



Organization Name
**EMPLOYEE IMMUNIZATION
 RECORD**

Employee Name: _____
 Form verified by: _____
 Name: _____ Date: _____
 Name: _____ Date: _____

All staff must meet the following health and safety requirements. Records will be kept by each employee and a copy should be given to the *Enter Tracking Coordinator Name*. Random review by supervisor or director can occur at any time.

SUBMITTED ONCE	SUBMITTED EVERY YEAR Circle the applicable letter in each box.
<input type="checkbox"/> TB Skin Test A. Two-step PPD Step 1 Date _____ Step 2 Date _____ OR B. Quantiferon (QFT) Date _____ OR C. IF new Positive/Exam/X-ray Date _____ OR D. Positive TB/Negative X-ray Date _____	<input type="checkbox"/> TB Skin Test A. Annual TB Skin Test – Follow-up PPD Dates _____, _____, _____ OR B. Annual Quantiferon Dates _____, _____, _____ OR C. IF new Positive/Exam/Chest X-ray Dates: PPD _____ Exam _____ X-ray _____ OR D. Known Positive//Possible Treatment Date _____
<input type="checkbox"/> Hepatitis B A. Vaccination Dates 1. _____ 2. _____ 3. _____ OR B. Immunity confirmed by titer Date _____ OR C. Signed waiver Date _____	<input type="checkbox"/> Influenza A. Proof of annual vaccination Date 1. _____ 2. _____ 3. _____ OR B. Signed waiver Date _____
<input type="checkbox"/> MMR (Measles, Mumps, Rubella) A. Vaccination Dates 1. _____ 2. _____ OR B. Immunity confirmed by titer Date _____ OR C. Born prior to 1957 DOB _____	<input type="checkbox"/> Insurance (optional) A. Liability Policy Date _____
<input type="checkbox"/> Varicella (Chicken Pox) A. Vaccination Dates 1. _____ 2. _____ OR B. Immunity confirmed by titer Date _____ OR C. Disease Date _____	<input type="checkbox"/> License (RNs) A. State(s) _____ Date _____ OR B. Not Applicable
<input type="checkbox"/> Tetanus A. Tdap _____	<input type="checkbox"/> Nursing Program Specific A. Hepatitis A Vaccine (2 doses) Date 1. _____ 2. _____
<input type="checkbox"/> Background Check (upon hire) A. National Criminal Background Check Dates _____, _____, _____ OR B. Washington State Patrol Check Dates _____, _____, _____	ONE-TIME ONLINE MODULES
<input type="checkbox"/> CPR HEALTH CARE PROVIDER (to be renewed as required) Expiration Date _____	<input type="checkbox"/> HIPAA Privacy Training Completed Date _____ <input type="checkbox"/> Bloodborne Pathogens Module Completed Date _____ <input type="checkbox"/> Fire Safety Module Completed Date _____ (Completion of this module is dependent on the assigned clinical agency)



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Employee Name: _____

These requirements are in place for the health and safety of Clark County Public Health employees and their patients.

All staff must meet the following health and safety requirements. Records will be kept by each employee and a copy should be given to the Emergency Management Program Coordinator. Random review by supervisor or director can occur at any time.

SUBMITTED ONCE	SUBMITTED EVERY YEAR
<p>TB Skin Test</p> <ul style="list-style-type: none"> • 2-Step PPD if no test in prior 12 months, otherwise 1 step PPD OR • Quantiferon (QFT) serum test OR • IF New + TB Test results → F/U by healthcare provider (chest X-ray, symptoms check and possible treatment) may need to complete health questionnaire OR • IF History of +TB results → provide proof of chest X-ray and submit negative symptom check from health care provider in past 12 months OR • IF no proof of +TB Test available, then chest X-ray OR • IF history of BCG vaccination → 2-step TB Test or QFT OR • IF History of +TB Test and +chest X-ray and symptoms: Must see health care provider for treatment before commencing work <p>Hepatitis B</p> <ul style="list-style-type: none"> • Proof of immunity by vaccination OR titer • IF Negative titer → must repeat vaccine series. Employee will be allowed in clinical setting during repeat series and considered a non-responder to vaccination after 2 complete vaccine series and negative titer • Signed waiver for employees who decline vaccination 	<p>TB Skin Test</p> <ul style="list-style-type: none"> • New one-step PPD OR • New Quantiferon Serum Test OR • IF New +TB Test results → F/U with healthcare provider, chest X-ray, & symptom check OR • Known +TB skin results and prior negative chest X-ray results: submit annual symptom check from healthcare provider <p>Influenza</p> <ul style="list-style-type: none"> • Proof of annual vaccination(s) OR • Signed waiver for employees who decline vaccination <p>Insurance (optional but recommended)</p> <ul style="list-style-type: none"> • Liability - \$1,000,000/3,000,000 policy <p>License (RNs)</p> <ul style="list-style-type: none"> • Current • Unencumbered • Washington State <p>Nursing Program Specific</p> <ul style="list-style-type: none"> • Vehicle Insurance • Hepatitis A Vaccine
<p>MMR (Measles, Mumps, Rubella)</p> <ul style="list-style-type: none"> • Proof of vaccination (2 doses) OR • Proof of immunity by titer <p>Varicella (Chicken Pox)</p> <ul style="list-style-type: none"> • Proof of vaccination (2 doses) OR • Proof of immunity by titer <p>Tetanus, Diphtheria, Pertussis</p> <ul style="list-style-type: none"> • Tdap <p>Background Check (upon hire)</p> <ul style="list-style-type: none"> • National Criminal Background Check covering WA state <p>CPR</p> <ul style="list-style-type: none"> • Health provider level (adult, infant, child, AED) 	<p style="text-align: center;">ONE-TIME ONLINE MODULES</p> <p>One-time online modules are to be completed upon hire.</p> <p>HIPAA Privacy Training Completed</p> <ul style="list-style-type: none"> • Training Module <p>Bloodborne Pathogens Module Completed</p> <ul style="list-style-type: none"> • Training Module <p>Fire Safety Module Completed</p> <ul style="list-style-type: none"> • Training Module (Completion of this module is dependent on the assigned clinical agency)