

## Research Interns/Observers

### Health Screening Instructions

To obtain clearance from the Occupational Health Clinic for all VUMC immunization and health screening requirements, the attached Health Screening Form must be completed by your healthcare provider and submitted to the following website:

<https://redcap.vanderbilt.edu/surveys/?s=H4E7PX8EK9>

**Please note:**

- All requirements listed on the Health Screening Form must be met by the Research Intern/Observer. No exceptions will be granted.
- Either a titer documenting immunity to varicella or two doses of the varicella vaccine will be accepted. A history of chicken pox is not sufficient and will not be accepted. If you need to get the two varicella vaccinations, there is a mandatory minimum 30-day waiting period between the first and second vaccinations.
- Two TB Skin Tests are required. The first must be completed within a year of the start date for the research experience. The second must be completed within 3 months of the start date. If you need both TB Skin Tests, there is a mandatory minimum 7-day waiting period between the first and second TB Skin Tests.
  - If a TB Skin Test is positive, a negative chest x-ray within 6 months of the start date is required. The date of the negative chest x-ray must be provided to the Occupational Health office by your healthcare provider's office.
  - An IGRA is an alternative option to the two TB Skin Tests. The negative results for the IGRA is required within 3 months of the start date.
- The Vanderbilt Occupational Health Clinic does not offer vaccinations or testing for the Research Interns/Observers. Vaccinations are usually covered through your healthcare insurance and will need to be done in by a healthcare facility of your choice.
- Alternative documentation can be uploaded in lieu of the Health Screening Form as long as it is official documentation from a healthcare provider's office and all requirements are included in the upload. Do not submit partial requirements. *Please note that documents must be signed by the Provider to be accepted.*

**APPENDIX B - HEALTH SCREENING FORM FOR VISITING RESEARCH INTERNS/OBSERVERS**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_\_

Start Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ End Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Sponsor\*: \_\_\_\_\_ Sponsor's email: \_\_\_\_\_

*\*The sponsor is the contact person in the host department who is accountable to ensure the visitor's compliance.*

Visiting Research Intern (HR record)  Observer

**THIS SECTION TO BE COMPLETED BY HEALTHCARE PROVIDER (NOT WORKER/VISITOR/VISITING STUDENT)**

<p><b>INITIAL ONE OPTION IN EACH SECTION &amp; PROVIDE DATES WHERE INDICATED ("See attached" not accepted)</b>  <b>*Approved exemptions from home institutions will be honored with submission of proper documentation.</b></p>
<p><b>MEASLES, MUMPS AND RUBELLA</b></p> <p>___ Two (2) doses of MMR vaccine after first birthday (vaccine dates: _____)</p> <p>___ Serologic proof of immunity to measles, mumps and rubella (positive IgG antibody)                  (Lab dates: Measles _____ Mumps _____ Rubella _____)</p> <p>___ Pt born prior to 1957 and has positive immunity to rubella (lab date: _____)</p>
<p><b>VARICELLA</b></p> <p>___ Documented serologic immunity to varicella (positive IgG antibody date: _____)</p> <p>___ Two (2) doses of varicella vaccine (vaccine dates: _____)</p>
<p><b>HEPATITIS B</b></p> <p>___ Three (3) doses of hepatitis B vaccines* _____</p> <p>___ Serologic Proof of Immunity (positive Hep B surface Antibody) _____ (*lab 4-8 weeks after vaccination is recommended)</p> <p>___ Wishes to decline vaccine.</p>
<p><b>TUBERCULOSIS</b></p> <p>If TB skin test or IGRA <b>positive</b>:</p> <p>___ Chest X-ray has no evidence of active TB <b>AND</b> Treatment for latent TB infection was offered                  X-ray date (must be more recent than 6 months before Start Date): _____</p> <p>If TB skin test or IGRA <b>negative</b>: (*note: if stay will be &lt; 2 weeks, only 1 TST within 3 months of start date is required).</p> <p>___ Two step TB testing completed                  Date of 1st TBST (must be within 1 year of start date): _____                  Date of 2nd TBST (must be more recent than 3 months before start date): _____</p> <p>___ IGRA completed more recently than 3 months before start date. IGRA date: _____</p>
<p><b>INFLUENZA</b> (only applicable if individual will be on VUMC campus for any day between Oct 1 and Mar 31)</p> <p>___ Date of annual influenza vaccine (must be between Jul 1 &amp; Mar 31 of current flu season): _____</p>
<p><b>PERTUSSIS</b> (required in pediatric, emergency, and women's health departments or "assignment pending/uncertain" status)</p> <p>___ One dose of Tdap vaccine (NOTE: DTP/DTaP and Td/TD vaccines do <u>not</u> meet this requirement.) Date: _____</p>
<p><b>COVID-19 (Full <u>primary</u> series of an FDA/WHO-approved/emergency authorized COVID-19 vaccine. Booster not required)</b></p> <p>___ Brand: _____ Vaccine dates: _____</p>

**I attest that I have reviewed official documentation for all vaccines, X-rays, and lab tests marked above and that the information is complete and accurate to the best of my knowledge:** (note: VUMC may, at its discretion, request additional/clarifying information if needed)

Healthcare Provider Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Healthcare Provider Signature \_\_\_\_\_

Office Address: \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

**THIS SECTION TO BE COMPLETED BY CONTRACTED WORKER/VISITOR/VISITING STUDENT:**

**I have received and reviewed the educational materials related to blood borne pathogens as required by OSHA.**

Contract Worker/Visitor/Visiting Student \_\_\_\_\_

Date \_\_\_\_\_