Last Name	First Name	Date of Birth	Job Classification

Date	Institution/Agency	Contact	Phone

COOK COUNTY HEALTH & HOSPITALS SYSTEM
INFECTION CONTROL SCREENING COMPLIANCE FORM

CCHHS Infection Control Policies apply to all personnel: Employees, Trainees, Contractors, Vendors, and Volunteers. You must provide documentation of designated health screenings and immunizations to comply with CCHHS policies and regulatory requirements. Annual updates are required. CCHHS will respond to CCHHS Infection Control and Public Health concerns and, if indicated, additional testing/treatment, or instructions to remain away from work may be required.

Other Academic Medical Center Screening: If you participate in an Annual Infection Control Screening Program at another institution, please forward screening documentation with this form. The information will be reviewed and we will notify you if further information is needed.

Test Result Documentation: Copies of all pertinent laboratory test results and radiological reports must be attached. Please check all sections for which you have provided documentation and complete the TB questionnaire.

☐ Influenza Vaccination: Vaccine program compliance is required for all personnel and documentation must be reviewed prior to work.

☐ Tuberculosis: Provide results of Interferon Gamma Release Assays (IGRA, e.g. Quantiferon) or Tuberculin Skin Tests. Test result should be from within the past 3 months, unless you are submitting documentation from Other Academic Medical Center Annual Screening.
Tuberculin Skin Tests (TST) can also be provided. A 2 step test is required.
If you have a history of a positive IGRA or TST, provide the documentation and a chest X result from within the past 6 months.
Annual Updates: An IGRA or one TST result is required. Chest Xrays do not need to be repeated for individuals with a history of positive TST unless there is a change in health status. You can submit previous information for review and we will advise of any other needs.

Please indicate whether you have had the problems listed below.

1.	Fever > 101.5 that lasted 7 days or longer?	☐ Yes ☐ No
2.	Cough that lasted more than 2 weeks?	☐ Yes ☐ No
3.	Increased or excessive sweating at night?	☐ Yes ☐ No
4.	Bloody sputum?	☐ Yes ☐ No
5.	Weight loss without dieting?	☐ Yes ☐ No

☐ Measles: Provide proof of immunity by antibody titer.
☐ Mumps: Provide proof of immunity by antibody titer.
☐ Rubella: Provide proof of immunity by antibody titer.
☐ Varicella: Provide proof of immunity by antibody titer.
☐ Hepatitis B: Hepatitis B Antibody and Hepatitis B Antigen test results –may be requested.

Tetanus Diptheria Pertussis Vaccine (Tdap) – 1 Tdap Booster Vaccine or Tetanus Booster within 10 years of previous Tetanus Vaccine is recommended.