

**REASON:**

Pre-Placement       1<sup>st</sup> Step       2<sup>nd</sup> Step  
 Annual  
 Annual Past Positive Screening  
 Exposure Baseline (with ACORD)  
 Post Exposure (10 week with ACORD)

**EMPLOYER:**

MUHA (Hospital)       Crothall  
 MUSC (University)       Sodexho  
 UMA/CFC       Other \_\_\_\_\_  
 Volunteer

Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Birth date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Emp ID \_\_\_\_\_

Dept \_\_\_\_\_ Position \_\_\_\_\_ Work # \_\_\_\_\_ Home # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Have you ever had a positive TST?  YES       NO      If yes, when? \_\_\_\_\_

Have you received a live vaccine within the past 30 days?  YES       NO  
If yes, what vaccine?  Measles, Mumps, Rubella (MMR)       Varicella (Chickenpox)       Other \_\_\_\_\_

Are you immune compromised or are you taking any immunosuppressant medications?  YES       NO

Do you currently have any of the following chronic conditions?

YES / NO

YES / NO

YES / NO

<input type="checkbox"/> <input type="checkbox"/> Chronic cough (>3 weeks)	<input type="checkbox"/> <input type="checkbox"/> Cough up sputum or blood	<input type="checkbox"/> <input type="checkbox"/> Poor appetite
<input type="checkbox"/> <input type="checkbox"/> Chronic fatigue (>3 weeks)	<input type="checkbox"/> <input type="checkbox"/> Shortness of breath	<input type="checkbox"/> <input type="checkbox"/> Recurrent infections
<input type="checkbox"/> <input type="checkbox"/> Chronic chest discomfort	<input type="checkbox"/> <input type="checkbox"/> Unexpected weight loss	
<input type="checkbox"/> <input type="checkbox"/> Persistent low grade fever	<input type="checkbox"/> <input type="checkbox"/> Night Sweats (excluding menopause)	