A8

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES

NON-COUNTY HEALTH CLEARANCE INSTRUCTIONS

Welcome to Los Angeles County, Department of Health Services (DHS). You are required to obtain a health clearance by Employee Health Services (EHS) prior to beginning your work 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 for your health clearance. **Completed E2s forms can be submited to EHS on the day or your appointment/visit or via email.**

This packet contains the following forms/questionnaires:

- ✓ **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.
      ****NOTE**:** N95 respirator is the most commonly used respirator in DHS facility, however, if you need a respirator greater than a N95 (such as full-face respirator), you must complete the Respirator Medical Evaluation Questionnaire (Form O-NC) and submit to your PLHCP prior to fit test. Form O-NC is available on EHS link at www.dhs.lacounty.gov .

Once you have been cleared by EHS, you may report to Human Resources to obtain an ID badge and begin your work assignment. If you have any questions, please contact the facility EHS.

Sincerely,

EMPLOYEE HEALTH SERVICES

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 8 & 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 to verify.

SECTION 1: FOR WORKFORCE MEMBER TO COMPLETE

TUBERCULOSIS SYMPTOM REVIEW – Check all appropriate boxes

☐ No ☐ Yes	Cough lasting more than 3 weeks	☐ No ☐ Yes	Excessive fatigue/malaise
☐ No ☐ Yes	Coughing up blood	☐ No ☐ Yes	Recent unprotected close contact with a person with TB
☐ No ☐ Yes	Unexplained/unintended weight loss (> 5 LBS)		
☐ No ☐ Yes	Night sweats (not related to menopause)	☐ No ☐ Yes	A history of immune dysfunction or are you receiving chemotherapeutic or immunosuppressant agents
☐ No ☐ Yes	Fever/chills		
☐ No ☐ Yes	Excessive sputum		

If you have any of the above symptoms, you should meet with your provider to determine whether a chest x-ray is indicated.

SECTION 2: FOR HEALTHCARE PROVIDER TO COMPLETE OR MUST PROVIDE SOURCE DOCUMENTS

A

TUBERCULIN SKIN TEST RECORD
0.1 ml of 5 tuberculin units (TU) purified protein derivative (PPD) antigen intradermal
Must have 2 negative TST < 12 months of start date.

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: Quantirferon or Tspot(<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 (no date requirement)	Date:	Results mm	☐ LA County ☐ Outside Document	STATUS
CXR (at or after date of +TST)	Date:	Results _____	☐ LA County ☐ 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#

D	Positive IGRA: Quantirferon or Tspot (no date requirement)	Date:	Results _____	☐ LA County ☐ Outside Document	**STATUS**
	CXR (at or after date of +IGRA)	Date:	Results _____	☐ LA County ☐ Outside Document	

OR

E	History of Active TB with Treatment	Date:	months with ____	☐ Outside Document	**STATUS**
	CXR (after date of completed Tx)	Date:	Results _____	☐ Outside Document	

OR

F	History of LTBI Treatment	Date:	_months with ___	☐ Outside Document	**STATUS**
	CXR (at or after date of Tx)	Date:	Results _____	☐ Outside Document	

AND

G

IMMUNIZATION DOCUMENTATION HISTORY (MANDATORY)

	Titer Result Date	Titer Result	If not immune, give Vaccination x 2, unless Rubella x 1		Date Received	Vaccine Received	Declined Vaccination (may be restricted from hospital/patient care)	
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

H

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

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 (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 Received**	**Vaccine**		☐ N/A (job duty does not involve blood or body fluid)
I	Hepatitis B Surface Ab Titer (HbsAb) anti-HBs	Titer Result Date	Titer	**AND**			**OR**	**Date** _____ ☐ Declination signed
			☐ Reactive ☐ Non-reactive					**Date** _____ **HbcAb/ anti-HBc** ☐Non-reactive ☐Reactive
								Date _____ **HbsAg** ☐Non-reactive ☐Reactive

AND

	Vaccination	**Date Received**	**Facility 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** ☐ **Powered Air Purifying Respirator** ☐ **N/A** (Job duty does not involve airborne precautions)
L	Color Vision (MANDATORY for WFM working with point of care POC testing or electrical)	Date:	☐ **Pass** ☐ **Fail** ☐ **N/A** (Job duty does not involve POC testing or electrical)

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:

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
	TUBERCULOSIS DOCUMENTATION HISTORY **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). Step 1: Administer TST test, with reading in seven days. 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. 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; b. Documentation of negative two-step TST within 12 months prior to placement will be accepted. WFM is cleared to work. 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. a. Documentation of negative IGRA within 12 months will be accepted. WFM is cleared to work. If IGRA is positive, record results and continue to Section D.
	TST POSITIVE RESULTS **If CHEST X-RAY IS POSITIVE, <u>DO NOT CLEAR</u> FOR HIRE/ASSIGNMENT, AND** **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 at or after first positive TST will be accepted for clearance to work as long as TB symptom screening is negative.
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 at or after first positive IGRA will be accepted for clearance to work as long as TB symptom screening is negative.
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 after active TB treatment will be accepted for clearance to work as long as TB symptom screening is negative.
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 after LTBI treatment will be accepted for clearance to work as long as TB symptom screening is negative.
	IMMUNIZATION DOCUMENTATION HISTORY 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	**<u>Td</u>** – 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. **<u>Tdap</u>** should replace a one time dose of Td for HCP aged 11 and up.
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) and documentation of a completed hepatitis b vaccine series. 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:	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:

Please check in the section(s) as apply AND indicate reason for the declination.

I. ☐ 8 CCR §5199. Appendix C1 - Vaccination Declination Statement

Check as apply: ☐ Measles ☐ Mumps ☐ Rubella ☐ Varicella

I understand that due to my occupational exposure to aerosol transmissible diseases (ATD), 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. If not immune, I must be immunized (unless medically contraindicated) or risk being restricted from areas of the health facility. I understand that by declining the vaccine(s) if medically contraindicated, I continue to be at risk of acquiring the above infection(s), a serious disease. If in the future I continue to have occupational exposure to ATD and want to be vaccinated, it is the responsibility of your School/Employer. DHS will provide services in accordance with terms of contract/agreement.

Reason for declination: _____

II. ☐ 8 CCR §5193. Appendix C1 - Vaccination Declination Statement

☐ Tdap/Td **Reason for declination:** _____

☐ Seasonal Influenza: I am aware that I will be required to wear a surgical mask whenever I have to work within an area that provides patient care/services during influenza season.

Reason for declination *(check as apply):*

☐ I believe I can get the flu if I get the shot
☐ I have severe reactive to previous vaccine
☐ I have history of Guillain-Barré syndrome within 6 weeks after previous vaccine
☐ I do not like needles
☐ I do not wish to say why I decline
☐ Other: _____

III. ☐ 8 CCR §5193. Appendix A - Hepatitis B Vaccine Declination

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, it is the responsibility of your School/Employer. DHS will provide services in accordance with terms of contract/agreement.

Reason for declination: _____

IV. ☐ Specialty Asbestos Surveillance Declination

I understand that due to my occupational exposure to asbestos at a combined total of 30 or more days a year warrant medical surveillance. 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, 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 strongly recommended enrollment, I will not be medically monitored for occupational exposure to this hazard. I also understand that if in the future I continue to have

PLEASE SIGN ON PAGE 2

K

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	E or C #:

occupational exposure to the hazard identified above and I want to be enrolled in the Medical Surveillance Program, to contact your School/Employer. DHS will provide services in accordance with terms of contract/agreement.

Reason for declination: _____

V. ☐ Specialty Hazardous Drug/ Anti-Neoplastic Surveillance Declination

I am aware that handling hazardous drugs / antineoplastic may cause adverse health effects, and workforce members of reproductive capability must confirm in writing that they understand the risks of handling hazardous drugs. I understand that due to my occupational risk 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, 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 strongly recommended enrollment, I will not be medically monitored for occupational exposure to this hazard. 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 to contact your School/Employer. DHS will provide services in accordance with terms of contract/agreement.

Reason for declination: _____

VI. ☐ Specialty Hearing Conservation Surveillance Declination

I understand that due to my occupational exposure that equals or exceeds an 8-hour time-weighted average of 85 decibels warrant medical surveillance. 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, 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 strongly recommended enrollment, I will not be medically monitored for occupational exposure to this hazard. 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, to contact your School/Employer. DHS will provide services in accordance with terms of contract/agreement.

Reason for declination: _____

VII. ☐ Microbiologist Only

Meningococcal vaccine is recommended to microbiologists who are routinely exposed to isolates of *Neisseria meningitidis.* Both MenACWY and MenB should be provided and boost with MenACWY every 5 years if risk continues. If in the future I continue to have occupational exposure risk and want to be vaccinated, it is the responsibility of your School/Employer. DHS will provide services in accordance with terms of contract/agreement.

Reason for declination: _____

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

WORKFORCE MEMBER SIGNATURE		DATE/TIME
SCHOOL/AGENCY/EHS STAFF (PRINT NAME)	SCHOOL/AGENCY/EHS SIGNATURE	DATE/TIME

N-NC

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES

RESPIRATORY FIT TEST RECORD

FOR NON-DHS/NON-COUNTY WFM

GENERAL INFORMATION on last page

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

RESPIRATOR, QUESTIONNAIRE, MEDICAL EVALUATION

RESET FORM N-NC

EQUIPMENT TYPE:	MANUFACTURER:	MODEL:	SIZE:
N95	Halyard/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

COMMENTS: _____

CONTINUE ON NEXT PAGE

N-NC

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	HSN NO.

Workforce member failed fit testing. A powered air-purifying respirator (PAPR) must 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:_____Date:_____

FIT Test Trainer (Print Name):_____Signature:_____Date:_____

DHS-EHS OFFICE STAFF ONLY			
Completion of this form:	Reviewed By (Print)	Signature	Date

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.

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 CFR Part 1635

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

Questionnaire for N95 Respirator

☞ **GENERAL INFORMATION on last page**

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 DHS.

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