Department of Behavioral Health

TRANSMITTAL LETTER

SUBJECT **Health Screenings**		
POLICY NUMBER **716.1A**	**DATE** JAN 0 4 2016	**TL#** 307

Purpose. To set forth the policy and procedures for health screenings for Department of Behavioral Health (DBH) direct care applicants and employees.

The main change in this policy is found in section 5a: Each individual who is involved in direct care to consumers/clients shall have a health screening not more than thirty (30) calendar days prior to entering on duty. Thereafter, employees shall receive an annual PPD/TB test or chest x-ray to rule out tuberculosis per medical examiner's decision. Procedures on how to accomplish this change are found in Section 6, 7 and 8 of this policy.

Applicability. Post-offer applicants who are selected for employment in a direct care position, and employees, student interns/trainees/residents who provide direct care to DBH consumers or clients.

Policy Clearance. Reviewed by affected responsible staff and cleared through appropriate Behavioral Health Authority (BHA) offices and providers.

Effective Date. This policy is effective immediately.

Superseded Policies. This policy replaces DMH Policy 716.1, same subject, dated December 17, 2013.

Distribution. This policy will be posted on the DBH web site at www.dbh.dc.gov under Policies and Rules. Applicable entities are required to ensure that affected staff are familiar with the contents of this policy.

Tanya A. Royster, MD
Director, DBH

GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF BEHAVIORAL HEALTH	Policy No. 716.1A	Date JAN 0 4 2016	Page 1
	Supersedes DBH Policy 716.1, Health Screenings dated Dec. 17, 2013		

Subject: Health Screenings

1. **Purpose**. To set forth the policy and procedures for health screenings for Department of Behavioral Health (DBH) direct care applicants and employees.

2. **Applicability**. Post-offer applicants who are selected for employment in a direct care position, and employees, student interns/trainees/residents who provide direct care to DBH consumers or clients.

3. **Authority**. Americans with Disabilities Act of 1990, as amended, 42 U.S.C. §12101 *et seq.*; 6 D.C.M.R. § B2049 (2013); 22 D.C.M.R. § B2017 (2013); Centers for Disease Control and Prevention, Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings, 2005, Morbidity and Mortality Weekly Report, Vol. 54 (No. RR-17); and 29 CFR § 1910.1030 (2013).

4. **Definitions**.

4a. Direct Care – positions identified by DBH Office of Human Resources that involve close physical contact with DBH consumers/clients on a regular basis, including, but not limited to, intake staff, nursing, physicians, and janitorial staff. *See also* Section 6a(1) below.

4b. Post-Offer Direct Care Applicants – applicants who are officially offered employment with DBH, subject to completion of any health screening required in this policy. This includes new employees and existing employees transferring to direct care positions.

5. **Policy**.

5a. The Americans with Disabilities Act (ADA) allows DBH to require a medical examination of an employee that is job-related and consistent with business necessity. Each individual who is involved in direct care to consumers/clients shall have a health screening not more than thirty (30) calendar days prior to entering on duty. Thereafter, employees shall receive an annual PPD/TB test or chest x-ray to rule out tuberculosis per medical examiner's decision.[1] *See* Exhibit 2, TB Test Result Form; Exhibit 3, TB Protocol Instructions; Exhibit 5, Annual

[1] A chest X-ray usually is done if you have:

- A positive tuberculin skin test (also called a TB skin test, PPD test, or Mantoux test).
- Symptoms of active TB, such as a persistent cough, fatigue, fever, or night sweats.
- An uncertain reaction to the tuberculin skin test because of a weakened immune system, or to a previous bacille Calmette-Guerin (BCG) vaccination. (Reference: http://www.webmd.com/lung/tc/tuberculosis-tb-exams-and-tests)

Tuberculosis Assessment Form.

5b. Post-offer direct care applicants shall be required to provide the DBH Office of Human Resources a completed Certificate of Medical Examination, Optional Form 178. *See* Exhibit 1, Certificate of Medical Examination, Optional Form 178. The individual will also be offered a Hepatitis B vaccination. *See* Exhibit 4, Hepatitis B Vaccination Consent/Declination Form.

5c. Students involved in direct care pursuant to an affiliation agreement are required to demonstrate current PPD and Hepatitis B vaccination or Hepatitis B declination prior to entering on duty at DBH.

6. **Procedures**.

6a. The DBH Office of Human Resources (OHR) shall:

(1) Identify, in collaboration with managers, the direct care positions that require health screenings.

(2) Ensure that official offer of employment specifies that the position requires a health screening as a condition of employment, as applicable.

(3) Request that hiring supervisor complete Part B of the Certificate of Medical Examination (Exhibit 1) at the time the vacancy announcement is developed.

(4) Provide the Certificate of Medical Examination to the post-offer applicant with instructions for completion.

(5) Advise the post-offer applicant that they have the option of obtaining the health screening from their own primary physician at their own expense or to utilize the Medical Clinic at Saint Elizabeths Hospital, if available.

(6) For post-offer applicants, ensure that each individual who will provide direct care satisfactorily completes required health screening prior to entering on duty as a condition of employment.

(7) For current employees, provide employee annual notice that a current TB/PPD test is required, and offer a Hepatitis B vaccination. Provide a copy of the employee's annual notice, staff compliance, and results to the supervisor.

(8) Ensure that in-service training on health screenings is included in staff orientation.

6b. Program Managers/Supervisors shall:

(1) Complete Part B of the Certificate of Medical Examination at the time the vacancy announcement is being developed for new hires.

(2) Remind all direct care employees during their annual performance evaluation that

they must have a TB/PPD test annually during the month of the employee's birthday, and document completion during their annual performance rating.

(3) Initiate corrective measures for failure to satisfactorily complete required TB/PPD test annually, in collaboration with OHR (*see* Section 7 below).

(4) Authorize administrative leave not to exceed three (3) hours to allow employees to complete the required testing.

(5) Be responsible for tracking compliance of this policy.

6c. Employees/Applicants shall:

(1) Undergo initial health screening upon selection for the direct care position.

(2) Obtain TB/PPD test annually during the employee's birth month. *See* Exhibit 3.

(3) Obtain required health screening or annual TB/PPD testing at a private physician, or, if available, the Saint Elizabeths Hospital Medical Clinic. *See* Exhibit 2; Section 7 below regarding non-compliance.

(2) If using a private physician, provide the Certificate of Medical Examination (Exhibit 1) to the private physician.

(3) Return the results to the OHR for clearance as follows:

- Prior to reporting for duty (may not be more than thirty [30] calendar days prior to entering on duty), and;
- Within ten (10) calendar days of employee's subsequent annual TB/PPD testing date.

(4) If declining the Hepatitis B vaccination, sign the Hepatitis B Vaccination Declination Form. *See* Exhibit 4.

7. **Corrective Measures for Failure to Complete Mandatory Health Screenings**.

7a. OHR may rescind offers of employment if post-offer applicants do not satisfactorily complete required health screenings.

7b. Employees may be subject to removal under Chapter 16 of the District Personnel Manual if the employee fails to satisfactorily complete required mandatory TB/PPD testing annually.

8. **Return to Work and Fitness for Duty Examination**.

Nothing in the policy prohibits or restricts DBH's right to request medical information that is job-related and consistent with business necessity when an employee returns to work following an illness or injury or when necessary to determine an employee's fitness for duty. In the event that a supervisor has a reasonable basis to believe that health-related factors are

having an adverse effect on the employee's ability to perform the essential functions of the employee's job, the matter shall be immediately referred to OHR.

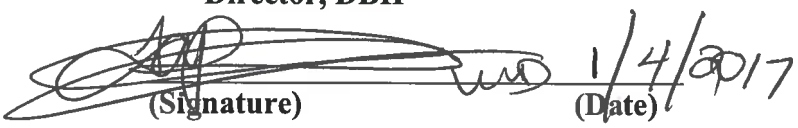
9. **Inquiries**. For questions regarding this policy, please contact OHR.

10. **Exhibits**.

1 – Certificate of Medical Examination, Optional Form 178
2 – TB Test Result Form
3 – TB Protocol Instructions
4 – Hepatitis B Vaccination Consent/Declination Form
5 – Annual Tuberculosis Assessment Form

Approved By:

Tanya A. Royster, MD
Director, DBH



(Signature) **(Date)** 1/4/2017

To be given to the individual examined with a pre-addressed envelope marked "Confidential - Medical".

CERTIFICATE OF MEDICAL EXAMINATION

U.S. OFFICE OF PERSONNEL MANAGEMENT

Form Approved
OMB No. 3206 - 0250

Privacy Act Statement

Solicitation of this information is authorized by Section 552a of Title 5, United States Code, regarding records maintained on individuals; Section 3301 of Title 5, United States Code, regarding determination as to an individual's fitness for employment with regard to age, health, character, knowledge and ability; and Section 3312 of Title 5 United States Code, regarding waiver of physical qualifications for preference eligibles. This form is used to collect medical information about individuals who are incumbents of positions in the Federal Government which require physical fitness testing and medical examinations, or individuals who have been selected for such a position contingent upon successful completion of physical fitness testing and medical examinations as a condition of their employment. The primary use of this information will be to determine the nature of a medical or physical condition that may affect safe and efficient performance of the work described. Additional potential routine uses of this information include using it to ensure fair and consistent treatment of employees and job applicants, to adjudicate requests to pass over preference eligibles, or to adjudicate claims of discrimination under the Rehabilitation Act of 1973, as amended. Completion of this form is voluntary; however, failure to complete the form may result in no further consideration of an applicant, or a determination that an employee is no longer qualified for his or her position. In addition, incomplete, misleading, or untruthful information provided on the form may result in delays in processing the form for employment, termination of employment, or criminal sanction.

Public Burden Statement

We estimate an average of two to three hours per response to complete, including the time for reviewing instructions, getting needed information, and reviewing the completed form. Send comments regarding our estimate or any other aspect of this form, including suggestions for reducing completion time, to the U.S. Office of Personnel Management (OPM), Strategic Human Resources Policy, Medical Policy and Programs Division, Attn: OMB Number (3206-0250), 1900 E Street, NW, Washington, D.C. 20415. The OMB number, 3206-0250, is currently valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.

Instructions

There are five parts in this form:

Part A - To be completed by applicant or employee. Signature of the applicant or employee certifies that the information provided is complete and accurate; and that the applicant or employee consents to the release of the examination results to the employing agency.

Part B - To be completed by the appointing officer before the medical examination: identifies the purpose of the examination; the position title, series and grade; generally describes the position; and shows the specific functional requirements and environmental factors that the work requires.

Part C - To be completed and signed by the examining physician, and returned to the employing agency in the pre-paid/ pre-addressed "Confidential-Medical" envelope provided.

Part D - To be completed by the agency medical officer who reviews the examination results and recommends action.

Part E - To be completed by the agency human resources officer in order to document the personnel action that is rendered.

To be given to the individual examined with a pre-addressed envelope marked "Confidential - Medical".

CERTIFICATE OF MEDICAL EXAMINATION

U.S. OFFICE OF PERSONNEL MANAGEMENT

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Part A. TO BE COMPLETED BY APPLICANT OR EMPLOYEE		
1. Name (Last, First, Middle Initial)		
2. Federal Employee Number	3. Sex ☐ Male ☐ Female	4. Birth Date *(month, day, year)*
5. Do you have any medical disorder or physical impairment which would interfere in any way with the full performance of the duties shown in Part B, No. 3? ☐ Yes ☐ No (If your answer is YES, explain fully to the physician performing the examination)		
6. Address (including City, State, Zip Code)		
7. E-mail Address	8. Telephone Numbers (with Area Code)	
9. Applicant or Employee Consent and Certification		
I certify that all of the information I have provided on this form is complete and accurate to the best of my knowledge, and that submitting information that is incomplete, misleading, or untruthful may result in termination, criminal sanctions, or delays in processing this form for employment. Furthermore, consistent with the Privacy Act Statement, I authorize the release to my employing agency of all information contained on this examination form and all other forms generated as a direct result of my examination.		
10. Signature (Do not print)	11. Date *(month, day, year)*	

To be given to the individual examined with a pre-addressed envelope marked "Confidential - Medical".

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Part B. TO BE COMPLETED BEFORE EXAMINATION BY APPOINTING OFFICER	
1. Purpose of examination ☐ Pre-placement ☐ Other (Specify)_____	2. Position Title, Series, and Grade
3. Brief description of what the position requires the employee to do.	

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Part B. CONTINUED - TO BE COMPLETED BEFORE EXAMINATION BY APPOINTING OFFICER

4. Check the box for each functional requirement in section 4a and each environmental factor in section 4b essential to the duties of this position. List any additional essential factors in the blank spaces. Also, if the position involves law enforcement, air traffic control, or fire fighting, attach the specific medical standards for the information of the examining physician.

4a. Functional Requirements

- ☐ Heavy lifting, 45 pounds and over
- ☐ Moderate lifting, 15-44 pounds
- ☐ Light lifting, under 15 pounds
- ☐ Heavy carrying, 45 pounds and over
- ☐ Moderate carrying, 15-44 pounds
- ☐ Light carrying, under 15 pounds
- ☐ Straight pulling (_____ hours)
- ☐ Pulling hand over hand (_____ hours)
- ☐ Pushing (_____ hours)
- ☐ Reaching above shoulder
- ☐ Use of fingers
- ☐ Both hands required
- ☐ Walking (_____ hours)
- ☐ Standing (_____ hours)
- ☐ Crawling (_____ hours)
- ☐ Kneeling (_____ hours)
- ☐ Repeated bending (_____ hours)
- ☐ Climbing, legs only (_____ hours)
- ☐ Climbing, use of legs and arms
- ☐ Both legs required
- ☐ Operation of crane, truck, tractor, or motor vehicle
- ☐ Ability for rapid mental and muscular coordination simultaneously
- ☐ Ability to use and desirability of using firearms
- ☐ Near vision correctable at 13" to 16" to Jaeger 1 to 4
- ☐ Far vision correctable in one eye to 20/20 and to 20/40 in the other
- ☐ Specific visual requirement (specify)

  _____
- ☐ Both eyes required
- ☐ Depth perception
- ☐ Ability to distinguish basic colors
- ☐ Ability to distinguish shades of colors
- ☐ Hearing (aid permitted)
- ☐ Hearing without aid
- ☐ Specific hearing requirements (specify)

Other (specify)

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

4b. Environmental Factors

- ☐ Outside
- ☐ Outside and inside
- ☐ Excessive heat
- ☐ Excessive cold
- ☐ Excessive humidity
- ☐ Excessive dampness or chilling
- ☐ Dry atmospheric conditions
- ☐ Excessive noise, intermittent
- ☐ Constant noise
- ☐ Dust
- ☐ Silica, asbestos, etc.
- ☐ Fumes, smoke, or gases
- ☐ Solvents (degreasing agents)
- ☐ Grease and oils
- ☐ Radiant energy
- ☐ Electrical energy
- ☐ Slippery or uneven walking surfaces
- ☐ Working around machinery with moving parts
- ☐ Working around moving objects or vehicles
- ☐ Working on ladders or scaffolding
- ☐ Working below ground
- ☐ Unusual fatigue factors (specify)

  _____
- ☐ Working with hands in water
- ☐ Explosives
- ☐ Vibration
- ☐ Working closely with others
- ☐ Working alone
- ☐ Protracted or irregular hours of work

Other (specify)

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

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Part C. TO BE COMPLETED BY EXAMINING PHYSICIAN

NOTE TO EXAMINING PHYSICIAN: The person you are about to examine will have to cope with the functional requirements and environmental factors checked in Part 4 of this form. Please take these, and the brief description of the job duties, into consideration as you make your examination and report your findings and conclusions.

1. Height _____ Feet, _____ Inches. Weight: _____ Pounds.

2. Eyes:

a. Distant vision (Snellen): without corrective lenses: right 20 ____ left 20 ____; with corrective lenses, if worn; right 20 ____ left 20 ____

b. Depth perception
Type of test: _____
_____ Seconds of Arc
Number correct: _____ of _____ tested
Interpretation ☐ Normal ☐ Abnormal

c. Peripheral vision
Right Nasal _____ degrees Temporal _____ degrees
Left Nasal _____ degrees Temporal _____ degrees

d. What is the longest and shortest distance at which the following specimen of Jaeger No. 2 type can be read by the applicant?

Test each eye separately.

Jaeger No. 2 Type
The President may -
(1) prescribe such regulations for the admission of individuals into the civil service in the executive branch as will best promote the efficiency of that service; (2) ascertain the fitness of applicants as to age, health, character, knowledge, and ability for the employment sought; and (3) appoint and prescribe the duties of individuals to make inquiries for the purpose of this section.
(Title 5 U.S. Code 3301)

	without corrective lenses:	with corrective lenses, if used:
	L _____ in. to _____ in.	L _____ in. to _____ in.
	R _____ in. to _____ in.	R _____ in. to _____ in.

e. Color vision: Is color vision normal by Ishihara or other color plate test? ☐ Yes ☐ No

If not, can applicant pass lantern test? ☐ Yes ☐ No

Can see red/green/yellow? ☐ Yes ☐ No

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CERTIFICATE OF MEDICAL EXAMINATION

U.S. OFFICE OF PERSONNEL MANAGEMENT

Form Approved
OMB No. 3206 - 0250

Part C. CONTINUED - TO BE COMPLETED BY EXAMINING PHYSICIAN

3. Ears: (Consider denominators indicated here as normal. Record as numerators the greatest distance heard.)

Ordinary conversation:

Right Ear _____ ;
20 ft.

Left Ear _____
20 ft.

Audiometer in dB (if given) for Right Ear:									
250	500	1000	2000	3000	4000	5000	6000	7000	8000

Audiometer in dB (if given) for Left Ear:									
250	500	1000	2000	3000	4000	5000	6000	7000	8000

4. Other Findings: Describe any abnormality (including diseases, scars, and disfigurations). Include brief pertinent history. If normal, so indicate.

a. Eyes, ears, nose, and throat (including tooth and oral hygiene)

b. Abdomen

c. Head and back (including face, hair, and scalp)

d. Peripheral blood vessels

e. Speech (note any malfunction)

f. Extremities (including strength, range of motion)

g. Skin and lymph nodes (including thyroid gland)

h. Urinalysis (if indicated)

SP. Gr. _____ Sugar _____ Blood _____

Albumen _____ Casts _____ Pus _____

i. Respiratory tract (X-ray if indicated)

j. Heart (size, rate, rhythm, function)

Blood pressure _____

Pulse _____

EKG (if indicated)

k. Back (special consideration for positions involving heavy lifting and other strenuous duties)

l. Neurological (including reflexes, sensation) and mental health

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Part C. CONTINUED - TO BE COMPLETED BY EXAMINING PHYSICIAN	
5. Conclusions: Summarize below any medical findings that in your opinion, would limit this person's ability to perform these job duties or make them a hazard to themselves or others. If none, so indicate. ☐ No limiting conditions for this job ☐ Limiting conditions as follows:	
6. Examining Physician's Name	7. E-Mail Address
8. Address (Including Street, City, State and ZIP Code)	9. Telephone Number
10. Signature of Examining Physician	11. Date (Month, Day, Year)
IMPORTANT: After signing, return the entire form intact in the pre-addressed "Confidential-Medical" envelope which the person you examined gave you.	

To be given to the individual examined with a pre-addressed envelope marked "Confidential - Medical".

CERTIFICATE OF MEDICAL EXAMINATION

U.S. OFFICE OF PERSONNEL MANAGEMENT

Form Approved
OMB No. 3206 - 0250

FOR AGENCY USE ONLY

Part D. TO BE COMPLETED BY AGENCY MEDICAL OFFICER (if one is available)

NOTE: Review the attached certificate of medical examination and make your recommendations in item 1 below.

1. Recommendation:

☐ Hire or retain; describe limitations, if any, here.

☐ Take action to separate or do not hire; explain why.

2. Agency Medical Officer's Name	3. E-Mail Address
4. Address (Including Street, City, State and ZIP Code)	5. Telephone Number
6. Signature of Agency Medical Officer	7. Date (Month, Day, Year)

FOR AGENCY USE ONLY

Part E. TO BE COMPLETED BY AGENCY HUMAN RESOURCES OFFICER

1. Action Taken:

☐ Hired or Retained

☐ Non-Selected for Appointment, or Eligibility Objected To

☐ Action Taken to Separate

2. Agency Human Resources Officer's Name	3. E-Mail Address
4. Address (Including Street, City, State and ZIP Code)	5. Telephone Number
6. Signature of Agency Human Resources Officer	7. Date (Month, Day, Year)

JAN 0 4 2016

DBH Policy 716.1A
Exhibit 2

TB Test Result Form

Name: _____

To be completed by the Medical Practitioner:

Name of Medical Practitioner who read the exam (please print):

_____

Date TB test was administered: _____

Date TB test result was read: _____

Result of Test (Please check): _____Positive _____Negative

Does Patient need to have a chest x-ray? _____Yes _____No

Printed Name and Official Title of Medical Practitioner who read the exam:

_____

Signature of Medical Practitioner who read the exam: _____

Date: _____

Medical Practitioner Address:

_____

Phone Number: _____

and/or email: _____

_____

Please Attach Form Here:
Note: Your physician's or Medical Practitioner's office may use its own TB test form to report the results, or you may be submitting results from a TB test administered within the thirty (30) calendar days. If so, please attach that documentation. Please indicate dates when the test was administered and read.

TB Protocol Instructions for DBH Conditional or Existing Employees with Direct Care Positions

I. New/Conditional Employee Screening

A. Upon offer of employment, all new direct care employees shall be screened for M. tuberculosis ("TB") using the Mantoux two-step TST skin test administered by the SEH Medical Clinic or external medical provider prior to the commencement of employment.

B. The employee shall return to the Medical Clinic or outside physician to have the test result read as required, detailed below.

1. **<u>If first step test is negative</u>:**

   (a) The second test of the two-step TST shall be administrated 1-3 weeks after the first TST result was read.

   (b) If the second test is negative, the employee is classified as not infected and is cleared to commence working.

2. **<u>If the first step or second step is positive:</u>**

   (a) The employee shall complete the Annual Tuberculosis Assessment Form (Exhibit 5) to check for symptoms of active TB; and

   (b) Obtain a chest x-ray from his/her healthcare provider within 7 days.

   (c) If employee does not have symptoms of active TB, he/she shall be referred to his/her primary provider for further evaluation.

   (d) The employee shall provide documentation from the primary care provider that the employee does not have active TB or is being managed for TB prior to being allowed to work.

C. Employees who have a documented history of a positive TST are not required to undergo skin testing

1. Instead, they are required to provide a baseline chest radiograph results (completed after the date of a documented TST conversion).
2. In addition, these employees will be screened annually at the SEH Medical Clinic or outside physician office for TB symptoms.

D. New employees who provide proof of outside TB screening within the previous twelve months shall only be required to have a one-step test only.

E. Information related to TB testing, including history of BCG, will be promptly entered into the employees' health data.

II. Annual Employee TB Screening

A. **<u>Employees with a negative skin test history</u>**:

1. Must have an annual TST every year during the month of the employee's

birth date or annually from the date of last skin test; and

2. Shall return to the SEH Medical Clinic or external medical provider for the reading of the test result.

B. <u>Employees with a positive skin test:</u>

1. Shall complete the Annual Tuberculosis Assessment Form immediately. *See* Exhibit 5.
2. If the employee is symptomatic:
   (a) Employee will be sent to their private physician or to the local health department for follow-up;
   (b) A chest X-ray shall be obtained within 7 days of reading of the TST test result.

C. <u>If the employee has symptoms of active TB and is at a DBH facility:</u>

1. Employee shall put on a mask.
2. Assigned staff shall call 911 to transport the employee to a facility that provides airborne precaution, and notify the DC DOH Tuberculosis and Chest Clinic. (Refer to DOH website for updated contact information).
3. The employee may return to work once cleared by a treating physician.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH

HEPATITIS B VACCINATION – CONSENT/DECLINATION FORM

LAST NAME:_____ **FIRST NAME:**_____

DEPARTMENT: _____ **LAST 4 DIGIT SSN:**_____

☐ **CONSENT:** As a healthcare professional having occupational exposure to blood or other potential infectious materials, which includes the risk of acquiring Hepatitis B virus (HBV) infection, I have been informed about and offered the opportunity to receive the Hepatitis B vaccine (at no cost to me). I understand that I must have 3 doses of vaccine to develop immunity. However, as with any medical treatment, there is no guarantee that I will become immune or that I will not experience any adverse side effect from the vaccine. I accept the offer at this time.

Employee Signature:_____ **Date:**_____

☐ **DECLINATION:** I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk to acquiring the Hepatitis B Virus (HBV) infection. I have been given the opportunity to be vaccinated with the Hepatitis B Vaccine at no charge to myself; however, I decline Hepatitis B Vaccination at this time.
However, I decline Hepatitis B vaccination at this time. I understand that 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 material and I want to be vaccinated with the Hepatitis B vaccine, I can receive the vaccination series at no charge to me if obtained at the Saint Elizabeth Hospital Medical Clinic.

I am declining the opportunity to receive the Hepatitis B vaccination series for the following reason: (please check one)

☐ I have previously received the complete Hepatitis B vaccination series.
☐ Antibody testing has revealed I am immune to Hepatitis B.
(Please submit laboratory numerical proof of immunity.)
☐ The vaccine is contraindicated for medical reason(s): (Please describe)_____
_____

Employee Signature:_____ **Date:**_____

- This statement is not a waiver; employees can request and receive the Hepatitis B vaccination at a later date if they remain occupationally at risk for Hepatitis B.

An employer cannot require:

- Employees to waive liability in order to receive the vaccine
- Participation in pre-screening as a prerequisite for receiving the vaccine

JAN 0 4 2010

DBH Policy 716.1A
Exhibit 5

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH

ANNUAL TUBERCULOSIS ASSESMENT

Please complete the following brief questionnaire about your health

Employee Last Name _____ **First Name** _____ **Date of Birth** _____

Do you currently have any of the following:

YES	NO	
		1. Cough lasting greater than two weeks?
		2. Unexplained weight loss?
		3. Loss of appetite?
		4. Unexplained fever?
		5. Night sweats?
		6. Blood tinged sputum production?

If yes to any question, please describe symptoms further. When did this start? Have you sought treatment? If yes, what treatment was received?

Please answer the following questions:

YES	NO	
		Have you ever had PPD Skin test?
		When was your last PPD Skin Test done? _____ Month/Year _____
		Have you ever had a Positive Skin Test?
		Did you have an X-ray done?
		If yes, when was your last X-ray? Month/year _____
		Have you ever received BCG vaccine?
		What is your country of Origin? _____
		Have you lived in any other country within the past 10 years?
		Have you been treated for TB?

Employee Signature: **Date:**

YES	NO	***FOR OFFICE USE ONLY***
		Was the patient referred for further evaluation?
		If yes, to whom?
		Chest X-ray?
		Medication?
		Work restrictions?
		If yes, describe:

MD/NP/RN Signature: **Date**