HUMAN RESOURCES
TUBERCULOSIS (TB) CLEARANCE

Instructions for Employees & Volunteers *Without* Paid Medical Benefits

As part of your employment with Southwestern Community College, TB clearance is required (Ed.Code 87408.6). If you have medical benefits with our College District, this is a covered medical expense. If you do not have medical benefits, the cost for your TB assessment and if necessary, testing and examination will be covered by the College District.
Southwestern College has contracted Sharp Rees-Stealy Occupational Medicine Centers to provide TB Assessment and Clearance at no cost to you. All six (6) Sharp locations will invoice Southwestern Community College District directly. Please follow the instructions below to proceed with TB Clearance.

Important Note

Any cost related to active Tuberculosis treatment or other related costs will not be covered by SWCCD.

STEP 1

Complete and sign all the required forms listed below. All forms are printable and are in PDF fillable format that can be completed and signed electronically. (For additional instructions on these forms, please refer to the Quick Guide on page 2.)

Required Forms:

- "California School Employee Tuberculosis(TB) Risk Assessment Questionnaire", page 4.
- "Certificate of Completion TB Risk Assessment and/or Examination", page 5 (To be completed by Sharp.)
- "Authorization for Use or Disclosure of Protected Health Information", pages 6-7.
- "Health Questionnaire Patient Registration", page 8

STEP 2

You have three (3) available methods to complete the TB assessment/clearance process.

1.) Via Email

Email all forms listed above in Step 1, to your preferred Sharp Occupational Medicine Center, listed on page 3. Sharp will contact you within 2-4 workdays with one of the following scenarios:

- If No risk factors are identified: Sharp will return the completed and signed "Tuberculosis Risk Assessment and/or Examination Certificate of Completion" via a secured email. You will be emailed instructions on how to access the secure email and its contents.
- If risk factors are identified: A Sharp representative will contact you via phone call or email to schedule an appointment for a TB test and TB exam, if necessary. Once you are determined to be free of infectious tuberculosis, Sharp will return the completed and signed "Tuberculosis Risk Assessment and/or Examination Certificate of Completion."

2.) Via Mail

Mail all forms in Step 1 to your preferred Sharp Occupational Medicine Center. Sharp will contact you within 2-7 workdays with one of the two following scenarios. (Please DO NOT include confidential information.)

- If No risk factors are identified: Sharp will return the completed and signed "Tuberculosis Risk Assessment and/or Examination Certificate of Completion" via mail.
- If risk factors are identified: A Sharp representative will contact you via phone call to schedule an appointment for a TB test and TB exam, if necessary. Once you are determined to be free of infectious tuberculosis, Sharp will return the completed and signed "Tuberculosis Risk Assessment and/or Examination Certificate of Completion".

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Instructions for Employees & Volunteers *Without* Paid Medical Benefits *(Continued)*

3.) Via In Person

Contact your preferred Sharp Occupational Medicine Center to schedule the best time for a TB assessment. At your TB assessment appointment, bring all the forms from Step 1. Once assessed, one of the following scenarios will occur.

- If No risk factors are identified: Sharp will return the completed and signed "Tuberculosis Risk Assessment and/or Examination Certificate of Completion".
- If risk factors are identified: Sharp will provide you with instructions on completing a TB test and/or TB exam, if necessary. Once you are determined to be free of infectious tuberculosis you will be returned a completed and signed "Tuberculosis Risk Assessment and/or Examination Certificate of Completion".

NOTE: If you don't hear back from Sharp within the specified timeframes, please contact them directly for an update on your assessment.

STEP 3

Submit the completed and signed "TB Assessment Certificate of Completion" to SWCCD.

- Mail or drop off in person a copy of the Certificate of Completion to SWCCD HR Department.
- *New Hires & Rehires*: Please submit directly to your HR Specialist *via email*:

Academic HR Specialists:
- Teri Ashabraner: tashabraner@swccd.edu
- Tiffany Lawrence: tlawrence@swccd.edu

Classified HR Specialists:
- (A-K) Cynthia Carreño: ccarreno@swccd.edu
- (L-Z) Alfredo Farah: afarah@swccd.edu

Southwestern Community College District
900 Otay Lakes Road. #46B-151
Chula Vista CA, 91910
Attn: Human Resources- Employment, TB Clearance

QUICK STEP GUIDE

Completing the TB Assessment and Sharp Rees-Stealy Forms

1. California School Employee Tuberculosis Risk Assessment Questionnaire Form
   - Enter name, current date, and date of birth.
   - Only check off the boxes that apply.
2. Certificate of Completion TB Risk Assessment and/or Examination Form
   - Leave blank. This form will be completed and signed by the Sharp Healthcare provider.
     (Must be included with all the forms you provide to Sharp.)
3. Authorization for Use or Disclosure of Protected Health Information Form
   - Complete all areas.
   - SIGN form at the bottom
   - Other Notes:
     a) #2: Dates of service are – one year from current date. (Ex:" From 1/15/21 to 1/15/22)
     b) #3: Initial, "Other" for TB Questionnaire
     c) #4: Initial, "Other" for Employment
     d) #6, Leave blank.
4. Health Questionnaire Patient Registration Form
   - Complete all areas.
   - SIGN Form at the bottom.

SHARP Rees-Stealy Medical Centers

Occupational Medicine Centers

CHULA VISTA

525 Third Ave.
Chula Vista, CA 91910
Phone: 619-585-4050
Fax: 619-585-4054
Supervisor:
Debbie Flores
Hours: Monday to Friday,
8 a.m. to 5 p.m.

Email forms to:
ChulaVista.OccupationalMedicine@sharp.com

LA MESA

5525 Grossmont Center Dr.
La Mesa, CA 91942
Phone: 619-644-6600
Fax: 619-644-6642
Supervisor:
Susan Horton
Hours: Monday to Friday,
8 a.m. to 5 p.m.

Email forms to:
LaMesa.OccupationalMedicine@sharp.com

GENESEE

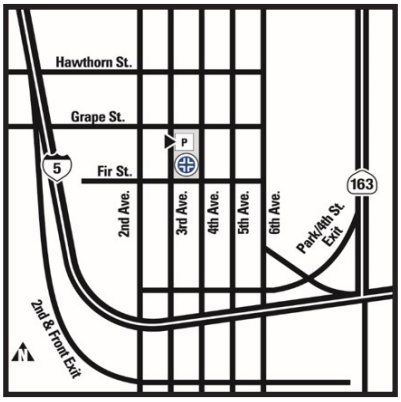
2020 Genesee Ave.
San Diego, CA 92123
Phone: 858-616-8400
Fax: 858-616-8420
Supervisor:
Cathy Simmerman
Hours: Monday to Friday,
8 a.m. to 5 p.m.

Email forms to:
Genesee.OccupationalMedicine@sharp.com

SORRENTO MESA

10243 Genetic Center Dr.
San Diego, CA 92121
Phone: 858-526-6150
Fax: 858-526-6153
Supervisor:
Michelle Radagio-Guzman
Hours: Monday to Friday,
8 a.m. to 5 p.m.

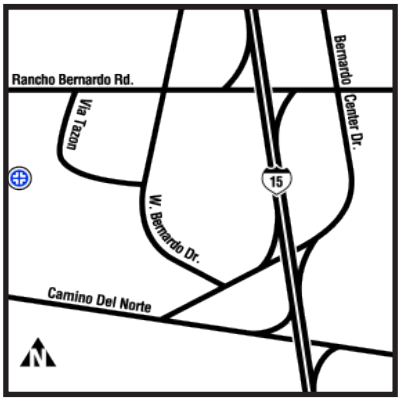
Email forms to:
SorrentoMesa.OccupationalMedicine@sharp.com



DOWNTOWN

300 Fir Street
San Diego, CA 92101
Phone: 619-446-1524
Fax: 619-234-9160
Supervisor:
Charleena Days
Hours: Monday to Friday,
8 a.m. to 5 p.m.

Email forms to:
Downtown.OccupationalMedicine@sharp.com



RANCHO BERNARDO

16899 West Bernardo Dr.
San Diego, CA 92127
Phone: 858-521-2350
Fax: 858-521-2354
Supervisor:
Jacqueline Hollins
Hours: Monday to Friday,
8 a.m. to 5 p.m.

Email forms to:
RanchoBernardo.OccupationalMedicine@sharp.com

California School Employee Tuberculosis (TB) Risk Assessment Questionnaire

(for pre-K, K-12 schools and community college employees, volunteers and contractors)

- Use of this questionnaire is required by California Education Code sections 49406 and 87408.6, and Health and Safety Code sections 1597.055 and 121525-121555.^
- The purpose of this tool is to identify adults with infectious tuberculosis (TB) to prevent them from spreading disease.
- Do not repeat testing unless there are new risk factors since the last negative test.
- Do not treat for latent TB infection (LTBI) until active TB disease has been excluded:
  For individuals with signs or symptoms of TB disease or abnormal chest x-ray consistent with TB disease, evaluate for active TB disease with a chest x-ray, symptom screen, and if indicated, sputum AFB smears, cultures and nucleic acid amplification testing.
  A negative tuberculin skin test (TST) or interferon gamma release assay (IGRA) does not rule out active TB disease.

Name of Person Assessed for TB Risk Factors: _____

Assessment Date: _____ Date of Birth: _____

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

☐ Yes
- If there is a documented history of positive TB test or TB disease, then a symptom review and chest x-ray (if none performed in the previous 6 months) should be performed at initial hire by a physician, physician assistant, or nurse practitioner. If the x-ray does not have evidence of TB, the person is no longer required to submit to a TB risk assessment or repeat chest x-rays.

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

TB testing is recommended if any of the 3 boxes below are checked

☐ One or more sign(s) or symptom(s) of TB disease
- TB symptoms include prolonged cough, coughing up blood, fever, night sweats, weight loss, or excessive fatigue.

☐ Birth, travel, or residence in a country with an elevated TB rate for at least 1 month
- Includes countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries.
- Interferon gamma release assay (IGRA) is preferred over tuberculin skin test (TST) for non-US-born persons.

☐ Close contact to someone with infectious TB disease during lifetime

Treat for LTBI if TB test result is positive and active TB disease is ruled out

^The law requires that a health care provider administer this questionnaire. 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. A Certificate of Completion should be completed after screening is completed (page 3).

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):

SHARP® Rees-Stealy Medical Centers

Health Questionnaire Patient Registration

PLEASE COMPLETE ALL FIELDS

Last Name: _____

First Name: _____

Social Security Number or Last 4 digits: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Primary Language: _____

Home Mailing Address: _____

City: _____ State: _____ Zip Code _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Country of Birth: _____

Employer: _____

Employer Address: _____

City: _____ State _____ Zip Code _____

Signature: _____ Date _____

SHARP

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:_____

Date of Birth:_____

Medical Record Number:_____

Please read carefully and complete the reverse side of this form.

All sections of this authorization must be completely filled out before Sharp is permitted to disclose your protected health information.

EXPLANATION: This form authorizes the use or disclosure of protected health information in the manner described below and is voluntary. Sharp HealthCare will still provide medical treatment for you if you do not sign this authorization, except under limited circumstances that are described in our Notice of Privacy Practices. **Please be aware that once your information leaves Sharp HealthCare, Sharp HealthCare will no longer be able to protect that information, and the recipients of your information may not be legally required to protect your information.**

NOTICE TO OCCUPATIONAL MEDICINE PATIENTS: California law allows your employer to access your health records only if you authorize the disclosure in writing, or for certain specific reasons. Some of the reasons include situations when your employer is required to do so by law; when you're involved in a lawsuit (or similar process) with your employer and your medical history is at issue; when the information requested was requested or paid for by your employer; when the information is required to evaluate your need for medical leave or disability related benefits; or when it is necessary to administer your employee benefits plan. If you have questions or concerns about whether any of the above situations apply to you, please notify your provider before beginning any procedure and consider notifying your employer.

AUTHORIZATION TO DISCLOSE SPECIFIC PROTECTED HEALTH INFORMATION: Federal and State laws require us to obtain specific authorization from patients to release especially sensitive information. Sensitive information is defined as treatment or documentation related to HIV and AIDS test results; Psychiatric care, and Treatment for Alcohol or Drug Abuse. Be aware that we will automatically try to exclude these types of information unless you specifically identify them for release.

RESTRICTIONS: I understand that Sharp HealthCare may not further use or disclose the information described on the reverse side of this form unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. I hereby release Sharp HealthCare from any/all liability that may arise from the release of this information to the party named on the reverse side of this form.

ADDITIONAL COPY: I further understand that I have a right to receive a copy of this authorization upon my request.

DURATION: I understand that I may revoke this authorization in writing at any time (see the Sharp HealthCare Notice of Privacy Practices for instructions), except to the extent that action has already been taken. Unless otherwise noted, this authorization will expire one year from the date of my signature.

CHARGES: If your health information is being released directly to you, you may be responsible for payment of a reasonable, cost based processing fee. The fee covers clerical costs as well as any/all costs associated with copying of the information.

Please complete the reverse side of this form

SHC-MR-1993

1. **Authorization:** I authorize disclosure of medical information and health records as described below:

   Patient Name:_____

   Date of Birth:_____/_____/_____ Telephone: (_____)_____

   Record Holder's Name:_____

   Address:_____City:_____State:_____Zip:_____

   Records Released To:_____

   Address:_____City:_____State:_____Zip:_____

2. **Information to be Released for these Dates of Service:** From_____To_____

3. **Information to Release:** Place your initials next to each category of information we will be releasing.

___HIV Test Results (Human Immunodeficiency Virus)
___Treatment for Alcohol and/or Drug Abuse
___Operative/Procedure Reports
___Radiology/Nuclear Medicine Reports
___Emergency Department Reports
___Consultation Reports
___Infection Control/Clinical Information
___Psychiatric Records
___Billing Information
___Discharge Summary
___Progress Notes
___Laboratory Tests
___History/Physical Exam
___Open Medical Record
___Still or Video Images and Sound Prepared for (Sharp/Non-Sharp) Marketing Purposes
___Other (Please Specify):TB Questionnaire
___I would like an electronic copy (e.g., compact disk) of the above indicated information (including diagnostic test results, problem list, medication lists, medication allergies, discharge summary and procedures, if available.)

4. **Use of Information:** The individual or entity identified above is permitted to use my information for the following purposes: Please initial all that apply.

____Continuing Medical Care ____Second Opinion ____Legal
____Print Marketing or Educational Media ____Personal ____Insurance
____Audio/Visual Marketing or Education Media
____Other (please specify):Employment

5. **Signature:**

   Printed Name:_____

   Signature:_____ Date/Time:_____

   If signed by other than patient, indicate relationship to patient:_____

   Witness Signature:_____ Date/Time:_____
   (Sharp HealthCare Representative)

   Attending Physician (Required for Behavioral Health):_____

   Date/Time:_____

6. Mailing Instructions: Please mail both sides of this authorization form to:

_____
(Sharp staff to enter appropriate address)