INFECTION CONTROL SCREENING

PLEASE PRINT LEGIBLY!

Today's Date: _____

Name: _____ Date of Birth: _____

Social Security #: _____ TT R#: _____
(Used for ID@UMC Lab ONLY)

Department: _____ Supervisor: _____

Clinical Designation (if applicable): _____
(MD, RN, FNP, LSW, LVN, CMA, etc..)

Emergency Contact: _____
Name Relationship Phone #

	YES	NO
1. Will you be seeing patients at UMC-EP or entering patient care units? **(If yes, Tb Skin Test is required)**	☐	☐
2. Will you provide patient care at Texas Tech Clinics?	☐	☐
3. Will you have DIRECT patient contact at UMC-EP or Texas Tech?	☐	☐
4. Do you have your complete Immunization Record with you?	☐	☐
5. When was your last TB Skin Test or Chest X-Ray? Date: _____		
6. Have you ever been treated for LTBI (Latent TB Infection)?	☐	☐
If so, what city & when? _____ (City) (Date)		
7. When was your last Tetanus Diphtheria Vaccine? Date: _____		
8. Have you ever received Tdap Vaccine? If so, when? Date: _____		
9. Have you received the Hepatitis B Series?	☐	☐
If yes, do you have documentation?	☐	☐
If no, Hepatitis B series may be required)		
10. Do you have Lab results for antibody titers? (re: Rubella, Rubeola, Varicella, Hep B)	☐	☐

Researches ONLY

11. Will you be in contact with infectious agents? ☐ HIV ☐ H1N1 Other _____

12. Will you be working in the animal lab? ☐ Mice ☐ Zebra Fish Other _____

TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER™
Paul L. Foster School *of* Medicine

Occupational Health Services
4801 Alberta Ave. El Paso, Texas 79905
Phone: (915) 521-4429 Fax: (915) 545-6680

TUBERCULOSIS SCREENING FORM

Last Name: _____ First Name: _____

Date of Birth: ___ / ___/ _____ Department: _____

This form is to be completed by all employees, volunteers, students and others who:

- Are New Texas Tech employees and do NOT work in "High Risk" clinics. (Internal Medicine and Family Medicine clinics are considered "High Risk").
- Have or have had a positive TB skin test (TST)
- Have had treated active TB

Have you had any of the following symptoms for more than three weeks at a time?

☐ No symptoms

☐ Persistent Cough

☐ Blood-tinged sputum when you cough

☐ Unexplained fever

☐ Unexplained weight loss

☐ Unexplained night sweats

☐ Unexplained general fatigue

To the best of my knowledge, the above statements are correct and complete and may be used to whatever extent necessary in connection with employment or other Texas Tech activity.

Fax completed form to Occupational Health Services (915) 545-6680.

_____ _____

Signature Today's Date