

Open Door Community Health Centers, Inc

## Exposure Risks to Hepatitis B, Rubella, Measles, and TB

BECAUSE OF EXPOSURE RISKS TO HEPATITIS B AND MEASLES, ODCHC WILL PROVIDE SCREENINGS OR VACCINATION FOR THE FOLLOWING STAFF:

HEPATITIS B VACCINE: MD'S, Mid Levels, Dentists, Dental Hygienists, Dental Assistants, Lab Staff, and any other staff who are at risk for exposure to bodily fluids during job performance.

RUBELLA AND MEASLES: Vaccination -- Any clinic staff who is not immune. Screening -- Any clinic staff that does not know if they are immune.

TB TINE TEST AND PHYSICAL: It is ODCHC policy that all staff gets a TB Tine test and physical when they begin employment for ODCHC and on an annual basis after that.

HEPATITIS B (Please sign and date one):

I have already been vaccinated \_\_\_\_\_

I would like to be vaccinated \_\_\_\_\_

I refuse vaccination after reading the above statement \_\_\_\_\_

RUBELLA (Please sign and date one):

I am immune or have been vaccinated \_\_\_\_\_

I am not immune and request vaccination \_\_\_\_\_

I am unsure of immunity and will need screening \_\_\_\_\_

I refuse screening or immunization after reading the above statement  
\_\_\_\_\_

MEASLES (Please sign and date one):

I am immune or have been vaccinated \_\_\_\_\_

I am not immune and request vaccination \_\_\_\_\_

I am unsure of immunity and will need screening \_\_\_\_\_

I refuse screening or immunization after reading the above statement  
\_\_\_\_\_

TB TINE TEST AND PHYSICAL (Please sign and date):

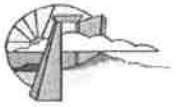
I understand that TB screening and physical is required yearly for personnel files.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Supervisor

\_\_\_\_\_  
Date



Open Door Community Health Centers  
**EMPLOYMENT MEDICAL ASSESSMENT – New Employee**

The purpose of this assessment is to:

- determine that the employee is able to perform essential job duties, and
- determine that no health condition exists that would create a hazard for the employee, fellow employees, patients, or visitors.

Please assist us in complying with regulations by completing this form and returning it to Open Door Community Health Centers Human Resources Department.

Employee Name: \_\_\_\_\_ Date of Employment: \_\_\_\_\_

Title: \_\_\_\_\_ Supervisor: \_\_\_\_\_ Hours per Day: \_\_\_\_\_ Days per Week: \_\_\_\_\_

*(This section to be completed by Employee)*

**Affirmation of Ability to Perform Essential Job Functions**

I hereby affirm that I understand the essential job functions of my new position, as described in the attached job description.

I hereby affirm that I am able to perform these essential job functions ☐ without accommodation, or  
☐ with accommodation, as described below:

Accommodation needs: \_\_\_\_\_

Signature of Employee: \_\_\_\_\_ Date: \_\_\_\_\_

*(This section to be completed by RN Clinic Coordinator)*

TB Screening: 1) If employee has a history of positive PPD, obtain baseline chest x-ray, review symptoms, and refer to provider for medical evaluation as necessary. 2) If employee has not had a PPD in the last 10 years, an initial negative screen must be repeated in 2-4 weeks, and the second result used.

Review of Symptoms for TB Chest X-Ray (please indicate Y or N) If any yes answers, refer to provider:

Unexplained weight loss \_\_\_\_\_ Fatigue \_\_\_\_\_ Night sweats \_\_\_\_\_ Persistent or bloody cough \_\_\_\_\_

PPD Date \_\_\_\_\_ Result \_\_\_\_\_ Repeat PPD date: \_\_\_\_\_ Result \_\_\_\_\_

If PPD result is 5-9 mm. induration, repeat in 2-4 weeks. If PPD is 10 mm or greater induration, obtain Chest X-Ray and refer to provider for evaluation.

Immunization screen (Form #438) completed & attached? ☐ Yes ☐ No Notes: \_\_\_\_\_

Immunizations ordered/given: \_\_\_\_\_

Job safety/risks review: \_\_\_\_\_

Other: \_\_\_\_\_

RN Clinica Coordinator Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*(This section to be completed by Employee)*  
**Authorization of Release of Medical Information**

I hereby release to Open Door Community Health Centers information contained in this report ☐ Yes ☐ No

Signature of Employee: \_\_\_\_\_ Date: \_\_\_\_\_

Routing: ☐ Original to Human Resources ☐ Copy to employee

ODCHC Form #406.1 (rev 05/10)