



## **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 submitted 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.

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



# 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 to verify.

### SECTION 1: FOR WORKFORCE MEMBER TO COMPLETE

#### TUBERCULOSIS SYMPTOM REVIEW – Check all appropriate boxes

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

*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

TUBERCULIN SKIN TEST RECORD											<b>STATUS</b> <small>Indicate: Reactor Non-Reactor Converter</small>
0.1 ml of 5 tuberculin units (TU) purified protein derivative (PPD) antigen intradermal Must have 2 negative TST < 12 months of start date.											
DATE PLACED	STEP	MANUFACTURER	LOT #	EXP	SITE	*ADM BY (INITIALS)	DATE READ	*READ BY (INITIALS)	RESULT		
	1 <sup>st</sup>								mm		
	2 <sup>nd</sup>								mm		

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

**OR**

<b>B</b>	Negative IGRA: QuantiFERON or Tspot (<12 months)	Date:	Results	<input type="checkbox"/> LA County <input type="checkbox"/> Outside Document	<b>STATUS</b>

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

<b>C</b>	Positive TST (no date requirement)	Date:	Results	mm	<input type="checkbox"/> LA County <input type="checkbox"/> Outside Document	<b>STATUS</b>
	CXR (at or after date of +TST)	Date:	Results	_____	<input type="checkbox"/> LA County <input type="checkbox"/> Outside Document	

**OR**

CONTINUE ON NEXT PAGE

E2

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	E or C#
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<b>D</b>	Positive IGRA: QuantiFERON or Tspot (no date requirement)	Date:	Results _____	<input type="checkbox"/> LA County <input type="checkbox"/> Outside Document	<b>STATUS</b>
	CXR (at or after date of +IGRA)	Date:	Results _____	<input type="checkbox"/> LA County <input type="checkbox"/> Outside Document	

OR

<b>E</b>	History of Active TB with Treatment	Date:	__ months with __	<input type="checkbox"/> Outside Document	<b>STATUS</b>
	CXR (after date of completed Tx)	Date:	Results _____	<input type="checkbox"/> Outside Document	

OR

<b>F</b>	History of LTBI Treatment	Date:	__ months with __	<input type="checkbox"/> Outside Document	<b>STATUS</b>
	CXR (at or after date of Tx)	Date:	Results _____	<input type="checkbox"/> Outside Document	

AND

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)
<b>G</b>	Measles	<input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune <input type="checkbox"/> Equivocal <input type="checkbox"/> Laboratory confirm of disease	OR	X 2			OR <input type="checkbox"/> Decline only for true medical contraindication, must include medical documentation
	Mumps	<input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune <input type="checkbox"/> Equivocal <input type="checkbox"/> Laboratory confirm of disease	OR	X 2			OR <input type="checkbox"/> Decline only for true medical contraindication, must include medical documentation
	Rubella	<input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune <input type="checkbox"/> Equivocal <input type="checkbox"/> Laboratory confirm of disease	OR	X 1			OR <input type="checkbox"/> Decline only for true medical contraindication, must include medical documentation
	Varicella	<input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune <input type="checkbox"/> Equivocal <input type="checkbox"/> Laboratory confirm of disease	OR	X 2			OR <input type="checkbox"/> Decline only for true medical contraindication, must include medical documentation

AND

<b>H</b>	Vaccination	Date Received	Date of Declination Signed
	Tetanus-diphtheria (Td) every 10 years		OR
Acellular Pertussis (Tdap) X 1			

AND

E2

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	E or C#
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I	<b>Vaccination (MANDATORY to offer to WFM who have potential to be exposed to blood or body fluid)</b>		<b>If not reactive, vaccinate with HepB series</b>	<b>Date</b>	<b>Vaccine</b>	<input type="checkbox"/> N/A (job duty does not involve blood or body fluid)
	Hepatitis B Surface Ab Titer (HbsAb) anti-HBs	<b>Date</b>	<b>Titer</b>	<b>AND</b> <input type="checkbox"/> 3 dose series (Engerix-B or Recombivax) Or <input type="checkbox"/> 2 dose series (Hepelisav-B)		<b>OR</b>
			<input type="checkbox"/> Reactive <input type="checkbox"/> Non-reactive			
						<b>Date</b> _____ <b>HbcAb/anti-HBc</b> <input type="checkbox"/> Non-reactive <input type="checkbox"/> Reactive
						<b>Date</b> _____ <b>HbsAg</b> <input type="checkbox"/> Non-reactive <input type="checkbox"/> Reactive

AND

J	<b>Vaccination</b>	<b>Date Received</b>	<b>Facility Received</b>	<b>OR</b>	<b>Date Declination Signed</b>		
	Seasonal Influenza (one dose for current season)				Note: Must wear mask during influenza season.		
J1	<b>Vaccination (Provide copy)</b>	<b>Date Received</b>	<b>Manufacturer</b>	<b>OR</b>	<b>Date of future appointment</b>	<b>OR</b>	<input type="checkbox"/> Not Vaccinated
	COVID Vaccine 1 <sup>st</sup> dose 2 <sup>nd</sup> dose						

AND

K	Respiratory Fit Test (Complete Form N-NC)	Date:	<input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Powered Air Purifying Respirator <input type="checkbox"/> N/A (Job duty does not involve airborne precautions)
	Manufacturer:	Make: N-95	Model: Size:
L	Color Vision (MANDATORY for WFM working with point of care testing)	Date:	<input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> N/A (Job duty does not involve POC testing or electrical)

<b>FOR HEALTHCARE PROVIDER:</b> <input type="checkbox"/> 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


<b>FOR WORKFORCE MEMBER:</b> <input type="checkbox"/> Required source documents attached.	
Workforce Member Signature:	Date:

DHS EHS STAFF ONLY

<input type="checkbox"/> WFM completed pre-placement health evaluation.	Date of clearance:
Signature:	Print Name: Today's Date:

**CONFIDENTIAL**  
**PRE-PLACEMENT TUBERCULOSIS HISTORY AND EVIDENCE OF IMMUNITY**  
**PAGE 4 OF 4**

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	E or C#
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SECTION	 GENERAL INSTRUCTIONS FOR EACH SECTION
<b>TUBERCULOSIS DOCUMENTATION HISTORY</b>	
<b>ALL WORKFORCE MEMBER (WFM) SHALL BE SCREENED FOR TB UPON HIRE/ASSIGNMENT</b>	
<b>A</b>	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>B</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.
<b>TST POSITIVE RESULTS</b> <b>IF CHEST X-RAY IS POSITIVE, DO NOT CLEAR FOR HIRE/ASSIGNMENT, AND REFER WORKFORCE MEMBER FOR IMMEDIATE MEDICAL CARE</b>	
<b>C</b>	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.
<b>D</b>	If IGRA is positive during testing in Section D above, send for a CXR. If CXR is negative, WFM 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.
<b>E</b>	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 < 12 months of start date will be accepted for clearance to work as long as TB symptom screening is negative. If documentation is supported, WFM is cleared to work.
<b>F</b>	If WFM have a documented history of latent tuberculosis infection (LTBI) treatment TB, send for a chest x-ray (CXR). If CXR is negative, WFM is cleared to work. Documentation of negative CXR after LTBI treatment will be accepted for clearance to work as long as TB symptom screening is negative.
<b>IMMUNIZATION DOCUMENTATION HISTORY</b>	
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.	
<b>G</b>	Documentation of laboratory evidence of immunity or laboratory confirmation of disease will be accepted <b>OR</b> 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 weeks between doses for WFM. If Equivocal, WFM needs either vaccination or re-draw with positive titer. <b>DHS-EHS must be notified if WFM does not demonstrate evidence of immunity.</b>
<b>H</b>	<b>Td</b> – 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. <b>Tdap</b> should replace a one-time dose of Td for HCP aged 11 and up.
<b>I</b>	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.
<b>J</b>	Seasonal influenza vaccine is offered annually to WFM when the vaccine becomes available.
<b>J1</b>	COVID-19 vaccine (e.g. Pfizer 2-dose series separated by 21 days or Moderna 2-dose series separated by 28 days) is offered to WFM. (Provide copy)
<b>RESPIRATORY FIT TEST</b>	
<b>K</b>	If WFM job assignment requires a N95 respirator, WFM must be fit tested for the N95 respirator. If WFM job assignment involves Airborne Infection Isolation Rooms (AIIR), WFM will need to be fit tested. Include manufacture, model and size of N95 WFM passed fit testing on.
<b>COLOR VISION</b>	
<b>L</b>	If WFM job assignment involves Point-of-Care testing or electrical duties, WFM will need to be tested for Color Vision (Mandatory for WFM working with Point-of-Care testing)

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


**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):

- |  |   |
|--|---|
| <input type="checkbox"/> I believe I can get the flu if I get the shot   | <input type="checkbox"/> I do not like needles              |
| <input type="checkbox"/> I have severe reactive to previous vaccine  | <input type="checkbox"/> I do not wish to say why I decline |
| <input type="checkbox"/> I have history of Guillain-Barré syndrome within 6 weeks after previous vaccine <input type="checkbox"/> 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**

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



**RESPIRATORY FIT TEST RECORD**

**GENERAL INFORMATION on last page**

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

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

<b>EQUIPMENT TYPE:</b> N95	<b>MANUFACTURER:</b>	<b>MODEL:</b>	<b>SIZE:</b>
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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. Loose 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)**

Qualitative (QLFT) **OR**  Quantitative (QNFT)  Modified QNFT\* (Federal Standards by OSHA)

**RESPIRATOR FIT, PRESSURE FIT CHECK, COMFORT**

QLFT (Bitrex or Saccharin): <input type="checkbox"/> X 10 <input type="checkbox"/> X 20 <input type="checkbox"/> X 30 <input type="checkbox"/> Fail	<b>ATTEMPT #1</b>	<b>ATTEMPT #2</b>	<b>ATTEMPT #3</b>
<b>Fit Check:</b> <input type="checkbox"/> <b>POSITIVE</b> and/or <input type="checkbox"/> <b>NEGATIVE</b> pressure	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Pass <input type="checkbox"/> Fail
<b>Overall Comfort Level</b>	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Pass <input type="checkbox"/> Fail
<b>Ability to Wear Eyeglasses</b>	<input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> NA	<input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> NA	<input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> NA

**FIT TEST**

	<b>ATTEMPT #1</b>	<b>ATTEMPT #2</b>	<b>ATTEMPT #3</b>
<b>Normal Breathing</b> (performed for one minute)	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Pass <input type="checkbox"/> Fail
<b>Deep Breathing</b> (performed for one minute)	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Pass <input type="checkbox"/> Fail
<b>Turning Head Side to Side*</b> (performed for one minute)	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Pass <input type="checkbox"/> Fail
<b>Moving Head Up and Down*</b> (performed for one minute)	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Pass <input type="checkbox"/> Fail
<b>Talking* – Rainbow Passage</b> (performed for one minute)	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Pass <input type="checkbox"/> Fail
<b>Bending Over*</b> (performed for one minute)	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Pass <input type="checkbox"/> Fail
<b>Normal Breathing</b> (performed for one minute)	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	<input type="checkbox"/> Pass <input type="checkbox"/> Fail

**COMMENTS:** \_\_\_\_\_

\*Turning head side to side, moving head up and down, talking, and bending over exercises' duration total is 2.29 minutes using the Modified QNFT.

**CONTINUE ON NEXT PAGE**

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	E or C#:
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<input type="checkbox"/> Workforce member failed fit testing. <u>A powered air-purifying respirator (PAPR) must be provided to workforce member.</u> <input type="checkbox"/> WFM trained on PAPR use. <input type="checkbox"/> N/A	
<input type="checkbox"/> <b>PASS Pre-Placement FIT Test on:</b> _____	<input type="checkbox"/> <b>PASS Annual FIT Test on:</b> _____
<b>ACKNOWLEDGMENT OF TEST RESULTS</b>	
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			
<b>Completion of this form:</b>	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



**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 <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
HEIGHT FT	IN	WEIGHT LBS	JOB TITLE		E or C#:
PHONE NUMBER		Best Time to reach you?	Has your employer told you how to contact the health care professional who will review this questionnaire? <input type="checkbox"/> Yes <input type="checkbox"/> 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").

NOT YES SURE NO	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	1. Have you ever had the following conditions?
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	a. Allergic reactions that interfere with your breathing?

**CONTINUE ON NEXT PAGE**

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	E or C#:
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NOT YES SURE NO	
	If "yes," what did you react to? _____ _____
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	b. Claustrophobia (fear of closed-in places)
	<b>2. Do you currently have any of the following symptoms of pulmonary or lung illness:</b>
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	a. Shortness of breath when walking fast on level ground or walking up a slight hill or incline
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	b. Have to stop for breath when walking at your own pace on level ground
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	c. Shortness of breath that interferes with your job
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	d. Coughing that produces phlegm (thick sputum)
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	e. Coughing up blood in the last month
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	f. Wheezing that interferes with your job
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	g. Chest pain when you breath deeply
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	h. Any other symptoms that you think may be related to lung problems: _____ _____
	<b>3. Do you currently have any of the following cardiovascular or heart symptoms?</b>
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	a. Frequent pain or tightness in your chest
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	b. Pain or tightness in your chest during physical activity
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	c. Pain or tightness in your chest that interferes with your job
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	d. Any other symptoms that you think may be related to heart problems: _____ _____
	<b>4. Do you currently take medication for any of the following problems?</b>
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	a. Breathing or lung problems
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	b. Heart trouble
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	c. Nose, throat or sinuses
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	d. Are your problems under control with these medications?
	<b>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).</b>
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	a. Skin allergies or rashes
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	b. Anxiety
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	c. General weakness or fatigue
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	d. Any other problem that interferes with your use of a respirator
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<b>6. Would you like to talk to the health care professional about your answers in this questionnaire?</b>
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	E or C#:
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**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

- Disposable Particulate Respirators (N95)
- Replaceable Disposable Particulate Respirator  a. Half-Facepiece  b. Full Facepiece
- Powered Air-Purifying Respirators (PAPRs)  a. Loose Fitting
- 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

- Disposable Particulate Respirators (N95)
- Replaceable Disposable Particulate Respirator  a. Half-Facepiece  b. Full Facepiece
- Powered Air-Purifying Respirators (PAPRs)  a. Loose Fitting
- 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	E or C#.
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### 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>**