FAIRVIEW

Fairview requires an attestation of compliance with the required criteria as described below **and** follow-up confirmation of certain immunizations or tests. Practitioners are responsible for obtaining satisfactory documentation and any associated costs to meet Fairview requirements.

Screening & Immunizations/Immunity	Required Documentation to Support Attestation Return Required Documentation To: DEPT-EOHS-CREDENTIALING@Fairview.org
Tuberculosis Symptom Survey Screen AND Tuberculin Test	**Acceptable historical record of tuberculosis screening includes:** (see attached form) • Completion of the attached TB symptom survey questions with your signature and date (required). Return to: DEPT-EOHS-CREDENTIALING@Fairview.org **AND** NOTE: The TB skin test section of the form can be used for skin test documentation purposes or you may submit like documentation from the clinic where the TB skin test or the blood assay for mycobacterium tuberculosis with results and reference range were performed • 2-Step Mantoux test (***completed up to 90 days prior*** to Fairview start date) **or** • Blood assay results for Mycobacterium Tuberculosis test (QGold or TSpot) (***completed up to 90 days prior*** to Fairview start date) **or** • Documentation of previous positive PPD or BAMT AND documentation of completed INH medication therapy AND documentation of chest x-ray ***within 1 year prior*** to Fairview start date ***and 12 months after the date a new conversion*** (if conversion was >12 months) **Return to: DEPT-EOHS-CREDENTIALING@Fairview.org**
Measles, Mumps and Rubella (MMR) & Varicella	**Acceptable historical record of measles, mumps, rubella and varicella immunity or vaccination includes:** Two **(2)** live virus vaccines for: • Measles, Mumps, Rubella (MMR) ***AND*** Varicella ***OR*** • Documentation of positive immunity titers for Measles, Mumps, Rubella ***AND*** Varicella *(Record of all four (4) vaccines or immunity results with lab values are required)* **Note: History of disease is not an acceptable form of documentation** **Return to: DEPT-EOHS-CREDENTIALING@Fairview.org**
Hepatitis B	**Acceptable historical record of Hepatitis B vaccination or immunity includes:** • Medical documentation of completed Hepatitis B vaccination series (including dates) ***OR*** • Medical documentation of positive Hepatitis B immunity titer ***OR*** • Signed and dated declination form **Note: Hepatitis B vaccination is not required.** **If you wish to decline the vaccination, sign and return the attached declination form to DEPT-EOHS-CREDENTIALING@Fairview.org**
Immunizations	**Requested Documentation** **Return Requested Documentation To: DEPT-EOHS-CREDENTIALING@Fairview.org**
Tdap	**Acceptable historical record of Tdap vaccination:** • Documentation of most recent adult Tdap vaccination **Return to: DEPT-EOHS-CREDENTIALING@Fairview.org**

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FAIRVIEW

Tuberculosis Screening

Return to: DEPT-EOHS-CREDENTIALING@Fairview.org

Legal Last name, First name, Middle initial	Date	( ) Work, Home or Cell Phone Number
Date of Birth	Fairview ID Number	SSN if not current Fairview Employee

Completion of the questions below with your signature and date are required. The TB skin test section can be used for documentation purposes or you may submit like documentation from the clinic where the TB test was performed or the blood assay for mycobacterium tuberculosis test results and reference range.

YES	NO	DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING SYMPTOMS? *
		Chest pain
		Coughing for more than 3 weeks
		Coughing up blood
		Unexplained fatigue (extremely tired without a reason)
		Unexplained fever/chills
		Unexplained night sweats
		Unexplained weight loss, poor appetite

YES	NO	HAVE YOU *
		Ever had the BCG (bacille Calmette-Guerin) vaccine (a vaccine for tuberculosis (TB) disease used in many countries with a high prevalence of TB)
		Ever been treated for latent TB infection (IF YES, DATES TREATED)_____
		Ever been treated for active TB disease (IF YES, DATES TREATED)_____
		Ever had an adverse reaction to a TB skin test (EXPLAIN)_____
		Received a live-virus vaccine within the past 6 weeks
		Ever had a positive reaction to a TB skin test or TB blood test If YES, Date _____ Number of MM induration_____
		Had a TB skin test in the past 12 months If YES, Date _____ Number of MM induration_____ Result_____

Date	**Legible Printed Name of Worker completing questions If TST administered, name of worker consenting to TST**	**Legible Signature of Worker completing questions If TST administered, name of worker consenting to TST**
Date	**Printed Name of OHN reviewing symptom survey**	**Signature of OHN reviewing symptom survey**

TUBERCULIN SKIN TEST (TST)

	TST – First Step	TST – Second Step
Administration		
Name of person administering test		
Date and time administered		
Location (circle)	L forearm R forearm Other:_____	L forearm R forearm Other:_____
Tuberculin manufacturer		
Tuberculin expiration date and lot #		
Signature of person who administered test		
Results (read between 48-72 hours)		
Date and time read:		
Number of mm of induration: (**across** forearm)	____mm	____mm
Interpretation of reading (circle)	Positive** Negative***	Positive** Negative
Reader's signature		

* Refer "YES" responses to EOHS before TST is administered

** If result is positive, refer to Tuberculosis Medical Surveillance Policy/Procedure for next steps

*** If result is negative, perform second step TST in one to three weeks *(as applicable)*

Adapted from MN DOH TB Screening Tools

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Hepatitis B Questionnaire/Declination for Credentialed Practitioners

Return to: DEPT-EOHS-CREDENTIALING@Fairview.org

Name _____ **Last four SS#** _____

Date of birth _____ **Job Title** _____

_____ 1) I have received Hepatitis B vaccine in the past.

☐**series of three completed:** MUST attach medical documentation to support (including dates vaccine was received)

☐**series incomplete, number of shots given _____ and year given _____**

Hepatitis B titer results

☐unknown / not previously drawn

☐not immune

☐known immune (MUST attach medical documentation to support)

_____ 2) I have not received Hepatitis B vaccine in the past and I would like to receive the Hepatitis B vaccination

☐I would like to receive the Hepatitis B vaccine. I will contact Employee Occupational Health Services at 612-672-5050 to schedule the vaccination series. I understand that the vaccination series will be 3 doses and that it is my responsibility to complete the entire series, or contact Employee Occupational Health Services to sign a declination. Failure to respond to an EOHS reminder letter within 2 weeks of letter date will serve as my declination.

_____ 3) DECLINATION **(OSHA 1910.1030, App A)**

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis vaccine, at no charge to Fairview employees. However, I decline Hepatitis B vaccination at this time. I understand by declining this vaccine I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials, and I want to be vaccinated with Hepatitis B vaccine, I can complete the vaccination series at no charge to Fairview employees.

I do not wish to receive the Hepatitis B vaccine at this time. (Please sign declination below)

Signature (for declination only) _____ **Date** _____