BAYLOR OCCUPATIONAL HEALTH
Phone (713)798-7880 Fax(713)798-3364

IMMUNIZATION REQUIREMENTS FOR RESIDENTS AND FELLOWS

Requirements based on Texas Department of State Health Services, OSHA policy and Centers for Disease Control recommendations.

Tetanus/Diphtheria/ Pertussis:	Booster dose of tetanus-diphtheria-pertussis (Tdap) within last 10 years. A Td booster is not sufficient.
Measles (Rubeola):	Acceptable proof of prior immunization with 2 doses of vaccine on or after first birthday at least 30 days apart; or serologic confirmation of immunity.
Mumps:	Acceptable proof of prior immunization with 2 doses of vaccine on or after first birthday at least 30 days apart; or serologic confirmation of immunity.
Rubella:	Acceptable proof of prior immunization with 2 doses of vaccine on or after first birthday at least 30 days apart; or serologic confirmation of immunity.
Varicella:	Acceptable proof of prior immunization with 2 doses of vaccine at appropriate interval; or serologic proof of immunity. Self-report or physician report of disease is not sufficient.
Hepatitis B:	Series of three immunizations: first dose, second dose 1 month after the first dose and third dose 5 months after second dose; or serologic confirmation of immunity.
Tuberculosis:	Only Mantoux results (in mm) for skin testing or IGRA blood test are accepted. Tine or Monovac are not accepted. Test should be placed and read by Occupational/Employee Health of your institution/hospital but may be completed through another clinic. The test must be done within 6 months prior to your start date. If your TB test is positive, you must provide documentation of the positive test. A chest x-ray done within 12 months prior to your start date is also required. A chest x-ray only or prior BCG is not sufficient documentation of a positive test.
Meningitis:	Immunization is not required.
OHP Forms:	There are two forms to complete and return - TB Respirator Questionnaire - Acknowledgment of Receipt of Privacy Notice (“HIPAA” form)

2022

Occupational Health Program

INCOMING RESIDENT/FELLOW IMMUNIZATION RECORD

Name ______________________________ Date of Birth______________ Phone______________

Residency/Fellowship Program______________________________ Email ______________________

Complete form and ATTACH SUPPORTING DOCUMENTATION

	DATE
A. **Tetanus-Diphtheria-Pertussis (Tdap)-** Td is not acceptable 1. ______Tdap booster within the last 10 years. (attach record)	______________ ______________
B. **M.M.R. (Measles, Mumps, Rubella)** (please document each dose) 1. _______Dose 1: Immunized at 12 months or after. (attach record). 2. _______Dose 2: Immunized after 1980. (attach record).	______________ ______________
C. **Measles (Rubeola)** - If given instead of M.M.R. check appropriate item 1. _______Serologic proof of immunity. (attach record). Or, 2. _______Two doses of vaccine, on or after first birthday. (attach records)	______________ ______________
D. **Mumps** - If given instead of M.M.R. check appropriate item 1. _______Serologic proof of immunity. (attach record). Or, 2. _______Two doses of vaccine, on or after first birthday. (attach records)	______________ ______________
E. **Rubella** - If given instead of M.M.R. check appropriate item 1. ______Serologic proof of immunity. (attach record). Or, 2. ______Two doses of vaccine, on or after first birthday. (attach records)	______________ ______________
F. **Varicella (Chickenpox)-** History of disease is not acceptable 1. ______Serologic proof of immunity. (attach record). Or, 2. ______Two doses of vaccine (attach record).	______________ ______________
G. **Hepatitis B** –provide documentation for all administered shots 1. ______Serologic proof of immunity. (attach record). Or, 2. ______Immunization (at least 3 doses and attach records)	______________ ______________ ______________ ______________
H. **Tuberculosis** 1. ______PPD (Mantoux) test or IGRA blood test done within 6 months prior to your start date. Refer to our Immunization Requirements (***Tine or Monovac not acceptable***) (attach record) 2. ______Had BCG vaccine. If yes, PPD still has to be done. 3. ______If prior positive PPD, (greater than 10 mm induration) or IGRA blood test positive, chest x-ray done within a year prior to your start date is required. (attach record and x-ray report)	______________ ______________ ______________
I. **OHP Forms** 1. ______ TB Respirator Questionnaire. 2. ______ Acknowledgment of Receipt of Privacy Notice. The “HIPAA” form.	

PLEASE SUBMIT ALL RECORDS THROUGH MEDHUB

Respirator Questionnaire for TB mask
Baylor Occupational Health Program

Fax 713-798-3364 scv_auto_print@bcm.edu

Section I: Employee Information (please print)

Name: ________________________________ BCM ID (if known): __________

Last First MI

Date of Birth: ________________ Age: ________ Phone Number: ____________________

Section II: Respirator/Work Information (Check all that apply)

DURATION OF RESPIRATOR USE:
✓__Only during patient care activities
___Only during emergency situations
___Regularly, but less than 5 hrs./week
___Over 1 hour per day every day

LEVEL OF EXERTION DURING RESPIRATOR USE:
✓__Light (mainly sedentary work, no lifting)
___Moderate (lifting up to 20 pounds occasionally)
___Heavy (carrying over 20 pounds or climbing frequently)

Section III: Medical History / Symptom Review

Do you have or have you ever had any of the following medical conditions?

___Heart Attack or angina
___Heart arrhythmias
___Other heart disease:
____
___Stroke
___Asthma (if yes, indicate if condition is active and how frequently you use medication)
____

___Tuberculosis
___Emphysema/Chronic bronchitis (with symptoms
___Pneumothorax (lung collapse)
___Any surgery or serious injury to the chest
___Pneumonia (if yes, when ___________)
___Other lung disease _____________________
____
___Anemia
___Skin allergies or rashes (if yes, substance _________)

Do you have or have you had any of the following problems? Please check any symptoms which you think are out of the ordinary.

___Shortness of breath
___Persistent cough (outside of colds)
___Wheezing (outside of colds)

___Persistent chest pains
___Palpitations or skipped heart beats
___Loss of consciousness

Are you taking any medications? _____Yes _____No
If yes, please list ____

Have you smoked within the last 30 days? ______Yes ____No
Have you ever worn a respirator before ______Yes ____No
If yes and you had problems with respirator use, please explain:
____

I understand that the above information is used to determine my ability to wear a respirator for protection from tuberculosis. The information I have furnished is true to the best of my knowledge. If I experience a significant change in my health status, I will notify Baylor Occupational Health..

Signature ______________________________ Date________________________

OHP use: Reviewer _______ ____ Y ____N Date_______________

Acknowledgment of Receipt Of Privacy Notice

By signing this form, you are agreeing that you have received a copy of the Baylor College of Medicine Privacy Notice, which describes how we use and disclose your health information. You have the right to refuse to sign this Acknowledgment, in which case we must document our good faith effort to obtain your acknowledgment and the reason why it was not obtained.

Receipt of Privacy Notice acknowledged by:

______________________ ___________________________________

Signature Print name (Please print clearly)

_____________ _____________________

Date BCM ID# (Use DOB, if you do not know your ID#)

Relationship to patient/employee:

☐ Self ☐ Other: ____