EH-4444-FRM
REV 6 01.27.26

CMC
CONWAY MEDICAL CENTER

EMPLOYEE ANNUAL TESTING - CHECK OFF

Employee Name:_____**Badge #:**_____**DOB:** _____

Dept:_____**Employee Type:** *Employee Contract Physician (MD, NP, PA) Student Volunteer*

TB RISK ASSESSMENT	**Yes**	**No**
Chronic persistent cough of > than 2 weeks		
Coughing up blood		
Chronic fatigue		
Unexplained weight loss		
Persistent low grade fever		
Previous Positive TB Test		
Have you had close contact to someone with infectious TB disease since your last TB test??		
Have you had a Temporary or permanent Residence ≥ 1 month in a country with high TB Rate? (Any country other than U.S., Canada, Australia, New Zealand, Northern or Western Europe??		
Are you or will you be Immunocompromised (HIV, organ transplant recipient, treated with TNF-Alpha antagonist (e.g. infliximab, etanercept, others), steroid therapy (> 15mg/day for >1 month), or other immunosuppressive medication?		

INFLUENZA VACCINE	
	I **CONSENT** to the Influenza Vaccine? _____**Signature** _____**Date**
The 2020 influenza Vaccination Information Sheet (VIS) has been made available to you through Cerner. You may access this form through your patient portal or view the form on the CDC website under Influenza VIS Form 2020 https://www.cdc.gov/vaccines/hcp/vis/vis-statements/flu.html	
	I **DECLINE** to the Influenza Vaccine? _____ **Signature**_____ **Date**
Check ALL that apply	
	ALLERGY: I have an Allergy to the vaccine, or have had a serious reaction to a previous influenza vaccine
	MEDICAL: I have a history of Guillain Barre Syndrom
	RELIGION: It is against my Religious Beliefs
	OTHER: *Specify:*

☐ **INFLUENZA** **Date:** _____ **Arm (Circle):** **RIGHT DELTOID** **LEFT DELTOID**

Given By (Please Print): _____

☐ **Received elsewhere – Documents provided**

FLU STICKER

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Employee Health Section: Entered into Cerner: Initials: