



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 IGRA blood test are accepted. Quantiferon is preferred but T-Spot is acceptable. The test must be done within 6 months prior to your start date. If you have a prior, positive TB blood test, 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)



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 at least 1 month after dose 1 (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. _____ IGRA blood test done within 6 months prior to your start date. (attach record) 2. _____ Had BCG vaccine. If yes, IGRA blood test still has to be done. 3. _____ If ever positive, provide record. Chest x-ray done within a year prior to your start date is required. Provide copy of 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?

- | | |
|--|---|
| <input type="checkbox"/> Heart Attack or angina | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart arrhythmias | <input type="checkbox"/> Emphysema/Chronic bronchitis (with symptoms) |
| <input type="checkbox"/> Other heart disease:
_____ | <input type="checkbox"/> Pneumothorax (lung collapse) |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Any surgery or serious injury to the chest |
| <input type="checkbox"/> Asthma (if yes, indicate if condition
is active and how frequently you use
medication)
_____ | <input type="checkbox"/> Pneumonia (if yes, when _____) |
| | <input type="checkbox"/> Other lung disease _____ |
| | <input type="checkbox"/> Anemia |
| | <input type="checkbox"/> 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.

- | | |
|--|--|
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Persistent chest pains |
| <input type="checkbox"/> Persistent cough (outside of colds) | <input type="checkbox"/> Palpitations or skipped heart beats |
| <input type="checkbox"/> Wheezing (outside of colds) | <input type="checkbox"/> 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: _____