University Health Partners of Hawaii (UMP)

INFECTION CONTROL - ANNUAL PPI) & HEALTH SURVEY FORM FOR TUBERCULOSIS *CONFIDENTIAL

This form must be completed for all employees who have patient contact

Employee Name: _____ Date: _____

Job Title: _____ Department: _____

I. Entry TB Clearance (New Hires) PPD/TST:

1st Step: Date Given: _____ Date Read: _____ mm: _____ Result (please circle based on mm of indurations): **Negative / Positive**

Read by: _____ Signature: _____

2nd Step: Date Given: _____ Date Read: _____ mm: _____ Result (please circle based on mm of indurations): **Negative / Positive**

Read by: _____ Signature: _____

Name of facility where 2 step TB skin test was completed: _____

OR, if a new hire has a history of TB or a history of having a PPD reading showing induration measuring 10mm or more, employee to be referred to the State of Hawaii TB clinic to obtain a clearance card. Employee is not allowed to work until receiving the clearance card. Attach a copy of the clearance card to this form.

la Option: IGRA type: _____ Date: _____ Result: _____ (include a copy of test result in HR personnel file)

II. Annual TB Test or Annual IGRA:

Date Given: _____ Date Read: _____ mm: _____ Result (please circle based on mm of indurations): **Negative / Positive**

Read by: _____ Signature: _____

Name of facility where TB skin test was completed: _____

IGRA Date: _____ Type: _____ Result: _____ (include copy in HR personnel file)

OR, if employee has a history of TB or Positive PPD/TST, the employee should complete Section Ill below.

_____ _____

Employee signature Date

Ill. Annual Questionnaire: Employees with History of TB or History of Positive PPD/TST must answer the Questions below: (This section is left blank if the employee has a PPD/TST of less than 10mm of induration).

This survey is to ensure all employees who have patient contact are free of the disease for their safety and for those of our patients and fellow employees. Please review the symptoms listed below and check "yes" or "no" in the appropriate box and include appropriate duration. The Chief Executive Officer or Chief Medical Officer will review this form and you will be contacted directly if any follow up action is required.

In the past year, have you experienced any of the following symptoms:

Symptoms	Yes	No	If yes, duration of symptoms (In Days)
l. Prolonged cough for 3 weeks or more			
2. Chest pain			
3. Persistent weight loss without dieting			
4. Persistent low grade fever			
5. Chills			
6. Night sweats			
7. Loss of appetite			
8. Coughing up blood (Hemoptysis)			
9. Shortness of breath			

Individuals with a positive TB skin test and possible TB symptoms (as indicated above) must be referred to a State of Hawaii TB Clinic or see their private physician for further evaluation and work clearance.

Employee Signature: _____ Date: _____

Thank you for completing this form. Please return this form to the Human Resources Department.
This document contains confidential information and must be submitted in a sealed envelope.

FOR OFFICE USE ONLY Human Resources Receipt: _____ Date: _____

CEO or CMO Review: _____ Date: _____