

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 Adult 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 *Certificate 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 health care provider'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 Medical Doctor (M.D.), Doctor of Osteopathic Medicine (D.O.), Physician Assistant (P.A.) or Nurse Practitioner (N.P.). 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 BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER ONLY (MD, DO, PA and NP)

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 an MD, DO, PA or NP 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 MD, D.O. PA & NP

State License Number

Phone Number

Signature of Health Care Provider

Today's Date

Date of Examination

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 MUST SUBMIT ORIGINAL IN A SEALED ENVELOPE WITH A STAMP FROM THE MEDICAL FACILITY IN PERSON TO:

MEDICAL FACILITY STAMP

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



LOS ANGELES UNIFIED SCHOOL DISTRICT
Human Resources Division
Employee Health Services
GUIDELINES FOR EXAMINING HEALTH CARE PROVIDER

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; 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 Questionnaire¹

(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 <input type="checkbox"/> No <input type="checkbox"/>
2. Close contact with someone with infectious TB disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>
5. Current or former residence or work in a correctional facility, long-term care facility, hospital, or homeless shelter	Yes <input type="checkbox"/> No <input type="checkbox"/>

**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>)



LOS ANGELES UNIFIED SCHOOL DISTRICT
HUMAN RESOURCES DIVISION – EMPLOYEE HEALTH SERVICES
TB COMPLIANCE PROGRAM

Name: _____

Date of Birth: _____

Job Title: _____

Phone: _____

Social Security No: _____ or Employee No: _____

Email Address: _____

TUBERCULOSIS CERTIFICATE OF COMPLETION

Check One:

- The patient does not have TB risk factors per the ADULT TUBERCULOSIS RISK ASSESSMENT.
- The patient had a negative skin or blood test on _____ (date).
APPLICANTS: Date of test must be within 60 days prior to date of hire.
- The patient had a positive skin or blood test, followed by a negative chest x-ray on _____ (date).
APPLICANTS: Date of x-ray must be within six months prior to date of hire.

The above named patient does not have risk factors, or if risk factors were identified, the patient has been examined and determined to be free of infectious tuberculosis.

Health Care Provider Signature (MD, DO, PA, NP, RN <u>ONLY</u>)	Date	
Print Health Care Provider's Name	Title	License No.
Address:	City	Zip Code
Telephone	Fax	

RETURN ORIGINAL COMPLETED FORM TO:
LAUSD 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

Refer to <http://publichealth.lacounty.gov/TB> for more information.

MEDICAL FACILITY STAMP (REQUIRED):

