LOS ANGELES UNIFIED SCHOOL DISTRICT
HUMAN RESOURCES DIVISION - EMPLOYEE HEALTH SERVICES

MEDICAL AND TUBERCULOSIS CLEARANCE FOR NEW CERTIFICATED EMPLOYEES

To ensure the attached forms are valid at the time of submission, do not proceed with these examinations until your employment has been officially approved.

ALL HEALTH FORMS MUST BE SUBMITTED IN A SEALED ENVELOPE FROM THE MEDICAL FACILITY

Prior to official employment in any certificated position, you must provide, at your own expense, evidence of tuberculosis (TB) clearance and medical examinations. To avoid any unnecessary delay in your employment processing, you and your physician should read and follow all instructions below AND on attached forms.

Tuberculosis Clearance – Certification of Completion (Form 8478) *or* Tuberculosis Test Results (Form 8472)

Effective January 1, 2015, all persons initially employed by a school district who have not been screened for TB in the past 60 days, must have a *TB Risk Assessment* by a Physician, Physician Assistant, Nurse Practitioner, or Registered Nurse. If no risk factors are identified, a *Certificate of Completion (Form 8478 attached)* must be completed by that provider **not more than sixty (60) days prior to the date of being hired** and submitted to Employee Health Services.

If risk factors are identified, a TB skin test (PPD) or blood test (Interferon-Gamma Release Assays or IGRA) is to be performed. If either test is positive, a chest X-ray will be taken. Once the Physician, Physician Assistant, or Nurse Practitioner performing these examinations determines the individual is free from infectious tuberculosis, they will complete the C*ertificate of Completion* with the dates for those results noted.
The *Certificate of Completion* must be signed within 60 days prior to the date of hire and the x-ray done within 6 months prior to the date of hire.

The *Adult TB Risk Assessment* consists of completing a questionnaire asked by your health care provider. A sample of the questionnaire developed by California state health agencies is enclosed **for use by the health care provider.** The *Adult TB Risk Assessment Questionnaire* is only for the doctor's use and does not need to be returned to LAUSD.

Certificate of Medical Examination (Form 8457)

All persons initially employed by a school district must undergo a medical examination **not more than six (6) months prior to the date of being hired and have Form 8457 signed by a licensed physician (MD or DO).** Exams performed by Physician's Assistants and/or Nurse Practitioners must be countersigned by their supervising MD. Only Form 8457 will be accepted.

LOS ANGELES UNIFIED SCHOOL DISTRICT
Human Resources Division
Employee Health Services

CERTIFICATE OF MEDICAL EXAMINATION

Personal Information (Please Print)

Last Name	First Name	M.I.	Social Security Number
Home Address	City	State / Zip	Employee Number (if applicable)
Phone Number / Cell Number	Email		Birthday (mm/dd/yyyy)

Position: ☐ Early Education ☐ K-12 ☐ Adult Education ☐ District Intern ☐ Substitute ☐ Other:

The Genetic Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting, or requiring, genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

TO BE COMPLETED BY A LICENSED PHYSICIAN ONLY (M.D. or D.O.)

On the basis of the patient's medical history and medical examination performed on him/her, I certify that this individual is free from any disabling disease unfitting him/her to instruct or associate with children. I hereby certify I am licensed to practice as a physician, M.D. OR D.O., and further certify the following:

Will this individual be a danger to self or others, including children? ☐ **Yes** ☐ **No**

If the individual has any restrictions or you answered Yes to the statement above, are there any reasonable accommodations that would allow the individual to perform the essential functions of the job, allow the individual to work safely with children and coworkers, and/or mitigate the danger to self or others? If so, please describe:

_____

_____

Printed Name of M.D. OR D.O.	**State License Number**	**Stamp AND Phone Number**
Signature of Physician	**Today's Date**	**Date of Examination**

CANDIDATE

I,_____, declare I have reviewed the above information and I attest to the accuracy of the information I provided to my medical practitioner as set forth herein above. I have reviewed all the questions and answers provided on this Certificate of Medical Examination and acknowledge they are truthful and do not contain any omissions.

Additionally, I understand, and I am fully aware (1) this examination must be conducted **not more than six (6) months prior to being hired**, (2) any incomplete and/or inaccurate information regarding my medical history may constitute grounds for the withdrawal and nullification of any offer of employment or separation from my current position if I'm found guilty of such violation, (3) **additional medical information and/or test results** may be requested, and (4) I hereby authorize the release of all my medical and/or psychiatric records/data to the Los Angeles Unified School District without restriction.

Executed this_____day of _____, 20_____, in _____, California, I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

_____
Signature

CANDIDATE

CANDIDATE MUST SUBMIT ORIGINAL IN A <u>SEALED ENVELOPE</u> <u>WITH A STAMP</u> FROM THE MEDICAL FACILITY <u>IN PERSON</u> TO:

Los Angeles Unified School District
Employee Health Services
333 S. Beaudry Ave., 14th Floor, Room 110
Los Angeles, CA 90017

FOR DISTRICT USE ONLY

LOS ANGELES UNIFIED SCHOOL DISTRICT
Human Resources Division
Employee Health Services

GUIDELINES FOR EXAMINING PHYSICIAN

The statements below are provided as an aid in the medical examination of applicants for instructional and non-instructional certificated positions in the Los Angeles Unified School District.

PRIMARY FUNCTIONS OF INSTRUCTIONAL PERSONNEL
Serves in a school or center as a classroom teacher or instructor of one or more subjects and/or grade levels; maintains proper control and a suitable learning environment; and performs other professional duties such as instructional planning, communicating and conferring with students and parents, and supervising the activities of students within and outside the classroom.

PRIMARY FUNCTIONS OF NON-INSTRUCTIONAL PERSONNEL
Serves in an office, school, or center to provide service in support of students and/or instructional personnel; performs the professional duties of administrative, technical or resource personnel such as physician, nurse, psychologist, librarian, counselor, instructional specialist or manager.

Mental Health

1. Free of disabling psychiatric disorders that will prevent successful performance of the core duties of the position
2. Exhibits emotional stability and mental alertness sufficient to cope with a classroom of students

General Physical Abilities

1. Auditory acuity and oral facility sufficient to respond to questions and to impart information to students, staff, and parents
2. Able to lift and carry items weighing at least 20 pounds

   If your patient is applying for a special education, nursing, or physical therapist position, this may require lifting or restraining disabled students ranging from 50 to 150 pounds, with or without help
3. Stamina to sit, stand, and move about for long periods of time and climb stairs
4. Visual acuity to read texts and other printed instructional materials

Special Physical Abilities

1. Teacher of physical education:
   a. Stamina to ensure physical activity such as calisthenics, running, and jumping for sustained periods of time
   b. Body flexibility and coordination sufficient to bend, stretch, twist, or reach out in order to demonstrate various sports, dance, and other physical education activities
2. Teacher of occupational/vocational/trades/crafts subjects:
   a. Manual dexterity to use hand tools and power equipment
   b. Auditory acuity to hear conversations in a noisy room and to discriminate among environmental (non-speech) sounds

Adult Tuberculosis (TB) Risk Assessment Questionnaire[1]

(To satisfy California Education Code Section 49406 and Health and Safety Code Sections 121525-121555)

To be administered by a licensed health care provider (physician, physician assistant, nurse practitioner, registered nurse)

Name: _____ Date of Risk Assessment: _____

Date of Birth: _____

History of positive TB test or TB disease Yes ☐ No ☐

If yes, a symptom review and chest x-ray (if none performed in previous 6 months) should be performed at initial hire.*
If no, continue with questions below.

If there is a "Yes" response to any of the questions 1-5 below, then a tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA) should be performed. A positive test should be followed by a chest x-ray, and if normal, treatment for TB infection considered.

Risk Factors	
1. One or more signs and symptoms of TB (prolonged cough, coughing up blood, fever, night sweats, weight loss, excessive fatigue) Note: A chest x-ray and/or sputum examination may be necessary to rule out infectious TB.[2]	Yes ☐ No ☐
2. Close contact with someone with infectious TB disease	Yes ☐ No ☐
3. Birth in high TB-prevalence country** (**Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.)	Yes ☐ No ☐
4. Travel to high TB-prevalence country** for more than 1 month (**Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.)	Yes ☐ No ☐
5. Current or former residence or work in a correctional facility, long-term care facility, hospital, or homeless shelter	Yes ☐ No ☐

**Once a person has a documented positive test for TB infection that has been followed by an x-ray that was deemed free of infectious TB, the TB risk assessment is no longer required.*

[1] Adapted from a form developed by Minnesota Department of Health TB Prevention and Control Program and Centers for Disease Control and Prevention.

[2] Centers for Disease Control and Prevention (CDC). *Latent Tuberculosis Infection: A Guide for Primary Health Care Providers*. 2013. (http://www.cdc.gov/tb/publications/LTBI/default.htm)

Do Not Submit Adult Tuberculosis (TB) Risk Assessment Questionnaire to LAUSD

LOS ANGELES UNIFIED SCHOOL DISTRICT

EMPLOYEE HEALTH SERVICES – TB COMPLIANCE PROGRAM

Name: _____ **Date of Birth:** _____

Job Title: _____ **Phone No:** _____

Social Security No: _____ **Employee No:** _____ **Email Address:** _____

CERTIFICATE OF COMPLETION

To be signed by the licensed health care provider completing the risk assessment and/or examination

*The above named patient has submitted to an **ADULT TUBERCULOSIS RISK ASSESSMENT**.*

☐ The patient does not have TB Risk factors.

☐ The patient has TB risk factors, but had a negative skin or blood test on _____ (date).

☐ The patient has been examined, had a chest X-Ray on _____ (date) and is determined to be free of infectious tuberculosis.

Health Care Provider Signature | Date

Print Health Care Provider's Name | Title | License No.

Address: | City | State | Zip Code

Telephone | Fax

RETURN ORIGINAL COMPLETED FORM TO:

Los Angeles Unified School District
Employee Health Services – TB Compliance Program
333 S. Beaudry Avenue, 14-110
Los Angeles, CA 90017
Phone: (213) 241-6326 Fax: (213) 241-8918
E-mail: employeehealth@lausd.net

Seal or Stamp:

DO NOT SUBMIT THE ADULT TB RISK ASSESSMENT QUESTIONAIRE TO LAUSD.

Adapted from the CDPH/CTCA Adult Tuberculosis (TB) Risk Assessment Questionnaire Certificate of Completion, TCB-01 (12/14)