaccine: ______________________	____________________
4. Immunity to Rubeola		
Rubeola Screen **or** Two Vaccines (MMR or MR)	Screen: ______________________ **or** #1 Vaccine: ______________________ #2 Vaccine: ______________________	____________________
5. Immunity to Varicella		
History of Disease **or** Varicella Screen **or** Two Vaccines	Documented Disease: ______________ **or** Screen: ________________________ **or** #1 Vaccine: ______________________ #2 Vaccine: ______________________	____________________

In case of emergency, notify:____

Phone #__________________________ Relationship:________________________________

List serious or life threatening allergies or accommodations needed: __________________________________

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Contingent Staff Signature/Date **Provider's Signature/Date**