Northside Hospital
Atlanta, GA

Students; Educational Affiliation Policy A-036

PURPOSE:

To define appropriate procedures for establishing educational affiliations with clinical and non-clinical training programs at any Northside Hospital facility, including its affiliated medical practices ("Northside") and to define the appropriate scope of activities for students in clinical training programs.

POLICY:

No student will be permitted to participate in an educational affiliation program at Northside without a current, written agreement between the educational institution and Northside Hospital.

All students and faculty members must be appropriately credentialed and meet specific orientation and/or competency requirements prior to participating in clinical or non-clinical training.

A Northside Hospital Medical Staff member must serve as sponsoring physician for medical students, interns and mid-level practitioner students (PA, NP, and CNM). A Medical Staff member may recommend educational affiliations for other clinical and non-clinical disciplines, but will not serve as sponsoring physician.

All student placements that do not involve sponsoring physicians are arranged through designated department personnel. Students and Educational Facilities should not directly arrange clinical training assignments with individual departments. Medical students, interns, and mid-level practitioner students or their Educational Facilities are responsible for directly identifying and contacting sponsoring physicians.

DEFINITIONS:

"Educational Affiliations" include any arrangement for participation of students in clinical or non-clinical training programs using facilities of Northside. Educational Affiliations may also be referred to as clinical affiliations, applied learning experiences, statements of relationships, or student affiliation agreements.

An "affiliated medical practice" is a medical practice that is accredited by the Joint Commission as a department or component of Northside Hospital.

PROCEDURE:

A. Contracting Process

1. All requests for Educational Affiliation Agreements must be reviewed and approved by the Supplemental Staffing Office.

a. Upon receipt of a request for a clinical affiliation agreement with a new school or new program at an existing school, a written request for detailed information regarding the educational program(s), accreditations or certifications and liability insurance will be sent to the school. (Student Affiliation RFI letter)
b. Responses to the request for information letter will be reviewed by the Supplemental Staffing Office, the Director of the Department where students would be placed, and Legal Services, if necessary, to determine if the program meets the standards set forth in this policy.

c. If a school or educational program does not meet the standards set forth in this policy, the school will be informed that it is currently ineligible for an Educational Affiliation Agreement with Northside. The school may be reevaluated upon submission of additional information.

d. If the response to the request for information letter requests placement of medical students or interns, the request will be sent to the Legal Services Department for review and preparation of an appropriate contract.

2. The educational facility must provide documentation of accreditation or certification of the educational facility and/or individual training program to the Supplemental Staffing Office in order for students/faculty members to be considered for participation in the educational affiliations program at Northside.

   a. A program is considered to be fully accredited if, upon completion of the program, the student will be eligible for licensure or certification in Georgia, and will meet Northside's minimum criteria for employment, Medical Staff membership or Affiliated Professional status.

   b. An educational facility wishing to place medical or dental students with a Northside affiliated medical practice must be accredited by the Liaison Committee on Medical Education, the American Osteopathic Association, or the Commission on Dental Accreditation, or a successor agency to one of the foregoing.

   c. The educational facility is responsible for notifying the Supplemental Staffing Office promptly upon any loss of accreditation or certification of the facility or the individual training program.

   d. Student placement personnel/coordinators must ensure a current accreditation or certification certificate is on file for the duration of the clinical rotation prior to accepting students.

3. All students and faculty members must have minimum insurance coverage of $1 million/$3 million, with an insurer that meets the financial responsibility requirements established from time to time by Northside's Risk Management Department.

4. All Educational Affiliation Agreements must be reviewed and approved by Supplemental Staffing Office and sent to Legal Services for review, as appropriate. Northside’s standard contracts will be used whenever feasible.

5. All Educational Affiliation Agreements must be signed by the Vice President for the hosting department (or his/her designee).

6. All executed agreements will be uploaded into the student credentialing system by Supplemental Staffing Office or Medical Staff Office. A current list of schools with contract expiration date will be maintained on the student credentialing system and will be available on the P drive-educational Resources-School Affiliations. The list will include the names of all sponsoring physicians and their approved students.

B. Requests for Student Assignments (without Physician sponsors)

1. All requests for student placement without physician sponsors must be submitted to the Northside Supplemental Staffing Office using the student placement request form available on
the Northside Hospital website. The request must be submitted electronically to nshstudents@northside.com.

2. The Northside Supplemental Staffing Office or designee will verify that a current agreement is on file for the school making the request.

3. After verifying a valid agreement, the Northside Supplemental Staffing Office or designee will forward the request to the appropriate clinical or non-clinical department contact.

4. The clinical or non-clinical department contact will confirm acceptance of students with both the requesting school contact and the Supplemental Staffing Office. A list of the Northside student credentialing requirements should be provided to the school placement personnel by the Supplemental Staffing Office for non-nursing students and by Patient Care Administration for nursing students.

C. Requests for Student Assignments (with Physician sponsors)

1. All requests for student placement involving physician sponsors must be submitted to the Medical Staff Office.

2. If the student assignment requests placement in a Hospital department with a Northside employed Affiliated Professional serving as a preceptor (e.g., nurse practitioner students in the ICU), the Medical Staff Office will defer to Patient Care Administration in approving and coordinating student placement.

3. The Medical Staff Office will verify that a current agreement is on file for the school making the request.

4. The Medical Staff Office will verify that the identified sponsoring physician has signed a statement acknowledging responsibility for supervision of the student at Northside and agreeing to comply with all Northside policies and procedures regarding activities of students. Sponsoring Physician Statement (APRN/PA) Sponsoring Physician Statement (Med Student/Intern)

D. Documentation Required Prior to Student Participation in Clinical Experience

1. The Educational Facility must provide all required documentation prior to any student or faculty member participating in clinical / non-clinical activities at Northside Hospital:
   Documentation for students and faculty members under educational affiliation agreements without physician sponsors must be submitted to the Supplemental Staffing Office through the online credentialing system. Documentation for students under educational affiliation agreements with physician sponsors must be submitted to the Medical Staff Office.

   a. Student and Faculty Health History Questionnaire and immunization records.

   b. Background Check & Drug Screen.

   c. Signed Acknowledgment and Release for Clinical Training Form confirming completion of on-line orientation.

   d. License (if appropriate).

   e. Current CPR certification (if clinical student / faculty member).

   f. A written statement from the school attesting that the student is in good standing and has completed all prerequisites required by the school prior to beginning clinical training;
g. Skills Checklist that includes a list of treatments and procedures students and faculty members are qualified to perform and/or a copy of the syllabus.

h. A signed consent statement (Acknowledgment and Release for Clinical Training Form) agreeing to comply with Northside Hospital policies and procedures while within the hospital, including, but not limited to maintaining confidentiality of all medical and health information pertaining to particular patients.

i. If the student or faculty member is a current Northside Hospital employee, a copy of the Employee Participation in Clinical Training Program Form must be submitted. In addition, the employee may not obtain clinical training in the department in which they routinely work. An employee working as clinical faculty must be credentialed as faculty and may not supervise students in the same department in which they routinely work.


E. Department Orientation

1. The Manager / Director or designee of each department hosting students is responsible for providing the faculty member with a department orientation. The faculty member will be responsible for providing the department orientation to the students. If there is no faculty member under an educational affiliation agreement, orientation will be provided directly to the student.

2. Department Orientation will include:

a. Program / department specific job duties and responsibilities.

b. Introduction to key personnel.

c. Department safety and security.

3. Upon satisfactory completion of department orientation, the faculty member or student will submit the appropriate documentation to Northside Supplemental Staffing Office or Medical Staff Office, as appropriate.

4. Documentation of completion of department orientation (the elements listed above) must be submitted in order to receive student badges or to begin clinical experience.

F. Attendance At Clinical Experience

1. The Northside Supplemental Staffing Office, Patient Care Administration, and/or Medical Staff Office will verify that each student’s file is complete. Confirmation of completion status will be provided to the faculty member and the accepting manager/designee, and sponsoring physician if applicable. The student’s file must be 100% complete in order to participate in the clinical experience. (An exception is permitted for students who begin a rotation prior to October 1, who may participate pending later flu vaccine.)

2. All students and faculty members must wear identification badges provided by the educational facility identifying the individual’s name, status (if a student), title (if a faculty member) and the name of the educational facility.

a. Northside Hospital provides temporary badges to designate an individual as a “student” or “faculty” which also list the name of Northside department hosting the student / faculty. The clinical/non-clinical assignment of the student must match the assignment detailed on the Northside temporary badge.
b. Faculty ONLY will be issued bar-code badges from Human Resources in order to perform selected clinical functions. The bar-code badge must be returned to Human Resources at the completion of the clinical activity.

c. Badges will be provided when the faculty / student has completed the credentialing process.

d. All students and faculty must present photo identification (i.e. driver’s license) to the assigned unit / department manager/designee for proof of identification prior to issuing badges.

e. Students with sponsoring physicians will receive temporary identification badges through the Medical Staff Office.

3. Students will be subject to the following supervision requirements:

a. Any time that a student is present in a patient care area, the student must be accompanied by a faculty member or preceptor, or if applicable, the sponsoring physician or his/her Affiliated Professional.

b. Any student who is directly participating in patient care, must be under the direct supervision of the faculty member or preceptor, or, if applicable, the sponsoring physician or his/her Affiliated Professional.

c. For purposes of this policy, direct supervision means that the faculty member, preceptor, sponsoring physician or Affiliated Professional is present in the room and prepared to immediately intervene in the procedure if necessary (e.g., gown and gloved). If the student is under the direct supervision of an Affiliated Professional, the Affiliated Professional must be fully credentialed to perform the patient care services in a solo capacity (e.g., a Certified Nurse Midwife may supervise a student nurse midwife performing a delivery that is within the scope of the CNM’s clinical functions).

G. Maintenance of Faculty Member & Student Files

1. Northside Supplemental Staffing Office is responsible for maintaining credentialing documents on non-nursing students and faculty (i.e. Radiology, Pharmacy, Surgical Services, and Lab) in the credentialing system.

2. Patient Care Administration will maintain credentialing documents on all nursing personnel housed in the credentialing system.

3. The Medical Staff Office is responsible for maintaining credentialing documents on students with sponsoring physicians.

4. The Northside Supplemental Staffing Office and Medical Staff Office will monitor and audit credentialing documents periodically to ensure compliance.

H. Scope of Practice

Student activities at Northside facilities, including affiliated medical practices, will be limited to the scopes of practice approved by Patient Care Administration or the hosting department for non-nursing students. The scope of practice will be determined, in part, based on the skills checklist provided by the educational institution, provided, however, that Northside has the right to limit scopes of practice to exclude any item on the skills checklist. Scope of Practice for medical students and interns will be limited to the activities outlined in Appendix A to this policy.
I. Patient Rights

All patients have the right to decline to allow participation or observation by students. The preceptor or patient care staff is responsible for introducing the student to patients and for verifying patient consent to participation or observation. For students with sponsoring physicians, the sponsoring physician or his or her Affiliated Professional is responsible for introducing the student and verifying patient consent.

J. Chain of Command

1. Concerns involving nursing students or faculty should be brought to the attention of unit leadership, who shall notify Northside’s Student Placement Coordinator. The Student Placement Coordinator will investigate the situation and involve other resources as appropriate.

2. Concerns involving medical students, interns or mid-level practitioners should be brought to the attention of the sponsoring physician and Medical Staff Services Department. The Director of Medical Staff Services will investigate the situation and involve other resources as appropriate.
ACKNOWLEDGEMENT AND RELEASE FORM FOR PARTICIPATION IN CLINICAL TRAINING PROGRAM

I, ____________________________, desire to participate in a clinical training program for __Northside Hospital__________________________ as part of completion of my studies at __AU/UGA Medical Partnership__________________________ (the Educational Facility). I am over eighteen years of age and am competent to consent on my behalf.

I understand that I am required to comply with all Hospital policies and the directions of the supervising nurse or other personnel. I further understand that I am required to maintain confidentiality of all information concerning a patient, or member of the Hospital staff. I understand that my failure to comply with these requirements may result in my immediate removal from the program.

I elect to be covered by Northside Hospital’s Worker’s Compensation Program for any accident or injury sustained during the course of my activities at Northside Hospital or its affiliated medical practices. I agree that I will not be considered to be an employee of Northside Hospital or its affiliates for any other purposes and am not entitled to any benefits available to employees. Northside Hospital and its affiliates do not control the time, manner or method of the services I perform.

I verify that I have completed the Northside Hospital website Student Orientation, including required documentation in the Northside Hospital Student Orientation instructions.

_________________________________________  Amber R Ramsey (MP Credentialing Specialist)
Student Date

_________________________________________  Date
Witness
As a Student or Faculty member participating in an educational affiliation at Northside Hospital or its affiliated medical practice ("NSH") it may be necessary to have access to NSH patient, medical, financial, employee, organizational, and other types of information to perform my responsibilities. I recognize that as a Student or Faculty Member, I have a duty, and agree, to protect the confidentiality and security of all such information. I will treat any and all information I am exposed to during the course of my interactions with NSH as highly confidential and will not disclose such information to anyone who does not need that information to perform his/her professional duties. This applies to all sources of information and methods of communication including, but not limited to, computer systems, smart phones, tablets and similar devices, paper documents, faxes, email, telephone, and direct verbal communication.

Furthermore, I acknowledge the following:

1. I will not use or disclose protected health information ("PHI"), as defined by the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA"), in a manner that would violate the privacy and security standards promulgated by HIPAA contained at 45 C.F.R. Part 164. I agree to implement necessary safeguards and prevent the unauthorized use or disclosure of PHI that I am exposed to during the course of performing my professional duties or that I come into contact with during the course of my interactions with NSH.

2. I will not access PHI unless I have a need to know this information to perform my job or duties; I further acknowledge that I will not access PHI associated with my spouse, children, other relatives, friends, staff, or colleagues, except to the extent needed to perform my job responsibilities.

3. I will not disclose PHI to any person or entity, other than as necessary to perform my job or duties and as permitted under HIPAA.

4. Upon cessation of my affiliation with NSH, I agree to continue to maintain the confidentiality of any information I learned while so affiliated and agree to turn over any keys, access cards, or other devices that would provide access to NSH information and computer systems.

5. I understand that only those individuals who have signed a "Confidentiality/Security of Information, Computer Access Code Agreement" will be given access to NSH information systems. I understand that I will not be provided access to NSH’s information systems unless I have signed this Agreement acknowledging my agreement to be bound by its terms. Furthermore, I understand that failure to abide by the terms of this Agreement may result in the restriction or revocation of my access.

6. I will not write down or otherwise document my username where it may potentially be viewed by another individual. I will not write down my password anywhere but rather will commit it to memory.

7. I will not attempt to learn another user’s username or password nor will I use any username or password other than my own.
8. I understand that access to the NSH information systems is a requirement for many positions within the organization and computer system access should be used with the utmost discretion. At no time am I authorized to utilize any NSH system for any reason other than its intended use to perform my professional duties nor may I use it for my own or other's personal or professional gain.

9. Once I have signed onto any NSH information system, I will not allow anyone else to use the information system for any reason, including to access patient, medical, financial, employee, organizational, or any other type of information.

10. I will ensure that my use of NSH computers, email, computer accounts, and networks as well as information accessed, stored, or used on any of these systems is restricted to authorized duties or activities.

11. I will not download, install, or run unlicensed or unauthorized software on any NSH system.

12. When I leave the immediate physical vicinity of a PC, laptop, or other workstation upon which I am signed into any NSH system (whether on any NSH campus or a remote site), I will ensure that I properly log out of the system.

13. If I have remote access to any of NSH's information systems, I will ensure appropriate security measures are implemented and maintained on the remote PC or device. Furthermore, I will ensure no PHI is downloaded or otherwise stored on the remote PC or device unless the device is approved to store PHI and utilizes NSH approved encryption technologies to secure such data. I will take all reasonable and practical measures to minimize the risk of unauthorized access to NSH's information systems. I understand that all terms and conditions of this agreement apply equally whether the systems are being accessed on any of NSH's campuses or from any remote site.

I have read and fully understand the above and agree to be bound by this agreement as well as NSH Administrative Policies & Procedures “Privacy/Confidentiality of Patient Information” and “Information Security Policy and Procedure”.

Student/Faculty Member Printed Name: ________________________________________________

Student/Faculty Member Signature: ___________________________ Date: ____________

Faculty Member Position: N/A

Manager / NSH Designee / Preceptor Signature: ____________________________

Educational Institution: AU/UGA Medical Partnership

Page 1 of 2

Rev: 12/29/2015
Provide documentation for Questions 1-4 & 11-12

- Annual Tuberculosis Skin Test/TST (PPD) is required.
- All dates must be in the form of month/day/year.
- Documentation must include official/authorized healthcare provider signature.
- Please submit one of the following as proof of immunization:
  1. Personal immunization record
  2. School medical records

**Tuberculosis Skin Test/TST (PPD):**

- **Negative TST (PPD) Skin Test:**
  - All new placements (staff that provide services for the first time at a Northside facility) must provide documentation of a 2 step negative TST (PPD) within the past one year (results must cover duration of clinical rotation).
  - Those placements returning to an assignment at Northside within one year of the last previous assignment must provide a negative TST (PPD) within the last 60 days.

OR

- **Negative T-Spot / Quanti-FERON Gold blood assay test**
  - All new placements (staff that provide services for the first time at a Northside facility) must provide documentation of a negative result within the past one year (results must cover duration of clinical rotation).
  - Those placements returning to an assignment at Northside within one year of the last previous assignment must provide a negative result within the past one year (results must cover duration of clinical rotation).

- **Positive TST (PPD) Skin Test Requirements:**
  To be assigned to a unit/department, you must meet ONE of the following:

  1. Annual Negative Quanti-FERON Gold blood test (recommended with prior BCG vaccination)

      OR

  2. Annual Negative T-SPOT blood test

      OR

  3. Provide documentation of the following:
     - Must provide documentation of first positive reading/results
     - Must have negative screening for symptoms of TB
     - Must have chest x-ray or radiology report within the past year
     - Must be evaluated by residential county health department AND provide evidence of taking or have taken prophylactic therapy if working in one of our high risk areas which include Women’s Services, Bone Marrow and Oncology, Child Development Center and ICU. Other units will be considered on an individual basis.
NORTHSIDE HOSPITAL HEALTH HISTORY FORM

Please Check One:
☐ Faculty
☒ Student
☐ Other

School  AU/UGA Medical Partnership   Dates of clinical experience at Northside Hospital

Name (Print)__________________________________________ Sex  Age ________________

Home Address_________________________________ Phone__________________________

School ID Number ____________________________ Birth Date __________________________

In case of emergency, please notify___________________________________________

Address_________________________________ Phone__________________________ Relation

Area of the hospital in which you will be working (list all areas)  NA

Are you a Northside Hospital employee?  ☐ Yes  ☐ No  If “Yes” STOP, go to Page 2 and sign.
If “Yes” Department/Unit Name: ____________________________

Annual Tuberculosis Test/TST (PPD) is required.
For Questions 1-4, please attach supportive documentation

1. Have you had an Influenza Vaccine for the current calendar year October – March?  ☐ Yes  Date_____/______/_____
☐ No, please check one of the reasons listed below:
☐ A severe allergic reaction to eggs or other components of the influenza vaccine,
☐ A history of Guillain-Barre’ Syndrome (a severe paralytic illness, also called GBS) within 6 weeks after a previous influenza vaccination
(Submit medical documentation of the contraindication identified).

2. Have you had a skin test for Tuberculosis within the past one year?  ☐ Yes  ☐ No (obtain Tuberculosis test)
If “Yes”, date_____/______/_____ Results ___________ (Must provide supporting document)

3. Have you ever had a positive skin test for Tuberculosis?  ☐ Yes  ☐ No
☐ If “Yes”, date of first positive skin test reading_____/______/_____ Results ___________ (Must provide supporting document)
☐ Have you been treated for a positive PPD?  ☐ Yes  ☐ No  If “Yes”, dates From ___________ To ___________
Medications given (Must provide supporting document) ___________

4. Have you had a Chest X-ray within the past year?  ☐ Yes  ☐ No Date_____/______/_____
If “Yes”, provide copy of radiology report from your physician describing your x-ray report results.

☐ If you have a positive skin test, please complete the following surveillance screening (annually)

Have you ever had any of the following? Check (x) all that apply.
☐ Positive reaction to a TST (PPD) skin test
☐ Taken medication for + TB skin test
☐ Productive cough lasting more than 3 weeks
☐ Unexplained fever, chills, or night sweats
☐ Coughing up blood
☐ Known exposure to active TB
☐ Unexplained weight loss
☐ None of the above

10/14/13
NORTHSIDE HOSPITAL HEALTH HISTORY FORM (continued)

Name

5. Have you experienced any condition(s) that would or does render you physically incapable of performing the activities of your educational program here at Northside Hospital?

6. Have you ever been treated for any serious illness or injury (including any back, neck or shoulder injury)? If so, list the name of the problem, dates, results, and present status.

7. To the best of your knowledge do you currently have a contagious disease? □ Yes □ No

8. Are you currently under a physician’s care? □ Yes □ No If “Yes”, please give physician’s name: ____________________________

9. List medication(s) you are presently taking.

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<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Drug</th>
<th>Dosage</th>
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10. Do you have a Latex allergy? □ Yes □ No

List any other allergies

For Questions 11-12, please attach supportive documentation (Titers must include results to determine immunity)

11. Must answer ONE of the following criteria?

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<thead>
<tr>
<th>If you were BORN BEFORE 1957:</th>
<th>If you were BORN AFTER 1957:</th>
</tr>
</thead>
</table>
| A. Have you had a positive titer for Rubella 
(German Measles)? □ Yes □ No | A. Do you have proof of 2 MMR vaccines? □ Yes □ No 
If “No”, go to “B” |
| B. Have you had a Rubella vaccine? □ Yes □ No | B. Documentation of one MMR and one Rubeola vaccine or positive Rubeola titer? □ Yes □ No 
If “No”, go to “C” |
| C. Have you had one dose of MMR vaccine? □ Yes □ No | C. Have you had positive titers for Rubella and Rubeola 
(Red Measles)? □ Yes □ No 
If “No” to all the above, you must obtain a Rubella Titer and provide result. |

12. Have you had one of the following?

A. Chicken Pox? □ Yes □ No If “Yes”, When? __________ |
B. Lived with a family member who has had documented chicken pox? □ Yes □ No |
C. Chicken Pox (Varicella) vaccine? □ Yes □ No If “Yes”, When? __________ |
D. Have you had a positive titer for Varicella? □ Yes □ No

PLEASE READ CAREFULLY BEFORE SIGNING:
I certify that all information provided in this questionnaire is true and correct to the best of my knowledge. I understand that any falsification or significant omission of any information requested herein will be considered sufficient cause for withdrawal from the facility without prior warning at any time during my affiliation with Northside Hospital.

I further authorize any hospital, clinic or physician(s) to release to Northside Hospital any information relative to my medical history, physical and mental condition for purposes of verifying the information provided on this form, determining my ability to perform my assignment. I further agree that this authorization will be valid throughout my assignment at Northside Hospital.

Signature ____________________________________ Date _________________

10/14/13
### ANNUAL TB SURVEILLANCE/HEALTH ASSESSMENT

#### FULL LEGAL NAME:
(First M L Last)

<table>
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<tr>
<th>JOB TITLE:</th>
<th>N/A</th>
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#### DEPT. NAME/NUMBER:
AU/UGA MEDICAL PARTNERSHIP STUDENT

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<tr>
<th>DO YOU CURRENTLY OR HAVE YOU HAD ANY OF THE FOLLOWING? (Please check all that apply):</th>
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<tbody>
<tr>
<td>☐ PREVIOUS POSITIVE REACTION TO A TB SKIN TEST (TST)</td>
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<tr>
<td>☐ PRODUCTIVE COUGH &gt; 3 WEEKS</td>
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<tr>
<td>☐ CHEST PAIN</td>
</tr>
<tr>
<td>☐ UNEXPLAINED FEVER, CHILLS OR NIGHT SWEATS</td>
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<tr>
<td>☐ LOSS OF APPETITE</td>
</tr>
<tr>
<td>☐ SHORTNESS OF BREATH</td>
</tr>
<tr>
<td>☐ T-SPOT BLOOD TEST Date (mm/dd/yyyy)</td>
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### ANNUAL HEALTH HISTORY (ALL QUESTIONS REFER TO THE PAST YEAR ONLY)

- **DO YOU HAVE A PRIMARY CARE PHYSICIAN THAT YOU SEE ON A REGULAR BASIS?**
  - [ ] YES 
  - [ ] NO

- **BEEN DIAGNOSED WITH A COMMUNICABLE DISEASE/ILLNESS SUCH AS HEPATITIS/TUBERCULOSIS/HIV?**
  - [ ] YES 
  - [ ] NO

- **ARE YOU WORKING WITH RESTRICTIONS FROM PHYSICIAN?**
  - [ ] YES 
  - [ ] NO

- **DO YOU HAVE A DIAGNOSED LATENT ALLERGY?**
  - [ ] YES 
  - [ ] NO

### ANNUAL HEALTH ASSESSMENT/TB SURVEILLANCE POLICY - EMPLOYEE ACKNOWLEDGMENT

"TO THE BEST OF MY KNOWLEDGE, ALL INFORMATION SUPPLIED BY ME ON THIS QUESTIONNAIRE AND DURING THE HEALTH ASSESSMENT IS CORRECT. I UNDERSTAND THAT ANY INTENTIONAL FALSIFICATION CAN BE CONSIDERED AS CAUSE FOR SUSPENSION OR TERMINATION. BY SIGNING BELOW, I INDICATE UNDERSTANDING THAT FAILURE TO COMPLETE THE TB SKIN TEST (TST) PROCEDURE AND/OR THE TB SURVEILLANCE QUESTIONNAIRE ASSESSMENT WILL RESULT IN NOT RECEIVING MY ANNUAL MERIT INCREASE AND/OR NOT BEING ALLOWED TO CONTINUE WORKING UNTIL I COMPLETE THIS REQUIREMENT ACCORDING TO HOSPITAL POLICY. IF YOU HAVE ANY QUESTIONS, PLEASE ASK THE EMPLOYEE HEALTH NURSE FOR MORE INFORMATION BEFORE SIGNING.

I AGREE TO HAVE THE TST ADMINISTERED. I AGREE TO HAVE THE TST READ IN 48-72 HOURS AS DIRECTED BY THE EMPLOYEE HEALTH NURSE. IF I DO NOT HAVE THE TST READ IN 48-72 HOURS, IT WILL BE NECESSARY TO HAVE THE TST REPEATED.

IF I HAVE A HISTORY OF A PREVIOUS TST, I AM NOT REQUIRED TO HAVE A TST BUT HAVE COMPLETED THE TUBERCULOSIS SURVEILLANCE QUESTIONNAIRE ABOVE. I WILL ALSO RETURN ON AN ANNUAL BASIS TO BE EVALUATED FOR TUBERCULOSIS EVEN THOUGH I DO NOT RECEIVE A TST. IN ADDITION, IF AT ANY TIME DURING THE YEAR, I EXPERIENCE ANY OF THE SYMPTOMS LISTED ABOVE WHICH LAST MORE THAN 3 WEEKS, I WILL REPORT TO EMPLOYEE HEALTH TO BE EVALUATED WITH A CHEST X-RAY.

**EMPLOYEE SIGNATURE:**

**ADMINISTRATION OF TST - PPD (MANTOUX) & TST INTERPRETATION**

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<thead>
<tr>
<th>DATE TST PLACED:</th>
<th>PLEASE SELECT TB PRODUCT:</th>
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<tr>
<td>(mm/dd/yyyy)</td>
<td>☐ TUBERSOL® (AVENTIS) 5 TU PPD 0.1 ml INTRADERMALLY</td>
</tr>
<tr>
<td></td>
<td>☐ APLOISOL® (HPI BRANDS) 5 TU PPD 0.1 ml INTRADERMALLY</td>
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- [ ] DEFERRED until (mm/dd/yyyy)

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<th>LOT NO:</th>
<th>EXP. DATE:</th>
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| FOREARM LOCATION: | ☐ Right | ☐ Left |

| TST PLACED BY: | ☐ NSH EMPLOYEE HEALTH NURSE | ☐ CERTIFIED TB PROFESSIONAL |

**NURSE SIGNATURE**

**DATE TST READING:**

<table>
<thead>
<tr>
<th>INDURATION (mm):</th>
<th>ERYTHEMA</th>
<th>☐ YES</th>
<th>☐ NO</th>
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**TST READ BY:**

| ☐ NSH EMPLOYEE HEALTH NURSE | ☐ CERTIFIED TB PROFESSIONAL |

**NURSE SIGNATURE**

**n/a - Please see results document**

### THE EMPLOYEE HAS COMPLETED ALL REQUIRED ANNUAL TB SURVEILLANCE REQUIREMENTS PER NORTHSIDE HOSPITAL POLICY

**NEXT ANNUAL TB SURVEILLANCE DUE**

(MONTH & YEAR)

<table>
<thead>
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**EMPLOYEE HEALTH NURSE/CERTIFIED TB PROFESSIONAL SIGNATURE**

**Date**