UC San Diego Health

Health Screening Requirements

Welcome to UC San Diego Health (UCSDH). UCSDH Policy 611.3 mandates ALL Health Care Workers demonstrate immunity to communicable disease. Return of this completed form satisfies compliance. (Revised 1/14/2022)

Instructions:

1. This form is to be completed, signed, and stamped by a medical provider from your home institution's Employee Health Department. **DO NOT SEND HEALTH RECORDS and DO NOT SUBSTITUTE THIS FORM.**
2. Email completed, signed, and stamped form to UCSD Graduate Medical Education at **azultner@health.ucsd.edu**.

Required Immunizations – Please check the method of delivery for requesting trainee:

1. **Tuberculosis Screening**
   - ☐ Two step Tuberculin Skin Test (TST) performed within the last 3 months, with first PPD completed in the past 12 mos. **~or~**
   - ☐ QuantiFERON®-Gold (QFT) performed within the last 3 months
   - ☐ Employee has previous documented positive TST or QFT. Please contact the GME office (619-543-8254) for a TB questionnaire. Employee also needs to provide a chest X-ray report from within the past 1 year.
2. **N95 Respirator Mask Fit Test** (Must be fitted within the past 12 months.):
   - ☐ 3M 1870+
   - ☐ 3M 1860 regular or 1860 small
   - ☐ Gerson 2130
   - ☐ Other NIOSH approved N95 Respirator: _____
     If using alternative N95 from an outside institution then Rotator must bring, store and have available at all times.
3. **Immunity to Measles, Mumps and Rubella**
   - ☐ Two (2) documented MMR vaccines **~or~**
   - ☐ Laboratory report (positive blood titers)
4. **Immunity to Varicella** (History of chicken pox is not sufficient.)
   - ☐ Two (2) documented varicella vaccines ~**or**~
   - ☐ Laboratory report (positive blood titers)
5. **Hepatitis B Screening**
   - ☐ Proof of three (3) Hepatitis B vaccinations ~**or**~
   - ☐ Positive blood test for Hepatitis B Surface antibody
6. **Vaccinations (Tdap,Flu,Covid-19)**
   - ☐ Tdap (Tetanus, diptheria, acellular pertussis) within the last 10 years ***Date:*** _____
   - ☐ Influenza (Flu) Vaccine (during flu season) ***Date:*** _____
   - ☐ Covid-19 Vaccination ***Manufacturer:*** _____ ***Date:*** _____ ***Date:*** _____
   - ☐ Covid-19 Booster ***Manufacturer***: _____ ***Date***: _____

CLINICAL USE ONLY: This section **MUST** be completed by a licensed health care provider. Incomplete forms cannot be accepted and will delay trainee's rotation start date.

I, _____ attest that _____
Health Care Provider Name, Title, License Number — Name of Trainee

is free of communicable disease and meets the above health screening requirements.

_____ _____
Health Care Provider Signature — Date

_____
Institution

_____
Attesting Department and Phone Number

_____
Address (Street, City, State and Zip)

Institutional Stamp