Post Offer Immunization and Communicable Disease

Occupational Health Services

Form content not retained in medical record. **Route to Occupational Health Services.**

For the protection of patients, employees, students, volunteers, and visitors, and in compliance with state and federal regulations, Mayo Clinic requires immunization against certain vaccine preventable diseases. Mayo Clinic also has a comprehensive plan to reduce the risk of tuberculosis transmission, which involves a screening process for all applicants.

Applicant Name (First Middle Last)		Choose One ☐ Allied Health ☐ Research Services ☐ Resident/Fellow ☐ Other ☐ New Consultant Staff
Employee ID/Person ID	Birth Date (mm-dd-yyyy)	

Instructions: Enter the month, day, and year for all doses of all vaccines. Note the date and result if you had a serology (blood test) done. **Documentation is required for all immunizations, serology results, and TB testing, and needs to be provided at the time of your appointment.** Complete all pages of this form.

Vaccine	Vaccine Date (mm-dd-yyyy)			Serology	
				Test Date (mm-dd-yyyy)	Test Result
Hepatitis B	1	2	3		
	4	5	6		
Heplisav-B	1	2			
	3	4			
Measles (rubeola, red measles, 7-day measles)	1	2	3		
Mumps	1	2			
Rubella (German measles, 3-day measles)	1				
MMR (measles, mumps, rubella)	1	2		NA	NA
DPT (diphtheria-pertussis-tetanus) TD (tetanus-diphtheria) booster	Primary series completed? ☐ Yes ☐ No Most Recent Date (mm-dd-yyyy) _____			NA	NA
Tdap (adult tetanus-diphtheria-pertussis)	Most Recent Date (mm-dd-yyyy) _____			NA	NA
Varicella (chicken pox)	1	2			
Influenza	1			NA	NA
Meningococcal MenACWY-Menactra	1	2	3	NA	NA
Meningococcal Men B-Bexsero	1	2	3	NA	NA
COVID-19; brand _____	1	2	3	NA	NA
COVID-19 booster; brand _____	1			NA	NA

OHS Staff Use Only

Vaccines Needed									Tests Ordered											Infectious Hazard
HBV				MMR		Varicella		COVID	TST		UDS	CXR	IGRA	HBsAB			Rubeola	Mumps	Rubella	Varicella	☐ Yes ☐ No
			Decl											Ord	Fut	Decl					Start Date (mm-dd-yyyy)

Signature

Nurse Signature ▶	Date (mm-dd-yyyy)
Nurse Printed Name (First Middle Last)	

ENTERPRISE: Applies to Mayo Clinic locations in Arizona, Florida, Rochester and Mayo Clinic Health System.

Post Offer Immunization and Communicable Disease (continued)

Tuberculosis Status Assessment

Tuberculin Skin Test (TST, Mantoux)	1st TST Date (mm-dd-yyyy)	Reaction Size mm	2nd TST Date (mm-dd-yyyy)	Reaction Size mm
Blood Assay Mycobacterium Test (Quantin-FERON Gold)	Date (mm-dd-yyyy)	Results ☐ Negative ☐ Positive		
Chest X-Ray	Date (mm-dd-yyyy)	Results ☐ Negative ☐ Positive		
Treatment for active or latent TB infection? ☐ Yes ☐ No		Medications and Dates of Treatment (mm-dd-yyyy)		

	Yes	No		Yes	No
1. Do you currently have any of the following symptoms?					
a. Persistent dry cough of 3 weeks or longer	☐	☐	e. Loss of appetite	☐	☐
b. Persistent productive cough of 3 weeks or longer	☐	☐	f. Fever of 100.4 degrees or greater	☐	☐
c. Productive cough with bloody sputum	☐	☐	g. Unintentional weight loss	☐	☐
d. Night sweats	☐	☐	h. Unexplained fatigue	☐	☐
2. Have you been exposed to tuberculosis (TB), or come into contact with someone who has had TB in the past or since your last TB test?				☐	☐
3. In the last 12 months have you been to a country with a high TB rate (any country other than the U.S., Canada, Australia, New Zealand, and those in Northern Europe or Western Europe) for ≥ 1 month?				☐	☐
4. Are you currently immunosuppressed or planning to become immunosuppressed (for example, human immunodeficiency virus [HIV] infection, organ transplant recipient, treatment with a TNF-alpha antagonist such as infliximab or etanercept, chronic steroids, [equivalent of prednisone ≥ 15 mg/day for ≥ 1 month] or other immunosuppressive medication)?				☐	☐
5. Have you ever had a prior positive TB test?				☐	☐
6. Have you experienced an ulceration or open weeping sore at the injection site of a prior TB skin test?				☐	☐
7. Have you received a live virus vaccine (for example, MMR, varicella, flu mist) in the last 4 weeks?				☐	☐
8. Have you ever cared for or lived with anyone diagnosed with active TB?				☐	☐
9. Have you worked or volunteered in a setting where TB may be more common (eg, homeless shelter, nursing home, group home, prison)?				☐	☐
Comments					

Active Communicable Disease Assessment

	Yes	No
1. In the last month, have you had a draining sore or wound?	☐	☐
2. Have you ever been told by a health care provider that you have a draining sore or wound?	☐	☐
3. In the last month, have you had a skin rash that can spread to others?	☐	☐
4. Have you ever been told by a health care provider that you have a skin rash that can spread to others?	☐	☐
5. In the last month, have you had any exposure to a contagious disease?	☐	☐
6. In the last month, have you returned from travel in another country?	☐	☐

7. In the last month, have you experienced any of the following symptoms that cannot otherwise be explained for another medical reason?

	Yes	No		Yes	No
a. Sore throat	☐	☐	g. Skin lesion, cyst, boil	☐	☐
b. Rash/Vesicles on skin	☐	☐	h. Nausea, vomiting	☐	☐
c. Cold sore	☐	☐	i. Diarrhea	☐	☐
d. Fever and rash	☐	☐	j. Cough lasting more than 3 weeks	☐	☐
e. Fever and respiratory symptoms; cough, runny nose	☐	☐	k. Swollen lymph nodes	☐	☐
f. Drainage from eyes or ears	☐	☐	l. Non-healing wound	☐	☐

Post Offer Immunization and Communicable Disease (continued)

Active Communicable Disease Assessment (continued)

8. Have you ever been told by a health care provider that you have any of the following conditions?

	Yes	No		Yes	No
a. Hepatitis A	☐	☐	e. Other communicable/contagious disease(s)	☐	☐
b. Hepatitis B	☐	☐	f. TB	☐	☐
c. Hepatitis C	☐	☐	g. Have you had an exposure to TB in the past year?	☐	☐
d. HIV	☐	☐			

Comments

Signature

I certify that the above information is true, and I consent to the disclosure of vaccination information collected for employment purposes to Mayo Clinic and affiliate health care providers including state immunization registries. I understand that this record will become part of my Occupational Health Service file.

Applicant Signature ▶	Date (mm-dd-yyyy)

Nurse Assessment (To be completed by nurse only.)

Far Vision Without correction 20/_____ With correction (CL/Glasses) 20/_____	Near Vision Without correction 20/_____ With correction (CL/Glasses) 20/_____	
Color Vision ☐ Pass ☐ Fail ☐ NA	Whisper Test ☐ Pass ☐ Fail ☐ NA	Provider Consulted ☐ Yes ☐ No
☐ Is able to perform essential functions of the job without restrictions/limitations ☐ Is able to perform essential functions of the job with restrictions/limitations	☐ Pre-Work Screening (PWS) ☐ Provider Appointment Time (hh:mm) ☐ am ☐ pm	Date (mm-dd-yyyy) Location
Comments/Restrictions		
Nurse Signature ▶		Date (mm-dd-yyyy)

Post Offer Immunization and Communicable Disease (continued)

Post Offer Health Assessment

The purpose of this evaluation is to screen you for communicable diseases and to determine whether you have any physical, mental, or emotional impairment that could affect your ability to perform the job that you have been offered. Whenever such impairment is identified, we will attempt to specify restrictions which may allow you to perform the job safely while still successfully performing the essential functions of the job. In the course of the evaluation, we may inadvertently identify conditions that should not affect your job status, but could adversely affect your future health. If we do, we will bring these to your attention. However, this evaluation is not a comprehensive medical examination to identify hidden disease or to offer medical treatment. Once you have begun your job, we encourage you to establish a relationship with a medical provider in accordance with age-appropriate guidelines and your specific needs.

I certify that the following information is true to the best of my knowledge. I understand and agree to authorize Mayo Clinic Occupational Health Service to collect pertinent information (including, but not limited to, information relating to psychiatric/psychological, alcohol, and drug diagnosis and treatment if any such information exists, but excluding any genetic information or family history) from Mayo Clinic or other health care providers regarding me for purposes related to my fitness for employment. I agree to any reasonable subsequent testing or evaluation deemed necessary to determine my fitness to perform this job, and I authorize the examining provider to forward pertinent information (excluding genetic information or family history) to those who would perform such testing or evaluation. I further understand that misrepresenting facts called for in this form may result in withdrawal of the offer of employment at Mayo Clinic. I understand that this record will become part of my Occupational Health file.

I acknowledge that my health and immunization information maintained by Employee Health for employment purposes may be shared with Mayo Clinic and health care providers for the duration of my employment. I understand that I have the right to revoke this authorization at any time by presenting a written request to Mayo Clinic Occupational Health Services.

Applicant Signature ▶	Date (mm-dd-yyyy)

Employment Information

Job Title Offered

Can you perform the essential functions of this job?
☐ Yes ☐ No ☐ Uncertain; explain _____

Do you have any current disability requiring restricted activity?
☐ Yes ☐ No If Yes, list restrictions _____
If Yes, are these restrictions:
☐ Permanent ☐ Temporary until, date (mm-dd-yyyy) _____

Will you require an accommodation for a disability?
☐ Yes ☐ No ☐ Uncertain If Yes or Uncertain, explain _____

Functional Self-Assessment

	Yes	No	Comments
Do you have any physical attributes or medical limitations which you feel may impair your ability to conduct the essential functions of this job with or without accommodation?	☐	☐	

Signature

I certify that the above information is true.

Applicant Signature ▶	Date (mm-dd-yyyy)