A5

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES

# PROFESSIONAL STAFF ASSOCIATION HEALTH CLEARANCE INSTRUCTIONS

Welcome to Los Angeles County, Department of Health Services. You are required to be cleared by Employee Health Services (EHS) prior to beginning your assignment. You must successfully complete the Human Resources in-processing and criminal background check prior to beginning the EHS health clearance process. This packet includes health screening forms and questionnaires that should be completed by you and your physician or a licensed health care professional (PLHCP) prior to your visit to EHS. Only return **the E2-Pre-Placement Tuberculosis History and Evidence of Immunity** and appropriate forms if indicated to EHS at your appointment/visit. **There are two options to meet this requirement:**

## OPTION 1: Health screening provided by your physician or licensed health care professional

Return completed **Form E2** to EHS.

- ✓ **E2 – Pre-Placement Tuberculosis History and Evidence of Immunity** -This form contains the pre-placement health screening requirements needed to work at a DHS facility. Tuberculosis screening and evidence of immunity to vaccine-preventable diseases are mandatory.

- ✓ **K-NC** – This form is a declination to receiving any non-mandatory vaccines

- ✓ **N-NC** – This form is used for a N95 respirator fit test to be completed by your PLHCP. If your job assignment requires a N95 respirator, you must be fit tested for the N95 respirator. If your job assignment involves Airborne Infection Isolation Rooms (AIIR), you will need to be fit tested. If your job assignment does not involve AIIR, you will not need to complete this form or the questionnaire below (Form P-NC).

    - **P-NC** – This form is an Aerosol Transmissible Disease Respirator Medical Evaluation Questionnaire. You must complete this questionnaire and submit to your PLHCP **prior** to the respirator fit test.

## OPTION 2: Health screening provided by EHS

Call Employee Health for appointment to have health screening performed at no cost. By providing these documents, you can help expedite the processing for an EHS health clearance:

1. **Tuberculosis (TB) Test Record** *(a copy of any **one** of the following)*:

**Completed within the last 12 months**

- ☐ 2 negative Tuberculin Skin Test (TST) records documented in millimeters (This is a two-step TST)
- ☐ 1 negative TST record documented in millimeters
- ☐ 1 negative single Interferon-Gamma Release Assays (IGRA)

**For a positive TB result, submit a Chest X-Ray Report within the last 12 months**

☐ 1 positive TST record documented in millimeters with a Chest X-Ray Report
☐ 1 positive IGRA record with a Chest X-Ray Report

2. **Immunizations Record** and/or Titers to the following:

☐ Measles ☐ Varicella ☐ Tdap ☐ Hepatitis B
☐ Mumps ☐ Rubella ☐ Influenza

## HEALTH CLEARANCE PROCESS

The following will be obtained at EHS:

- A two-step TST will be conducted if you cannot provide documentation of 2 negative TST records within the previous 12 months. This may require a total of 3 office visits.
- A TST will be conducted if you can only provide documentation of 1 negative TST record within the previous 12 months. This may require a total of 2 office visits.
- If you have been documented with a positive TST or positive IGRA result, you will be required to have a baseline posterior anterior chest x-ray prior to assignment **OR** provide written documentation of a normal chest x-ray taken no more than 12 months prior to assignment.
- EHS will assess the immunization documents you provide to determine if you meet evidence of immunity to vaccine-preventable diseases as a requirement for you assignment.

## APPOINTMENT

☐ **YOUR APPOINTMENT IS SCHEDULED ON _____ AT _____ AM / PM.**

☐ **APPOINTMENT NEEDED, PLEASE CALL _____.**

☐ **NO APPOINTMENT NEEDED, PLEASE WALK IN DURING THE FOLLOWING OFFICE HOURS:**

| DAY | TIME | LOCATION |
|---|---|---|
| Monday | | |
| Tuesday | | |
| Wednesday | | |
| Thursday | | |
| Friday | | |

If you have any questions or need assistance, please contact the facility EHS office.

Thank you,

DHS EMPLOYEE HEALTH SERVICE

.

E2

Health Services
LOS ANGELES COUNTY

# EMPLOYEE HEALTH SERVICES
# PRE-PLACEMENT TUBERCULOSIS HISTORY AND EVIDENCE OF IMMUNITY

☞ See GENERAL INSTRUCTIONS on last page.

**FOR NON-DHS/NON-COUNTY WFM**

| LAST NAME: | FIRST, MIDDLE NAME: | BIRTHDATE: | E or C#: |
|---|---|---|---|
| E-MAIL ADDRESS: | HOME/CELL PHONE #: | DHS FACILITY: | DEPT/WORK AREA/UNIT: |
| JOB CLASSIFICATION: | NAME OF SCHOOL/EMPLOYER/AGENCY/SELF: | AGENCY CONTACT PERSON: | AGENCY PHONE #: |

**In accordance with Los Angeles County, Department of Health Services policy 705.001, Title 22, and CDC guidelines all contactors/students/volunteers working at the health facilities must be screened for communicable diseases prior to assignment. This form must be signed by a healthcare provider attesting all information is true and accurate OR workforce member may supply all required source documents to DHS Employee Health Services.**

**A**

**TUBERCULIN SKIN TEST RECORD**
**0.1 ml of 5 tuberculin units (TU) purified protein derivative (PPD) antigen intradermal**

| DATED PLACED | STEP | MANUFACTURER | LOT # | EXP | SITE | *ADM BY (INITIALS) | DATE READ | *READ BY (INITIALS) | RESULT | STATUS (Indicate: Reactor / Non-Reactor / Converter) |
|---|---|---|---|---|---|---|---|---|---|---|
| | 1st | | | | | | | | mm | |
| | 2nd | | | | | | | | mm | |

**If either result is positive, send for CXR and complete Section C below.**

**OR**

| | | | | | |
|---|---|---|---|---|---|
| **B** | Negative IGRA (<12 months) | Date: | Results | ☐ LA County ☐ Outside Document | **STATUS** |

**If CXR is positive for TB, DO NOT CLEAR for hire/assignment.**
**Refer Workforce Member for immediate medical care.**

| | | | | | |
|---|---|---|---|---|---|
| **C** | Positive TST | Date: | Results _____mm | ☐ LA County ☐ Outside Document | **STATUS** |
| | CXR (<12 months) | Date: | Results _____ | ☐ LA County ☐ Outside Document | |

**OR**

| | | | | | |
|---|---|---|---|---|---|
| **D** | Positive IGRA | Date: | Results _____ | ☐ LA County ☐ Outside Document | **STATUS** |
| | CXR (<12 months) | Date: | Results _____ | ☐ LA County ☐ Outside Document | |

**OR**

| | | | | | |
|---|---|---|---|---|---|
| **E** | History of Active TB with Treatment | Date: | months with ____ | ☐ Outside Document | **STATUS** |
| | CXR (<12 months) | Date: | Results _____ | ☐ Outside Document | |

**OR**

**CONTINUE ON NEXT PAGE**

**E2**

**CONFIDENTIAL**

**PRE-PLACEMENT TUBERCULOSIS HISTORY AND EVIDENCE OF IMMUNITY**



| LAST NAME | FIRST, MIDDLE NAME | BIRTHDATE | E or C# |
|---|---|---|---|
| | | | |

| | | | | | |
|---|---|---|---|---|---|
| **F** | History of LTBI Treatment | Date: | _months with ___ | ☐ Outside Document | **STATUS** |
| | CXR (<12 months) | Date: | Results _____ | ☐ Outside Document | |

**AND**

**IMMUNIZATION DOCUMENTATION HISTORY (THESE VACCINATIONS ARE MANDATORY)**

| | **Date Received** | **Titer** | **If not immune, give Vaccination x 2, unless Rubella x 1** | | **Date Received** | **Vaccine** | **Declined Vaccination (may be restricted from hospital/patient care)** | |
|---|---|---|---|---|---|---|---|---|
| **G** Measles | | ☐ Immune ☐ Non-Immune ☐ Equivocal ☐ Laboratory confirm of disease | **OR** | **X 2** | | | **OR** | ☐ Decline only for true medical contraindication, must include medical documentation |
| Mumps | | ☐ Immune ☐ Non-Immune ☐ Equivocal ☐ Laboratory confirm of disease | **OR** | **X 2** | | | **OR** | ☐ Decline only for true medical contraindication, must include medical documentation |
| Rubella | | ☐ Immune ☐ Non-Immune ☐ Equivocal ☐ Laboratory confirm of disease | **OR** | **X 1** | | | **OR** | ☐ Decline only for true medical contraindication, must include medical documentation |
| Varicella | | ☐ Immune ☐ Non-Immune ☐ Equivocal ☐ Laboratory confirm of disease | **OR** | **X 2** | | | **OR** | ☐ Decline only for true medical contraindication, must include medical documentation |

**AND**

| | **Vaccination** | **Date Received** | **Date of Declination Signed** | |
|---|---|---|---|---|
| **H** | Tetanus-diphtheria (Td) every 10 years | | **OR** | |
| | Acellular Pertussis (Tdap) X 1 | | | |

**AND**

| | **Vaccination (MANDATORY to offer to WFM who have potential to be exposed to blood or body fluid)** | | | **If not reactive, vaccinate with HepB series (3 doses)** | **Date** | **Vaccine** | | ☐ N/A (job duty does not involve blood or body fluid) |
|---|---|---|---|---|---|---|---|---|
| **I** | Hepatitis B Surface Ab Titer (HbsAb) anti-HBs | Date | Titer | **AND** | | | **OR** | **Date** _____ ☐ Declination signed |
| | | | ☐ Reactive ☐ Non-reactive | | | | | **Date** _____ **HbcAb/ anti-HBc** ☐ Non-reactive ☐ Reactive |
| | | | | | | | | **Date** _____ **HbsAg** ☐ Non-reactive ☐ Reactive |

**AND**

**CONTINUE ON NEXT PAGE**

**E2**

**CONFIDENTIAL**

**PRE-PLACEMENT TUBERCULOSIS HISTORY AND EVIDENCE OF IMMUNITY**



| LAST NAME | FIRST, MIDDLE NAME | BIRTHDATE | E or C# |
|---|---|---|---|
| | | | |

| | Vaccination | Date Received | Location Received | | Date Declination Signed |
|---|---|---|---|---|---|
| **J** | Seasonal Influenza (one dose for current season) | | | **OR** | **Note:** Must wear mask during influenza season. |

**AND**

| | | | |
|---|---|---|---|
| **K** | Respiratory Fit Test (Complete Form N-NC) | Date: | ☐ **Pass** ☐ **Fail** ☐ **PAPR**<br>☐ **N/A** (Job duty does not involve airborne precautions) |
| **L** | Color Vision (MANDATORY for WFM working with point of care testing.) | Date: | ☐ **Pass** ☐ **Fail**<br>☐ **N/A** (Job duty does not involve point of care testing) |

**FOR HEALTHCARE PROVIDER:**

☐ I attest that all dates and immunizations listed above are correct and accurate.

| Date: | Physician or Licensed Healthcare Professional Signature: | Print Name: |
|---|---|---|
| Facility Name/Address: | | Phone #: |

**OR**

**FOR WORKFORCE MEMBER:**

☐ Required source documents attached.

| Workforce Member Signature: | Date: |
|---|---|
| | |

**DHS-EHS STAFF ONLY**

| ☐ WFM completed pre-placement health evaluation. | | Date of clearance: |
|---|---|---|
| Signature: | Print Name: | Today's Date: |

| SECTION | ☞ GENERAL INSTRUCTIONS FOR EACH SECTION |
|---|---|
| | **TUBERCULOSIS DOCUMENTATION HISTORY**<br>**ALL WORKFORCE MEMBER (WFM) SHALL BE SCREENED FOR TB UPON HIRE/ASSIGNMENT** |
| **A** | WFM shall receive a baseline TB screening using two-step Tuberculin Skin Test (TST).<br>Step 1: Administer TST test, with reading in seven days.<br>Step 2: After Step 1 reading is negative, administer TST test, with reading within 48-72 hours. If both readings are negative, WFM is cleared to work. WFM shall receive either TST or IGRA and symptom screening annually.<br>a. Documentation of negative TST within 12 months prior to placement will be accepted. WFM shall receive a one-step TST with reading within 48-72 hours. If result is negative, WFM is cleared to work;<br>b. Documentation of negative two-step TST within 12 months prior to placement will be accepted. WFM is cleared to work.<br>If TST is positive, record results and continue to Section C. |
| **B** | WFM shall receive a baseline TB screening using a single blood assay for M. tuberculosis (IGRA). If negative result, WFM is cleared to work. WFM shall receive either TST or IGRA and symptom screening annually.<br>a. Documentation of negative IGRA within 12 months will be accepted. WFM is cleared to work.<br>If IGRA is positive, record results and continue to Section D. |

**CONTINUE ON NEXT PAGE**

**E2**

**CONFIDENTIAL**

**PRE-PLACEMENT TUBERCULOSIS HISTORY AND EVIDENCE OF IMMUNITY**



| LAST NAME | FIRST, MIDDLE NAME | BIRTHDATE | E or C# |
|---|---|---|---|
| | | | |

| SECTION | GENERAL INSTRUCTIONS FOR EACH SECTION |
|---|---|
| | **TST POSITIVE RESULTS**<br>**If CHEST X-RAY IS POSITIVE, DO NOT CLEAR FOR HIRE/ASSIGNMENT, AND**<br>**REFER WORKFORCE MEMBER FOR IMMEDIATE MEDICAL CARE** |
| **C** | If TST is positive during testing in Section A or C above, send for a chest x-ray (CXR). If CXR is negative, WFM is cleared to work. Documentation of negative CXR within 12 months prior to placement will be accepted for clearance to work. WFM shall be symptom screened for TB annually. |
| **D** | If IGRA is positive during testing in Section D above, send for a CXR. If CXR is negative, WMF is cleared to work. Documentation of negative CXR within 12 months prior to placement will be accepted for clearance to work. WFM shall be symptom screened for TB annually. |
| **E** | If WFM have a documented history of active TB, send for a chest x-ray (CXR). If CXR is negative, WFM is cleared to work. Documentation of negative CXR within 12 months prior to placement will be accepted for clearance to work. If documentation is supported, WFM is cleared to work. WFM shall be symptom screened for TB annually. Record documentation result in this section. |
| **F** | If WFM have a documented history of latent tuberculosis infection (LTBI) treatment, send for a chest x-ray (CXR). If CXR is negative, WFM is cleared to work. Documentation of negative CXR within 12 months prior to placement will be accepted for clearance to work. If documentation is supported, WFM is cleared to work. WFM shall be symptom screened for TB annually. Record documentation result in this section. |
| | **IMMUNIZATION DOCUMENTATION HISTORY**<br>Documentation of immunization or adequate titers will be accepted. If WFM is not immune against communicable diseases as listed in this section, WFM shall be immunized (unless medically contraindicated). WFM who declines the vaccination(s) must sign the mandatory declination form. WFM who declines the vaccination(s) may be restricted from patient care areas of the hospital or facility. If WFM is non-immune or decides at a later date to accept the vaccination, DHS or WFM contract agency will make the vaccination available. |
| **G** | Documentation of laboratory evidence of immunity or laboratory confirmation of disease will be accepted **OR** documentation of two doses (live measles, mumps and varicella) and one dose of live rubella virus vaccine. Measles vaccine shall be administered no earlier than one month (minimum 28 days) after the first dose. Mumps second dose vaccine varies depending on state or local requirements. Varicella doses shall be at least 4 week between doses for WFM. If Equivocal, WFM needs either vaccination or re-draw with positive titer. **DHS-EHS must be notified if WFM does not demonstrate evidence of immunity.** |
| **H** | **Td** – After primary vaccination, Td booster is recommended every 10 years. If unvaccinated WFM, primary vaccination consists of 3 doses of Td; 4-6 weeks should separate the first and second doses; the third dose should be administered 6-12 months after the second dose.<br>**Tdap** should replace a one time dose of Td for HCP aged 19 though 64 years who have not received a dose of Tdap previously. An interval as short as 2 years or less from the last dose of Td is recommended for the Tdap dose. |
| **I** | All WFM who have occupational exposure to blood or other potentially infectious materials shall have a documented post vaccination antibody to Hepatitis B virus, HBsAb (anti-HBs). Hepatitis B vaccine series is available to WFM. Non-responders should be considered susceptible to HBV and should be counseled regarding precautions to prevent HBV infection and the need to obtain HBIG prophylaxis for any known or probable parenteral exposure to HBsAg positive blood. |
| **J** | Seasonal influenza is offered annually to WFM when the vaccine becomes available. |

This form and its attachment(s), if any, such as medical records shall be maintained and filed at non-DHS/non-County workforce member's School/Employer. The School/Employer shall verify completeness of DHS-Employee Health Services (EHS) form(s) and ensure confidentiality of non-DHS/non-County WFM health information.

Upon request by DHS-EHS, the non-DHS/non-County WFM School/Employer shall have this form and its attachment(s) readily available within four (4) hours.

All workforce member health records are confidential in accordance with federal, state and regulatory requirements.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. 29 C.F.R. Part 1635

K-NC

Health Services
LOS ANGELES COUNTY

**EMPLOYEE HEALTH SERVICES**

# DECLINATION FORM

**FOR NON-DHS/NON-COUNTY WFM**

| LAST NAME | FIRST, MIDDLE NAME | BIRTHDATE | HSN NO. |
|---|---|---|---|
| | | | |

| JOB TITLE | DHS FACILITY | DEPT/DIVISION | WORK AREA/UNIT | SHIFT |
|---|---|---|---|---|
| | | | | |

| E-MAIL ADDRESS | WORK PHONE | CELL/PAGER NO | SUPERVISOR NAME |
|---|---|---|---|
| | | | |

| NAME OF SCHOOL/EMPLOYER *(If applicable)* | PHONE NO. | CONTACT PERSON |
|---|---|---|
| | | |

Please check in the section(s) as apply AND indicate reason for the declination. Submit original to DHS-EHS.

## I. ☐ 8 CCR §5199. Appendix C1 - Vaccination Declination Statement (Mandatory)*

*Please check as apply*: ☐ Measles ☐ Mumps ☐ Rubella ☐ Varicella ☐ Td/Tdap

I understand that due to my occupational exposure to aerosol transmissible diseases, I may be at risk of acquiring infection as indicated above. I have been given the opportunity to be vaccinated against this disease or pathogen at no charge to me. However, I decline this vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring the above infection, a serious disease. If in the future I continue to have occupational exposure to aerosol transmissible diseases and want to be vaccinated, I can receive the vaccination from my School/Employer or DHS-Employee Health Services (EHS) at no charge to me.

**Reason for declination:** _____

_____

☐ Seasonal Influenza

Reason for declination *(check as apply):*

- ☐ I am allergic to vaccine components.
- ☐ I believe I can get the flu if I get the shot.
- ☐ I am concerned about vaccine side effects.
- ☐ It's against my personal belief.
- ☐ I don't believe I need it.
- ☐ I'm concerned about vaccine safety.
- ☐ I do not like needles.
- ☐ Other: _____

## II. ☐ 8 CCR §5193. Appendix A-Hepatitis B Vaccine Declination (Mandatory)*

☐ Hepatitis B

I understand that due to my occupational exposure to blood or other potentially infectious material (OPIM) I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to me. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or OPIM and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series from my School/Employer or DHS-EHS at no charge to me.

**Reason for declination:** _____

_____

**CONTINUE ON NEXT PAGE**

| LAST NAME | FIRST, MIDDLE NAME | BIRTHDATE | HSN NO. |
|---|---|---|---|
| | | | |

## III. ☐ Specialty Surveillance Declination (Mandatory)**

*Please check as apply:*

☐ Asbestos ☐ Hazardous/Anti-Neoplastic Drugs ☐ Hearing Conservation ☐ Other:_____

I understand that due to my occupational exposure as indicated above, I am eligible and have been given the opportunity to enroll in the Medical Surveillance Program. This will enable me to receive specific initial, periodic and exit medical examinations for the hazard identified above, at no charge to me and at a reasonable time and place.

However, I decline to be enrolled in this program at this time. I understand that by declining this enrollment, I will not be medically monitored for occupational exposure to this hazard. I understand that it is strongly recommended that I complete a medical questionnaire or examination. I also understand that if in the future I continue to have occupational exposure to the hazard identified above and I want to be enrolled in the Medical Surveillance Program, I can do so at any time at no charge to me.

**Reason for declination:** _____

_____

## SIGN BELOW

By signing this, I am declining as indicated on this form.

| WFM OR RESPONSIBLE PERSON SIGNATURE | PRINT NAME | DATE | TIME |
|---|---|---|---|
| | | | |
| WITNESS SIGNATURE | | DATE | TIME |
| | | | |
| WITNESS (PRINT NAME) | RELATIONSHIP TO WORKFORCE MEMBER | | |
| | | | |

## MAKE A COPY FOR YOUR RECORDS
## SUBMIT ORIGINAL AND ANY SUPPORTING DOCUMENT(S)

*Vaccination(s) is available to all workforce members (WFM), and free of charge for County employees and volunteers. Non-County WFM should obtain the vaccinations from their physician or licensed health care professional. Services provided through DHS will be billed to the non-County WFM School/Employer, as appropriate.

**Non-County WFM who has potential exposure to occupational hazards will be included in the surveillance program, but will not have their assessments done through the County, unless specified in contract/agreement. Medical surveillance/post-exposure regulations are the responsibility of the school/contract agency. If the non-County WFM School/Employer chooses to have DHS-Employee Health Services (EHS) to perform such surveillance/post-exposure services, the non-County WFM School/Employer will be billed accordingly. Emergency services will be provided post-exposure within the allowable time frames, but will be billed to the contractor/agency, as appropriate.

Workforce member must complete this form if declining DHS recommended and mandatory vaccinations or medical surveillance program. The School/Employer must verify completeness and ensure declination form is submitted to DHS-EHS. **The School/Employer must notify DHS-EHS if workforce member does not provide evidence of immunity.**

This form and its attachment(s), if any, such as health records shall be maintained and kept in workforce member's EHS health file.

All workforce member EHS health records are confidential in accordance with federal, state and regulatory requirements.

N-NC

Health Services
LOS ANGELES COUNTY

**EMPLOYEE HEALTH SERVICES**

# RESPIRATORY FIT TEST RECORD

**FOR NON-DHS/NON-COUNTY WFM**

| LAST NAME: | FIRST, MIDDLE NAME: | BIRTHDATE: | E or C #: |
|---|---|---|---|
| E-MAIL ADDRESS: | HOME/CELL PHONE #: | DHS FACILITY: | DEPT/WORK AREA/UNIT: |
| JOB CLASSIFICATION: | NAME OF SCHOOL/EMPLOYER/AGENCY/SELF: | AGENCY CONTACT PERSON: | AGENCY PHONE #: |

## RESPIRATOR, QUESTIONNAIRE, MEDICAL EVALUATION

| EQUIPMENT TYPE: | MANUFACTURER: | MODEL: | SIZE: |
|---|---|---|---|
| **N95** | **Kimberly-Clark** | ☐ **PFR95-174** ☐ **PFR95-170** | ☐ **Small** ☐ **Regular** |

Based on review of the respirator health questionnaire: ☐ 8 CCR §5144 (Form O-NC) ***OR*** ☐ 8 CCR §5199 (Form P-NC), this individual is:

☐ Medically approved for only the following types of respirator subject to satisfactory fit test:

- ☐ 1. Disposable Particulate Respirators
- ☐ 2. Replaceable Disposable Particulate Respirators: ☐ a. Half-Facepiece ☐ b. Full-Facepiece
- ☐ 3. Powered Air Purifying Respirators (PAPRs): ☐ a. Tight Fitting
- ☐ 4. Self-Contained Breathing Apparatus (SCBA)

Recommended time period for next questionnaire: ☐ 4 years ☐ Other _____ with justification _____

Date Completed: _____ Next Due Date: _____

List any facial fit problem conditions that apply to you (e.g., beard growth, sideburns, scars, deep wrinkles): _____

## TASTE THRESHOLD SCREENING (NO food, drink, smoke, gum X 15 minutes before testing)

(Bitrex or Saccharin): ☐ X 10 ☐ X 20 ☐ X 30 ☐ Fail

## RESPIRATOR FIT, PRESSURE FIT CHECK, COMFORT

| | ATTEMPT #1 | ATTEMPT #2 | ATTEMPT #3 |
|---|---|---|---|
| **Fit Check:** ☐ **POSITIVE** and/or | ☐ Pass ☐ Fail | ☐ Pass ☐ Fail | ☐ Pass ☐ Fail |
| ☐ **NEGATIVE** pressure | ☐ Pass ☐ Fail | ☐ Pass ☐ Fail | ☐ Pass ☐ Fail |
| **Overall Comfort Level** | ☐ Pass ☐ Fail | ☐ Pass ☐ Fail | ☐ Pass ☐ Fail |
| **Ability to Wear Eyeglasses** | ☐Pass ☐Fail ☐NA | ☐Pass ☐Fail ☐NA | ☐Pass ☐Fail ☐NA |

## FIT TEST

| | ATTEMPT #1 | ATTEMPT #2 | ATTEMPT #3 |
|---|---|---|---|
| **Normal Breathing** *(performed for one minute)* | ☐ Pass ☐ Fail | ☐ Pass ☐ Fail | ☐ Pass ☐ Fail |
| **Deep Breathing** *(performed for one minute)* | ☐ Pass ☐ Fail | ☐ Pass ☐ Fail | ☐ Pass ☐ Fail |
| **Turning Head Side to Side** *(performed for one minute)* | ☐ Pass ☐ Fail | ☐ Pass ☐ Fail | ☐ Pass ☐ Fail |
| **Moving Head Up and Down** *(performed for one minute)* | ☐ Pass ☐ Fail | ☐ Pass ☐ Fail | ☐ Pass ☐ Fail |
| **Talking – Rainbow Passage** *(performed for one minute)* | ☐ Pass ☐ Fail | ☐ Pass ☐ Fail | ☐ Pass ☐ Fail |
| **Bending Over** *(performed for one minute)* | ☐ Pass ☐ Fail | ☐ Pass ☐ Fail | ☐ Pass ☐ Fail |
| **Normal Breathing** *(performed for one minute)* | ☐ Pass ☐ Fail | ☐ Pass ☐ Fail | ☐ Pass ☐ Fail |

**CONTINUE ON NEXT PAGE**

**T1-NC**

# NON-DHS/NON-COUNTY WORKFORCE MEMBER GENERAL CONSENT



| LAST NAME | FIRST, MIDDLE NAME | BIRTHDATE | HSN NO. |
|---|---|---|---|
| | | | |

**COMMENTS:** _____

_____

_____

_____

☐ Workforce member failed fit testing. A powered air-purifying respirator (PAPR) will be provided to workforce member.

☐ WFM trained on PAPR use. ☐ N/A

| ☐ **PASS Pre-Placement FIT Test on:** _____ | ☐ **PASS Annual FIT Test on:** _____ |
|---|---|

## ACKNOWLEDGMENT OF TEST RESULTS

I have undergone fit testing on the above respirator. I have been instructed in and understand the proper fitting, use and care of the respirator.

| **WORKFORCE MEMBER SIGNATURE:** | **WORKFORCE PRINT NAME:** | **DATE:** | **TIME:** |
|---|---|---|---|
| | | | |
| **FIT TEST TRAINER SINGNTURE:** | **FIT TRAINER PRINT NAME:** | **DATE:** | **TIME:** |
| | | | |

## GENERAL INFORMATION

Pursuant to Title 8 of the California Code of Regulations, Sections 5144 and 5199 (8 CCR §5144 and §5199), all workforce member (WFM) who are required to use respiratory protection must be fit tested with the same make, model, style, and size of respirator to be used. Fit testing procedures for respirators must be conducted for the following:

- Initial fit test must be conducted after the WFM has passed medical evaluation and clearance.
- Newly hired/assigned workforce members who have passed medical evaluation and clearance.
- When new style of respirator face piece is to be worn by WFM.
- Annual fit test for all WFM required to wear a respirator.
- WFM reports, or the Physician or Licensed Health Care Professional (PLHCP), supervisor, or Program Administrator makes visual observations of changes in the workforce member's physical condition that could affect respirator fit. Such conditions include, but are not limited to, facial scarring, facial hair, dental changes, cosmetic surgery, or an obvious change in body weight.
- WFM must be given a reasonable opportunity to select a different respirator face piece and be re-fit tested, if required.
- If WFM is unable to be fit-tested or has failed the fit test, WFM must be provided with a powered air-purifying respirator (PAPR).

This form and its attachment(s), if any, such as medical records shall be maintained and filed at non-DHS/non-County WFM School/Employer. The School/Employer shall verify completeness of DHS-Employee Health Services (EHS) form(s) and ensure confidentiality of non-DHS/non-County WFM medical information.

Upon request by DHS-EHS, the non-DHS/non-County WFM School/Employer shall have this form and its attachment(s) readily available within four (4) hours.

All workforce member health records are confidential in accordance with federal, state and regulatory requirements.

DHS-EHS will obtain the workforce member's written authorization before using or disclosing health information, include to self, unless the disclosure is required by State or Federal law such as to a public health authority or governmental regulatory agency.

**Workforce members have the right to access their medical records and obtain a copy, thereof, within fifteen (15) days after the request.**

P-NC

Health Services
LOS ANGELES COUNTY

# EMPLOYEE HEALTH SERVICES

## CONFIDENTIAL
## NON-DHS/NON-COUNTY WORKFORCE MEMBER
## 8 CCR SECTION 5199 – APPENDIX B
## ATD RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

☞ **GENERAL INFORMATION on last page**

**Questionnaire for N95 Respirator**

**COMPLETE ONCE EVERY FOUR (4) YEARS OR AS NEEDED**

**This Appendix is Mandatory if the Employer chooses to use a Respirator Medical Evaluation Questionnaire other than the Questionnaire in Section 5144 Appendix C (Form O-NC).**

**To the PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL**: Answers to questions in Section 1, and to question 6 in Section 2 do not require a medical examination. Workforce member must be provided with a confidential means of contacting the health care professional who will review this questionnaire.

**To the WORKFORCE MEMBER**: Can you read and understand this questionnaire (check one): ☐ Yes ☐ No

**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.**

Please complete this questionnaire in PEN and present to the staff at the examination clinic. **To protect your confidentiality, it should not be given or shown to anyone else.** On the day of your appointment, you must bring a valid driver's license or other form of identification which has both your photograph and signature.

## SECTION 1

The following information must be provided by every workforce member who has been selected to use any type of respirator.

**PLEASE PRINT LEGIBLY**

| TODAY'S DATE: | | | |
|---|---|---|---|
| LAST NAME | FIRST, MIDDLE NAME | BIRTHDATE | GENDER ☐ MALE ☐ FEMALE |
| HEIGHT FT IN | WEIGHT LBS | JOB TITLE | HSN NO. |
| PHONE NUMBER | Best Time to reach you? | Has your employer told you how to contact the health care professional who will review this questionnaire? ☐ Yes ☐ No | |

Check type of respirator you will use (you can check more than one category):
- ☐ N, R, Or P disposal respirator (filter-mask, non-cartridge type only)
- ☐ Other type (specify): _____

| Have you worn a respirator? ☐ Yes ☐ No | If "yes", what type: |
|---|---|

## SECTION 2

Questions 1 through 6 below must be answered by every workforce member who has been selected to use any type of respirator (please check "YES", "NOT SURE" or "NO").

| YES | NOT SURE | NO | |
|---|---|---|---|
| | | | 1. Have you ever had the following conditions? |
| ☐ | ☐ | ☐ | a. Allergic reactions that interfere with your breathing? |

**CONTINUE ON NEXT PAGE**

| LAST NAME | FIRST, MIDDLE NAME | BIRTHDATE | HSN NO. |
|---|---|---|---|
| | | | |

| YES | NOT SURE | NO | |
|---|---|---|---|
| | | | If "yes," what did you react to? _____ |
| ☐ | ☐ | ☐ | b. Claustrophobia (fear of closed-in places) |
| | | | 2. **Do you currently have any of the following symptoms of pulmonary or lung illness:** |
| ☐ | ☐ | ☐ | a Shortness of breath when walking fast on level ground or walking up a slight hill or incline |
| ☐ | ☐ | ☐ | b. Have to stop for breath when walking at your own pace on level ground |
| ☐ | ☐ | ☐ | c. Shortness of breath that interferes with your job |
| ☐ | ☐ | ☐ | d. Coughing that produces phlegm (thick sputum) |
| ☐ | ☐ | ☐ | e. Coughing up blood in the last month |
| ☐ | ☐ | ☐ | f. Wheezing that interferes with your job |
| ☐ | ☐ | ☐ | g. Chest pain when you breath deeply |
| ☐ | ☐ | ☐ | h. Any other symptoms that you think may be related to lung problems: _____ |
| | | | 3. **Do you currently have any of the following cardiovascular or heart symptoms?** |
| ☐ | ☐ | ☐ | a. Frequent pain or tightness in your chest |
| ☐ | ☐ | ☐ | b. Pain or tightness in your chest during physical activity |
| ☐ | ☐ | ☐ | c. Pain or tightness in your chest that interferes with your job |
| ☐ | ☐ | ☐ | d. Any other symptoms that you think may be related to heart problems: _____ |
| | | | 4. **Do you currently take medication for any of the following problems?** |
| ☐ | ☐ | ☐ | a. Breathing or lung problems |
| ☐ | ☐ | ☐ | b. Heart trouble |
| ☐ | ☐ | ☐ | c. Nose, throat or sinuses |
| ☐ | ☐ | ☐ | d. Are your problems under control with these medications? |
| | | | 5. **If you've used a respirator, have you ever had any of the following problems while respirator is being used?** ***(If you've never used a respirator, check the following space and go to question 6).*** |
| ☐ | ☐ | ☐ | a. Skin allergies or rashes |
| ☐ | ☐ | ☐ | b. Anxiety |
| ☐ | ☐ | ☐ | c. General weakness or fatigue |
| ☐ | ☐ | ☐ | d. Any other problem that interferes with your use of a respirator |
| ☐ | ☐ | ☐ | 6. **Would you like to talk to the health care professional about your answers in this questionnaire?** |

| Workforce Member Signature | Date |
|---|---|
| | |

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. 29 C.F.R. Part 1635

**PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL TO COMPLETE NEXT PAGE**

| LAST NAME | FIRST, MIDDLE NAME | BIRTHDATE | HSN NO. |
|---|---|---|---|
| | | | |

## FOR COMPLETION BY A PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL
## PROVIDE A COPY OF THIS PAGE TO THE WORKFORCE MEMBER

### Part 1: Fit Testing Recommendation – Based on Questionnaire

☐ Questionnaire above reviewed.
☐ Medical Approval to Receive Fit Test
1. ☐ Disposable Particulate Respirators (N95)
2. ☐ Replaceable Disposable Particulate Respirator ☐ a. Half-Facepiece ☐ b. Full Facepiece
3. ☐ Powered Air-Purifying Respirators (PAPRs) ☐ a. Tight Fitting
4. ☐ Self-Contained Breathing Apparatus (SCBA)

Recommended time period for next questionnaire: ☐ 4 years ☐ Other _____ with justification _____

Date Completed: _____ Next Due Date: _____

Any recommended limitations for respirator use on workforce member: _____

☐ The above workforce member has not been cleared to be fit tested for a respirator.
- ☐ Additional medical evaluation is needed. Physician or Licensed Health Care Professional to complete Part 2 below.
- ☐ Medically unable to use a respirator.

☐ Informed workforce member of the results of this examination.

Comments: _____

### Part 2: Additional Medical Evaluations ☐ NOT APPLICABLE

☐ Medical evaluation completed.
☐ Medical Approval to Receive Fit Test
1. ☐ Disposable Particulate Respirators (N95)
2. ☐ Replaceable Disposable Particulate Respirator ☐ a. Half-Facepiece ☐ b. Full Facepiece
3. ☐ Powered Air-Purifying Respirators (PAPRs) ☐ a. Tight Fitting
4. ☐ Self-Contained Breathing Apparatus (SCBA)

Recommended time period for next questionnaire: ☐ 4 years ☐ Other _____ with justification _____

Date Completed: _____ Next Due Date: _____

Any recommended limitations for respirator use on workforce member: _____

☐ Medically unable to use a respirator.

☐ Informed workforce member of the results of this examination.

Comments: _____

| Physician or Licensed Health Care Professional Signature: | Print Name: | Date: | Time: |
|---|---|---|---|
| Facility Name/Address: | | Phone No. | |

| LAST NAME | FIRST, MIDDLE NAME | BIRTHDATE | HSN NO. |
|---|---|---|---|
| | | | |

## GENERAL INFORMATION

**THIS QUESTIONNAIRE IS TO BE REVIEWED BY A PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL.**

**8 CCR §5199**
Medical evaluation: DHS-EHS or non-DHS/non-County workforce member (WFM) School/Employer shall provide a medical evaluation, in accordance with 8 CCR §5144(e) of these orders, to determine the workforce member's (WFM) ability to use the respirator before the WFM is fit tested or required to use the respirator. For WFM who use respirators solely for compliance with subsections (g)(3)(A) and subsections (g)(3)(B), this alternate questionnaire may be used.

**8 CCR §5144(e)**

1. General. DHS-EHS or non-DHS/non-county WFM School/Employer shall provide a medical evaluation to determine the WFM's ability to use a respirator, before the WFM is fit tested or required to use the respirator in the workplace. DHS-EHS may discontinue a WFM's medical evaluations when the WFM is no longer required to use a respirator.
2. Medical evaluation procedures.
   a. DHS-EHS or non-DHS/non-County WFM School/Employer shall identify a physician or other licensed health care professional (PLHCP) to perform medical evaluations using a medical questionnaire or an initial medical examination that obtains the same information as the medical questionnaire.
   b. The medical evaluation shall obtain the information requested by this questionnaire in Sections 1 and 2, Part A.
3. Follow-up medical examination.
   a. DHS-EHS or non-DHS/non-County WFM School/Employer shall ensure that a follow-up medical examination is provided for a WFM who gives a **positive response to any question among questions 1 through 8 in Section 2, Part A** of this questionnaire or whose initial medical examination demonstrates the need for a follow-up medical examination.
   b. The follow-up medical examination shall include any medical tests, consultations, or diagnostic procedures that the PLHCP deems necessary to make a final determination.

If WFM is unable to be fit-tested or has failed the fit test, WFM must be provided with a powered air-purifying respirator (PAPR).

This form and its attachment(s), if any, such as health records shall be maintained and filed at non/DHS/non-County WFM School/Employer. The School/Employer shall verify completeness of DHS-EHS form(s) and ensure confidentiality of non-DHS/non-County WFM health information.

Upon request by DHS-Employee Health Services (EHS), the non-DHS/non-County WFM School/Employer shall have this form and its attachment(s) readily available within four (4) hours.

All workforce member health records are confidential in accordance with federal, state and regulatory requirements.

Health records will be maintained by DHS-EHS or non-DHS/non-County WFM School/Employer and kept for thirty (30) years after the workforce member's employment/assignment ends, in accordance with State and Federal medical records standards and DHS policies and procedures.

DHS-EHS will obtain the workforce member's written authorization before using or disclosing medical information, include to self, unless the disclosure is required by State or Federal law such as to a public health authority or governmental regulatory agency.

**Workforce members have the right to access their medical records and obtain a copy, thereof, within fifteen (15) days after the request.**

**A copy of the respiratory protection regulation Title 8 CCR §5144 and §5199 can be found at http://www.dir.ca.gov/title8/5144.html and http://www.dir.ca.gov/Title8/5199.html**