E2

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES

HEALTH CLEARANCE CERTIFICATION

FOR NON-DHS/NON-COUNTY WFM

LAST NAME *	FIRST, MIDDLE NAME *	BIRTHDATE *	GENDER *	HSN NO. USC ID *
JOB TITLE	DHS FACILITY	ONSITE DEPT/DIVISION	ONSITE WORK AREA/UNIT	
ONSITE WORK PHONE	ONSITE COORDINATOR NAME	YOUR E-MAIL ADDRESS *	YOUR CELL/PAGER NO. *	
NAME OF SCHOOL/CONTRACT AGENCY/INDEPENDENT CONTRACTOR USC KSOM Visiting Student	PHONE NO. 323 442-2418	CONTACT PERSON Estella Turla		

Completion of this certificate certifies the individual identified above has met the Los Angeles County Department of Health Services (DHS) Pre-placement Health Screening **Section A**, OR Annual Health Screening **Section B**, requirements in accordance with DHS policy.

I. FOR COMPLETION BY THE PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL (PLHCP)

INSTRUCTIONS TO THE PLHCP: Please complete the following forms. All fields on the forms must be completed in order to meet DHS health clearance requirements to work in DHS health care facilities. Return completed forms to the patient. ***Only complete one section (Section A or B).***

Section A **FOR PRE-PLACEMENT HEALTH SCREENING** *(ONE TIME use for initial pre-placement only)*:
(Must complete form B-NC. Complete forms K-NC, N-NC and P-NC, as applicable)

- ☐ **B-NC** Tuberculosis History and Evidence of Immunity Form
- ☐ **K-NC** Declination Form, if workforce member (WFM) declined any vaccination(s). ***(If applicable, complete and submit form K-NC to DHS-EHS)***
- ☐ **N-NC** FIT Test – *Only if N95 respirator is needed for job assignment (WFMs such as laboratory, clinicians, custodians and others who may be assigned work in airborne precaution areas or procedures.)*

  WFM must complete the following medical questionnaire form P-NC prior to Fit Test, then every 4 years thereafter or more frequently, as needed)

  - ☐ **P-NC** Appendix B – ATD Respirator Medical Evaluation Questionnaire ***(for N95 respirator only*)***
    ***NOTE**: If WFM requires a respirator *greater than N95 respirator*, please obtain and complete the Respirator Medical Questionnaire (Form O-NC) from EHS website link at www.dhs.lacounty.gov

Section B **FOR ANNUAL HEALTH SCREENING** *(Use annually)*:
(Must complete form E-NC. Complete forms K-NC, N-NC and P-NC, as applicable)

- ☐ **E-NC** Annual Health Screening Form
  NOTE: For new TB Conversion, attach form E-NC and submit to DHS-EHS.
- ☐ **K-NC** Declination Form, if WFM declined any vaccination(s). ***(If applicable, submit form K-NC to DHS-EHS)***
- ☐ **N-NC** FIT Test *(Only if N95 respirator is needed for job assignment (WFMs such as laboratory, clinicians, custodians and others who work in airborne precaution areas or procedures.)*

  WFM must complete the following medical questionnaire form P-NC prior to Fit Test, then every 4 years thereafter or more frequently, as needed)

  - ☐ **P-NC** Appendix B – ATD Respirator Medical Evaluation Questionnaire ***(for N95 respirator only*)***
    ***NOTE**: If WFM requires a respirator *greater than N95 respirator*, please obtain and complete the Respirator Medical Questionnaire (Form O-NC) from EHS website link at www.dhs.lacounty.gov

I certify that the individual identified above has met the Los Angeles County Department of Health Services Pre-placement OR Annual health screening requirements AND verified completion of the forms.

DATE OF COMPLETED HEALTH CLEARANCE

PRINT NAME	PLHCP SIGNATURE	LICENSE NO.	TODAY'S DATE
FACILITY NAME/ADDRESS		PHONE NO.	

E2

NON-DHS/NON-COUNTY WORKFORCE MEMBER HEALTH CLEARANCE CERTIFICATION

LAST NAME *	FIRST, MIDDLE NAME *	BIRTHDATE *	HSN NO. USC ID *

II. FOR COMPLETION BY THE WORKFORCE MEMBER

INSTRUCTION TO THE WORKFORCE MEMBER: You must provide authorization to release your health information to your School/Contract Agency/Independent Contractor (SCAIC) and to DHS-EHS by signing below. Return all completed forms to your SCAIC for verification of completion and to store source documents.

I authorize the release of my health information as listed in Section A or B to my SCAIC and to DHS-EHS, and upon request by DHS-EHS for regulatory requirements and auditing purposes. The purpose of releasing my health information is to meet DHS pre-placement or annual health screening requirements. DHS forms shall be maintained and filed at my SCAIC and at DHS-EHS as applicable. I understand that my SCAIC and DHS-EHS may not use or disclose my health information unless another authorization is obtained from me or unless such use or disclosure is specially required or permitted by law. By signing this, I am authorizing the release of my health information.

PRINT NAME *	SIGNATURE *	DATE *

III. FOR COMPLETION BY THE SCHOOL/CONTRACT AGENCY/INDEPENDENT CONTRACTOR (SCAIC)

INSTRUCTION TO THE HOME SCHOOL/CONTRACT AGENCY/INDEPENDENT CONTRACTOR: You must verify all forms are accurately completed and ensure the workforce member (WFM) has met the DHS health clearance requirements. Sign below and **return this E2 certificate only** (original to be kept by SCAIC) **unless specifically noted to submit form(s)** in Section A or B to DHS-EHS.

E2 certificate ONLY must be presented to DHS-EHS for final health clearance.

In accordance with DHS policy, the WFM's SCAIC shall:

1. Maintain and file original E2, B-NC or E-NC and other forms as applicable at the WFM's Home SCAIC, and must ensure the confidentiality and privacy of WFM's health information.
2. Ensure the above WFM completes a health screening annually **by the end of the month of last health screening.** Failure to provide documentation of timely health screening/clearance will result in immediate termination of assignment and placement in a "Do Not Send" status until compliant.
3. Provide health surveillance/post-exposure services to WFM. If the WFM's SCAIC chooses to have DHS-EHS perform such surveillance/post-exposure services, the WFM's SCAIC will be billed, as appropriate.

As the WFM's SCAIC, I certify that I have verified DHS forms are complete to ensure the health clearance requirements are complete and, upon DHS request, will supply supporting document(s) within four (4) hours. WFM will comply with DHS policy and will complete health screening annually.

PRINT NAME	SIGNATURE		DATE
E-MAIL ADDRESS	NAME OF SCHOOL/CONTRACT AGENCY/SELF		PHONE NO.
SCHOOL/CONTRACT AGENCY/SELF ADDRESS		STATE	ZIP CODE

SAVE ORIGINAL FOR YOUR RECORDS
SUBMIT COPY OF E2 FORM INCLUDING K-NC or E-NC, AS NECESSARY

DHS-EHS STAFF ONLY		
DATE CLEARED BY EHS	PRINT NAME	SIGNATURE

DHS-EHS is to provide Form A2 or E3 to WFM for Area/Unit File

All workforce member EHS health records are confidential in accordance with federal, state and regulatory requirements.
REV 5/2012