Wake Forest™ Baptist Health
Employee Health Services

WFBMC Health Documentation Record
On-Boarding of New HCW and WFSM Students

Last Name: _____ First Name: _____ Middle Name: _____

SSN: ___ ___ ___ - ___ ___ -___ ___ ___ ___ Date of Birth:___ ___ / ___ ___ / ___ ___ ___ ___
(**Please include all 9-digits**)

MEASLES VACCINES OR 2 MMR (1st Vaccination after 1st Birthday) **OR**	**MEASLES/RUBEOLA ANTIBODY**
Date 1: ___ ___ / ___ ___ / ___ ___ Date 2: ___ ___ / ___ ___ / ___ ___	Date: ___ ___ / ___ ___ / ___ ___ **Results: ❑Positive ❑Negative**
MUMPS VACCINE OR 2 MMR **OR**	**MUMPS ANTIBODY**
Date 1: ___ ___ / ___ ___ / ___ ___ Date 2: ___ ___ / ___ ___ / ___ ___	Date: ___ ___ / ___ ___ / ___ ___ **Results: ❑Positive ❑Negative**
RUBELLA VACCINE OR 1 MMR **OR**	**RUBELLA ANTIBODY**
Date: ___ ___ / ___ ___ / ___ ___	Date: ___ ___ / ___ ___ / ___ ___ **Results: ❑Positive ❑Negative**

HEPATITIS B (FOR 'AT RISK) HEALTHCARE WORKER	**HEPATITIS B VACCINE** **AND**	**HEPATITIS B ANTIBODY**
❑Yes ❑No	Date 1: ___ ___ / ___ ___ / ___ ___ Date 2: ___ ___ / ___ ___ / ___ ___ Date 3: ___ ___ / ___ ___ / ___ ___	Date: ___ ___ / ___ ___ / ___ ___ **Results: ❑Positive ❑Negative**

VARICELLA VACCINATION (2 VACCINATIONS) **OR**	**VARICELLA ANTIBODY**
Date 1: ___ ___ / ___ ___ / ___ ___ Date 2: ___ ___ / ___ ___ / ___ ___	Date: ___ ___ / ___ ___ / ___ ___ Results: **❑Positive ❑Negative**

OR

2 MANTOUX TB SKIN TESTS (THE DATE WITHIN IS 12 MONTHS & 60 DAYS FROM START DATE)

1 IGRA/TB LAB TEST (QUANTIFERON GOLD OR T-SPOT) WITHIN 12 MONTHS (ATTACH LAB RESULT)

Date 1 **Apply**: ___ ___ / ___ ___ / ___ ___ (**Date** 1 **within** 12 months) Date 2 **Apply**:___ ___ / ___ ___ / ___ ___ (**Date** 2 **within** 60 days of start date)	**Results**: Date **Read**:___/___/___ ___ **❑Positive ❑Negative** _____**mm** **Results**: Date **Read**:___/___/___ ___ **❑Positive ❑Negative** _____**mm** **If Positive:** Documentation of TB test with measurement **required**. Chest X-Ray **within 3 years of Start/Hire date required**. WFBMC TB Questionnaire **required**.

OTHER PERTINENT HEALTH HISTORY

Tetanus booster OR Tdap within past 10 years

Tetanus _____ **Tdap** _____ Date: ___ ___ / ___ ___ / ___ ___

Seasonal Influenza Vaccine Date: ___ ___ / ___ ___ / ___ ___

To my knowledge, this individual is free from communicable diseases that could pose significant risk to the health and safety of others, and has no physical or mental conditions that would prevent him/her from performing the essential duties required with or without reasonable accommodations.

Signature of Health Care Provider OR Stamp of Health Care Provider Clinic **Date Signed/Stamped**