FOOTHILL-DE ANZA COMMUNITY COLLEGE DISTRICT

Office of Human Resources & Equal Opportunity

**TUBERCULIN RISK ASSESSMENT/TB TEST INFORMATION**

You have four (4) options to complete your TB test requirements. They are:

1. If you have had a TB test done within the last 4 years, simply provide your physician's signed note.
2. If you have worked at another community college or school district, ask them to forward your result directly to us, provided the TB clearance isn't over 4 years old.
3. Go to Kaiser Cupertino Occupational Health Center. There is no fee for this service. Please see page 2 for more information.
4. Or, you may be tested by your private physician – please be advised that we will not reimburse the cost. Please see page 4 for more information.

# TEST WITH KAISER CUPERTINO OCCUPATIONAL HEALTH CENTER

To satisfy job-related requirements in the California Education Code and the California Health and Safety Code, all new employees and those with an expired TB certificate are required to have a Tuberculosis Risk Assessment and, if necessary, a Skin Test (TST) and any follow-up completed.

Those employees who test positive with a TST must have a chest x-ray to rule out active Tuberculosis. Kaiser Cupertino Occupational Health Center will refer the employee to the appropriate medical facility for treatment and follow-up, if needed.

Those employees who have previously tested positive are required to provide evidence of the positive TST followed by a negative chest x-ray. Such evidence shall be taken in person to Kaiser Cupertino Occupational Health Center for assessment.

**Instructions:**

**What to bring:** please complete and bring the Referral Form (page 3) with you. At your visit, please advise the staff that you are from the Foothill-De Azna Community College District and need to complete your TB requirement.

**Where to go:** Kaiser Occupational Health Center in Cupertino offers the Assessment and TST free of charge to our employees. **AN APPOINTMENT IS REQUIRED**. For dates and times of testing please contact their office at 408-236-6160. Their address is: 10050 N. Wolfe Rd, Suite SW1-190, Cupertino, CA 95014.

**Please note:** you do not need to have an active Kaiser membership to receive the free TB service from Kaiser Occupational Health Center in Cupertino. If you were never a Kaiser member they will need to set up a profile (medical record number) in order to make an appointment for you. Please have your name, social security number, phone number and address ready before you call them.

**What to turn in to HR:** Kaiser will fax the result directly to the HR office. We highly recommend that you obtain a copy from them for your record.

KAISER PERMANENTE®

# Occupational Health and Safety Services

## Referral Form

*Please complete and bring this form to the clinic location where services are to be provided. To inquire about appointment availability or to change or cancel an appointment, please call the Occupational Health Clinic and ask for the OHSS service representative or a clinic staff member.*

Clinic Location: _____ Date: _____

Phone: _____ Fax: _____

Company Name: **X Foothill De Anza Community College District - 0901187578**

**☐ Foothill-De Anza Community College District/Interns - 0901223061**

Department/Location: FHDA CCD Employee

Company Contact for results/questions: Johnny Shay

Phone: (650) 949-6221 Fax: (650) 949-2831

Employee Name: _____ Kaiser MR# _____

If Kaiser MR# not available, please provide the following:

Address: _____

Home Phone: _____ Work Phone: _____

SS#: *(last 4 digits only)* _____ Date of Birth: _____

Maiden Name (when applicable) _____

Gender: ☐ Male ☐ Female Job Title: _____

## Services Requested

| Foothill-De Anza CCD/ Interns | |
|---|---|
| **Preplacement Services:**<br>**___ (PP1) Preplacement Exam (Rad Tech, Pharm Tech, DA, EMT, Paramedic)**<br>**___ (PP2) Preplacement Exam (Dental Hygiene)**<br>**___ (PP3) Preplacement Exam (DMS, Resp)** | **Non-Preplacement Services:**<br>**___ (VAX) Vaccination Only:**<br>**___ TDAP**<br>**___ (DRUG) Drug Screen**<br>**___ (TB Clearance)** |
| **Foothill-De Anza CCD** | |
| **Preplacement Services**<br>**___ (POSTPP) Preplacement Exam** | **Non-Preplacement Services:**<br>**_X_ (PPD/TB) TB Clearance**<br>Only a TB Risk Assessment is required. A TST and any follow-up are required only if the person did not pass the TB Risk Assessment |
| **Other services may be provided and billed at the physician/clinician's discretion to give clearance on an applicant/employee as identified in your Letter of Agreement (LOA) under the "As Clinically Indicated" section of that visit category. If other screening/testing is needed and is not outlined in the LOA, we will call for authorization.** | |

Preferred date and/or timeframe for appointment: _____

**APPT IS SCHEDULED FOR:** _____

Comments/Additional Requests: _____

**For clinic use only:**

| | | | |
|---|---|---|---|
| **1st attempt for notification to employee:** | **Date:** | **Time:** | **Initials:** |
| **2nd attempt for notification to employee:** | **Date:** | **Time:** | **Initials:** |
| **3rd attempt for notification to employee:** | **Date:** | **Time:** | **Initials:** |

## TEST WITH YOUR PRIVATE PHYSICIAN

To satisfy job-related requirements in the California Education Code and the California Health and Safety Code, all new employees and those with an expired TB certificate are required to have a Tuberculosis Risk Assessment and, if necessary, a Skin Test (TST) and any follow-up completed.

Those employees who test positive with a TST must have a chest x-ray to rule out active Tuberculosis. Your physician should refer you to the appropriate medical facility for treatment and follow-up, if needed.

Those employees who have previously tested positive are required to provide evidence of the positive TST followed by a negative chest x-ray. Such evidence shall be taken in person to your personal physician office for assessment.

**Instructions:**

**What to bring:** please bring page 5-7. Some health care providers will have their own form which is acceptable as long as it includes the date of the certification and signature of your health care provider.

**Where to go:** you may go to a physician of your choice. If you are already a Kaiser member and choose to do the test with your own Kaiser facility this is also considered as your private physician. **Please be advised that we will not reimburse the cost.**

**What to turn in to HR:** please have your health care provider sign and complete pages 5-7. Again, some health care providers will have their own form which is acceptable as long as it includes the date of the certification and signature of your health care provider.

You may return the results/certificate by email, fax or US mail.
Email: shayjohnny@fhda.edu
Fax: 650-949-2831
US mail: 12345 El Monte Rd. Los Altos Hills, CA 94022. Attn: Johnny Shay (HR)

To be completed by employee:

_____ _____ _____

(Print) Last Name First Name Phone # CWID#

To be completed by Health Care Provider:

CERTIFICATION OF TUBERCULOSIS EXAMINATION AND REPORT:

☐ Tuberculosis Risk Assessment Certificate of Completion attached. No additional examination necessary.

☐ TST:

☐ Negative_____(millimeter) ☐Positive_____(millimeter) Date Give:_____

Date Read:_____

☐ QUANTIFERON TB GOLD

☐Negative ☐ Positive ☐Indeterminate Date:_____

Clinical Notations:

☐ SURVELLANCE/SYMPTOMS REVIEW FORM:

☐ Negative ☐ Positive Date:_____

☐ CHEST X-RAY

☐ Negative ☐ Positive Date:_____

☐ OTHER:_____ Date:_____

Follow-up: ☐ Yes ☐ No

_____ Date:_____

Signature of Health Care Provider

# School Staff & Volunteers: Tuberculosis Risk Assessment

Job-related requirement for child care, pre-K, K-12, and community colleges

The purpose of this tool is to identify **adults** with infectious tuberculosis (TB) to prevent them from spreading TB. Use of this risk assessment is required in the California Education Code, Sections 49406 and 87408.6 and the California Health and Safety Code, Sections 1597.055 and 121525, 121545, and 121555.

The law requires that a health care provider administer this risk assessment. A health care provider, as defined for this purpose, is any organization, facility, institution or person licensed, certified or otherwise authorized or permitted by state law to deliver or furnish health services. Any person administering this risk assessment is to have training in the purpose and significance of the risk assessment and Certificate of Completion.

Name of Employee/Volunteer Assessed for TB Risk Factors: _____

Assessment Date: _____ Date of Birth: _____

## History of Tuberculosis Infection or Disease (Check appropriate box below)

☐ Yes

If there is a documented history of positive TB test (infection) or TB disease, then a symptom review and chest x-ray (if none performed in previous 6 months) should be performed at initial hire by a physician, physician assistant, or nurse practitioner. Once a person has a documented positive test for TB infection that has been followed by an x-ray that was determined to be free of infectious TB, the TB risk assessment (and repeat x-rays) is no longer required. If an employee or volunteer becomes symptomatic for TB, then he/she should seek care from his/her health care provider.

☐ No (Assess for Risk Factors for Tuberculosis using box below)

## Risk Factors for Tuberculosis (Check appropriate boxes below)

If any of the 5 boxes below are checked, perform a Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA). Re-testing with TST or IGRA should only be done in persons who previously tested negative, and have new risk factors since the last assessment. A positive TST or IGRA should be followed by a chest x-ray, and if normal, treatment for TB infection considered. (Centers for Disease Control and Prevention [CDC]). *Latent Tuberculosis Infection: A Guide for Primary Health Care Providers*. 2013)

☐ One or more signs and symptoms of TB: prolonged cough, coughing up blood, fever, night sweats, weight loss, excessive fatigue.

Evaluate for active TB disease with a TST or IGRA, chest x-ray, symptom screen, and if indicated, sputum acid-fast bacilli (AFB) smears, cultures and nucleic acid amplification testing. A negative TST or IGRA does not rule out active TB disease.

☐ Close contact to someone with infectious TB disease at any time

☐ Foreign-born person from a country with an elevated TB rate

Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe. IGRA is preferred over TST for foreign-born persons

☐ Consecutive travel **or residence of ≥ 1 month** in a country with an elevated TB rate

Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe.

☐ Volunteered, worked or lived in a correctional or homeless facility

# Certificate of Completion
# Tuberculosis Risk Assessment and/or Examination

*To satisfy **job-related requirements** in the California Education Code, Sections 49406 and 87408.6 and the California Health and Safety Code, Sections 1597.055, 121525, 121545 and 121555.*

**First and Last Name** of the person assessed and/or examined:

_____

**Date** of assessment and/or examination: _____mo./_____day/_____yr.

**Date of Birth**: _____mo./_____day/_____yr.

**The above named patient has submitted to a tuberculosis risk assessment. The patient does not have risk factors, or if tuberculosis risk factors were identified, the patient has been examined and determined to be free of infectious tuberculosis.**

X_____
Signature of Health Care Provider completing the risk assessment and/or examination

**Please print, place label or stamp with Health Care Provider Name and Address (include Number, Street, City, State, and Zip Code)**:

**Telephone and FAX**: