Baylor College of Medicine

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)

2025

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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

12/17/2024

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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 <u>out of the ordinary.</u>

___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_____

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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: _____