ZUCKERBERG
SAN FRANCISCO GENERAL
Hospital and Trauma Center

San Francisco Department of Public Health
Volunteer Services
1001 Potrero Ave 7th Floor Room 7F8
San Francisco, CA 94110
628-206-2444

Volunteer Services
Medical Clearance Packet

Health Requirements:

Please have all tests at your Primary Care Provider's Office and have your PCP complete the provider sections on the forms below.

I. TUBERCULOSIS SCREENING:

A. If Previously Unknown PPD Status

- Two-Step PPD Skin Test (4 appointments required for two-step testing).
- Place first PPD and have the employee return in 48 to 72 hours for test to be read. If S1 Omm induration, stop.
- If first PPD is negative, give the employee an appointment to return for placement of the second test in 7-21 days from date of initial PPD placement. Second PPR> test is to be read 48 to 72 hours after second test is placed.
- If positive at either step, obtain CXR and follow standard protocol for PPD positive referral.

B. If Previously Known PPD negative

- If PPD or Quantiferon negative result within the last 14 months, place single PPD and read in 48-72 hours.
- If >14 months since last testing, proceed as I.A Two-Step above.
- If positive, obtain CXR and follow standard protocol for PPD positive referral.
- If induration unknown, follow separate Quantiferon and CXR protocol.

C. If Previously Known PPO positive

- If induration documented, CXR within previous 24 months negative, and current symptom screen negative, TB screening complete for preplacement.
- If induration documented, but current symptom screen positive OR no negative CXR within 24 months, obtain new CXR.
- If induration unknown, follow separate QuantiFERON and CXR protocol.

II. INFECTIOUS DISEASE IMMUNITY:

- Measles: (Mandatory) Proof of two previous doses of MMR OR a positive titer If neither, initiate MMR series.
- Mumps: (Mandatory) Proof of two previous doses of MMR OR a positive titer. If neither, initiate MMR series.
- Rubella: (Mandatory) Proof of one previous dose of MMR OR a positive titer If neither: initiate MMR series (two if also lacking either measles or mumps immunity; one MMR if only rubella is deficient).
- Varicella: (Mandatory) Proof of two doses of Varicella vaccine OR a positive, titer. If neither, . initiate appropriate Varicella vaccination series.
- Annual Flu Vaccination: (Declination Permitted) Vaccination OR signed declination (During influenza season only - generally September through March, ZSFG imposes a mandatory masking policy for all unvaccinated, declining employees.)
- Tetanus, Diphtheria, Pertussis (Tdap): (Declination Permitted) Proof of vaccination within the last 10 years. If not, complete booster OR obtain signed declination.
- Hepatitis B: (Declination Permitted) Documentation of appropriate vaccination's series AND positive liter. If neither, vaccination booster or series and follow-up titers OR signed HBV.

NOTES: Vaccination series will depend on prior vaccination history and presumes po contraindications. Prior zoster ("Shingles") vaccination does not indicate varicella immunity. Prospective employees can be cleared after any indicated vaccination series initiated and booster has been administered and TB screening complete.

ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL

VOLUNTEER DEMOGRAPHIC INFORMATION

All the following information is **required** to create an electronic medical record for the volunteer.

FIRST NAME	
LAST NAME	
DATE OF BIRTH	
GENDER	
EMAIL ADDRESS	hugo.calderon@ucsf.edu
HOME ADDRESS	
SOCIAL SECURITY NUMBER	
PHONE NUMBER	

ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL

TUBERCULOSIS SCREENING FORM

VOLUNTEER INFORMATION

FIRST NAME: _____ LAST NAME: _____ DATE OF BIRTH: _____

SYMPTOM REVIEW: TO BE COMPLETED BY THE VOLUNTEER CANDIDATE					
Have you ever had any of the following symptoms for more than three weeks at a time? (Please check **ALL** appropriate boxes)					
Excessive sweating at night	☐ Yes	☐ No	Coughing up blood	☐ Yes	☐ No
Excessive weight loss	☐ Yes	☐ No	Hoarseness	☐ Yes	☐ No
Persistent coughing	☐ Yes	☐ No	Persistent fever	☐ Yes	☐ No
Excessive fatigue	☐ Yes	☐ No			
If you answered "yes" to any of the above, you must meet with your provider to determine whether a chest x-ray is indicated. If a chest x-ray is indicated, please attach documentation.					
BCG History					
Have you ever received BCG vaccine?	☐ Yes	☐ No	☐ Don't know		
Year of most recent BCG vaccine:					
Country:					

TB TESTING HISTORY: TO BE COMPLETED BY THE CANDIDATE'S PRIMARY CARE PROVIDER	
In lieu of 2 PPDs, 1 negative Interferon Gamma Release Assay (e.g., QuantiFERON-TB Gold (QFT)) test result within 12 months of start date may be submitted.	
Recent TB Skin Test (within 3 months of start)	**Prior TB Skin Test (within one year of start)**
Date applied: _____ Date read: _____ mm reading: ____ mm	Date applied: _____ Date read: _____ mm reading: ____ mm
Interferon Gamma Release Assay (e.g., QFT)	
Date: _____ Result: _____	
PPD POSITIVE HISTORY (induration ≥ 10 mm)	
Year of TB skin test conversion: mm reading: ____ mm Chest X-ray date: _____ X-ray results: ☐ Normal ☐ Abnormal	INH therapy taken? ☐ Yes ☐ No Length of treatment: ____ months Other therapy taken? ☐ Yes ☐ No Length of treatment: ____ months

PROVIDER ATTESTATION: I attest that the above information is complete and accurate	
Name:	Signature:
Title:	License #:
Phone:	Fax:
Address:	

ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL
PROOF OF IMMUNITY FORM

VOLUNTEER INFORMATION

FIRST NAME: _____ LAST NAME: _____ DATE OF BIRTH: _____

PROOF OF IMMUNITY: TO BE COMPLETED BY THE CANDIDATE'S PRIMARY CARE PROVIDER			
MEASLES (Rubeola)		**MUMPS**	
1) 2 doses of vaccine ***OR***	*2) Positive measles titer*	*1) 2 doses of vaccine* ***OR***	*2) Positive mumps titer*
Date: _____ Dose 1: ☐Measles or ☐MMR Date: _____ Dose 2: ☐Measles or ☐MMR	Date: _____	Date: _____ Dose 1: ☐Mumps or ☐MMR Date: _____ Dose 2: ☐Mumps or ☐MMR	Date: _____
RUBELLA (German measles)		**VARICELLA (chicken pox)**	
1) 1 dose of vaccine ***OR***	*2) Positive rubella titer*	*1) 2 doses live varicella vaccine* ***OR***	*2) Positive varicella titer*
Date: _____ Dose 1: ☐Rubella or ☐MMR	Date: _____	Date: _____ Dose 1 Date: _____ Dose 2	Date: _____
HEPATITIS B VIRUS (Please note that only 1 of the options listed down below need to be completed to meet this requirement)			
1) Complete vaccine series ***OR*** ***A N D*** *Declination*	*2) anti-HBs Titer* ***OR***	*3) Declination*	
☐ Two-dose series (CpG-adjuvanted) ☐ Three-dose series (conventional) Date: _____ Dose 1 Date: _____ Dose 2 Date: _____ Dose 3 ☐Signed declination attached	Date: _____ Result: ☐ Pos ☐ Neg	☐ Signed declination attached	
Tdap (Tetanus, Diphtheria, Pertussis)			
1) 1 dose of vaccine ***OR***		*2) Declination*	
Date: _____(must be within 10 years of start date)		☐ I attest that the candidate declines Tdap vaccination	

PROVIDER ATTESTATION: I attest that the above information is complete and accurate	
Name:	Signature:
Title:	License #:
Phone:	Fax:
Address:	

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Hospital and Trauma Center

San Francisco Department of Public Health
Occupational Health Service
1001 Potrero Avenue
Building 9, Room 115
San Francisco, CA 94110
Telephone (628) 206-6581 • Fax (628) 206-3669

Hepatitis B Virus Vaccination
Declination Form

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. This could be because I do not have documentation of having received the complete HBV vaccine series in the past, or because I do not have documentation of an antibody titer confirming my immunity to HBV. I have been advised to consider vaccination with hepatitis B vaccine from my personal healthcare provider. However, I decline hepatitis B vaccination and/or an antibody titer 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 materials and I want to be vaccinated with hepatitis 8 vaccine, I will contact my personal healthcare provider to obtain the vaccination series.

Please indicate your selection below:

☐ I DECLINE the Hepatitis B vaccination (or) do not have the documentation as described above.

Signature: _____ Date: _____

Print Full Name: _____ Date of Birth: _____

☐ I DO NOT DECLINE the vaccination and have provided proper documentation. You are not required to sign this form if you select this option.