TUBERCULOSIS CLEARANCE
Instructions for Employees Without Paid Medical Benefits

Please follow the instructions below, and the cost for your TB assessment and if necessary, testing and examination will be covered by SDCCD. The six (6) Sharp Rees-Stealy Occupational Medicine Center locations listed on page 3 will invoice San Diego Community College District for the cost and you will not be required to pay.

Important Note

Any cost related to active Tuberculosis treatment or other related costs will not be covered by SDCCD.

Step 1 – Complete and sign all required forms listed below. All forms are printable and are in PDF fillable format that can be completed and signed electronically. For questions on these forms please see the quick Guide on page 2.

- "California School Employee Tuberculosis Risk Assessment Questionnaire" page 4.
- "Certificate of Completion TB Risk Assessment and/or Examination" page 5, to be completed by Sharp.
- "Authorization for use or Disclosure of Protected Health Information" pages 6-7.
- "Health Questionnaire Patient Registration" page 8.

Step 2 – Select one of the three available methods to begin the TB assessment process. If you don't hear back from Sharp within the specified timeframe, please contact them directly for an update on your assessment.

Method 1 – Email

- Email all forms in Step 1 to your preferred Sharp Occupational Medicine Center listed on page 3.
- Sharp will contact you within 2-4 workdays with one of the two following scenarios.
    - If No risk factors are identified, you will be returned a completed and signed "Tuberculosis Risk Assessment and/or Examination Certificate of Completion" via a secured email. Sharp will email you instructions to access the secure email and its contents.
    - If risk factors are identified, then you will be contacted via phone call or email by a Sharp representative to schedule an appointment for a TB test and if necessary, a TB exam. If you are determined to be free of infectious tuberculosis you will be returned a completed and signed "Tuberculosis Risk Assessment and/or Examination Certificate of Completion".

Method 2 – Mail

- Mail all forms in Step 1 to your preferred Sharp Occupational Medicine Center listed on page 3.
- Sharp will contact you within 2-7 workdays with one of the two following scenarios.
    - If No risk factors are identified, you will be returned a completed and signed "Tuberculosis Risk Assessment and/or Examination Certificate of Completion".
    - If risk factors are identified, then you will be contacted via mail or phone call by a Sharp representative to schedule an appointment for a TB test and if necessary, a TB exam. If you are determined to be free of infectious tuberculosis you will be returned a completed and signed "Tuberculosis Risk Assessment and/or Examination Certificate of Completion".

Method 3 - In Person

- Contact your preferred Sharp Occupational Medicine Center listed on page 3 to determine the best time for a TB assessment.
- At your TB assessment, provide all the forms from Step 1.
- Once assessed, one of the two following scenarios will occur.
    - If No risk factors are identified, you will be returned a completed and signed "Tuberculosis Risk Assessment and/or Examination Certificate of Completion".
    - If risk factors are identified, then you will receive instructions on completing a TB test and if necessary, a TB exam. If you are determined to be free of infectious tuberculosis you will be returned a completed and signed "Tuberculosis Risk Assessment and/or Examination Certificate of Completion".

Step 3 – Submit the completed and signed "TB Assessment Certificate of Completion" to SDCCD HR.

- Email, mail or drop off in person a copy of the Certificate of Completion to SDCCD HR Department.

San Diego Community College District
3375 Camino del Rio South, #330
San Diego CA, 92108
Attn: Human Resources – Employment, TB Clearance
rnaungay@sdccd.edu

Quick Guide
Completing the TB Assessment and Sharp Rees-Stealy Forms

1. California School Employee Tuberculosis Risk Assessment Questionnaire
    - This form is straight forward, enter name, current date, and date of birth. Only check off the boxes that apply.

2. Certificate of Completion TB Risk Assessment and/or Examination
    - This form stays blank, it will be completed and signed by a Sharp healthcare provider. Make sure it is included with all the forms you will provide to Sharp.

3. Authorization for use or Disclosure of Protected Health Information
    - The majority of this from is straight forward with only a few things to point out. Don't forget to sign at the bottom.
    - Page 1
        - No medical record number is required.
    - Page 2
        - #2, Dates of service are 1 year from current date e.g. "From 1/15/21 To 1/15/22"
        - #3, Initial "Other" for TB Questionnaire
        - #4, Initial "Other" for Employment
        - #6, leave blank.

4. Health Questionnaire Patient Registration
    - This form is straight forward, just make sure to sign at the bottom.

SHARP Rees-Stealy Medical Centers

Occupational Medicine Centers

CHULA VISTA

525 Third Ave.
Chula Vista, CA 91910
Phone: 619-585-4050
Fax: 619-585-4054
Supervisor:
Debbie Flores
Hours: Monday to Friday,
8 a.m. to 5 p.m.

Email forms to:
ChulaVista.OccupationalMedicine@sharp.com

LA MESA

5525 Grossmont Center Dr.
La Mesa, CA 91942
Phone: 619-644-6600
Fax: 619-644-6642
Supervisor:
Susan Horton
Hours: Monday to Friday,
8 a.m. to 5 p.m.

Email forms to:
LaMesa.OccupationalMedicine@sharp.com

GENESEE

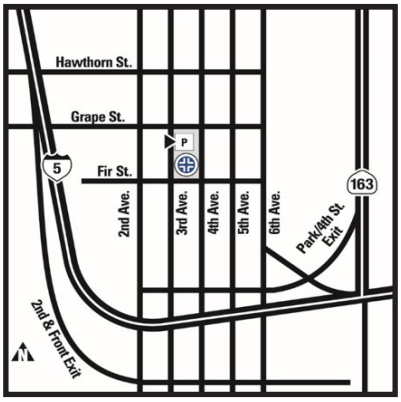
2020 Genesee Ave.
San Diego, CA 92123
Phone: 858-616-8400
Fax: 858-616-8420
Supervisor:
Cathy Simmerman
Hours: Monday to Friday,
8 a.m. to 5 p.m.

Email forms to:
Genesee.OccupationalMedicine@sharp.com

SORRENTO MESA

10243 Genetic Center Dr.
San Diego, CA 92121
Phone: 858-526-6150
Fax: 858-526-6153
Supervisor:
Michelle Radagio-Guzman
Hours: Monday to Friday,
8 a.m. to 5 p.m.

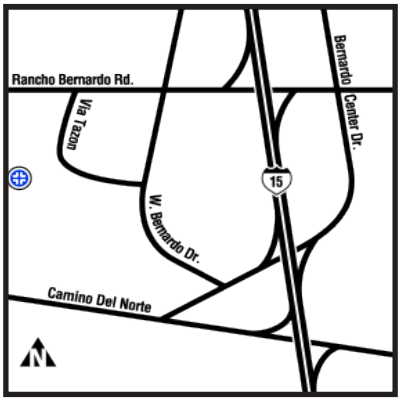
Email forms to:
SorrentoMesa.OccupationalMedicine@sharp.com



DOWNTOWN

300 Fir Street
San Diego, CA 92101
Phone: 619-446-1524
Fax: 619-234-9160
Supervisor:
Charleena Days
Hours: Monday to Friday,
8 a.m. to 5 p.m.

Email forms to:
Downtown.OccupationalMedicine@sharp.com



RANCHO BERNARDO

16899 West Bernardo Dr.
San Diego, CA 92127
Phone: 858-521-2350
Fax: 858-521-2354
Supervisor:
Jacqueline Hollins
Hours: Monday to Friday,
8 a.m. to 5 p.m.

Email forms to:
RanchoBernardo.OccupationalMedicine@sharp.com

California School Employee Tuberculosis (TB) Risk Assessment Questionnaire

(for pre-K, K-12 schools and community college employees, volunteers and contractors)

- Use of this questionnaire is required by California Education Code sections 49406 and 87408.6, and Health and Safety Code sections 1597.055 and 121525-121555.^
- The purpose of this tool is to identify adults with infectious tuberculosis (TB) to prevent them from spreading disease.
- Do not repeat testing unless there are new risk factors since the last negative test.
- Do not treat for latent TB infection (LTBI) until active TB disease has been excluded:
  For individuals with signs or symptoms of TB disease or abnormal chest x-ray consistent with TB disease, evaluate for active TB disease with a chest x-ray, symptom screen, and if indicated, sputum AFB smears, cultures and nucleic acid amplification testing.
  A negative tuberculin skin test (TST) or interferon gamma release assay (IGRA) does not rule out active TB disease.

Name of Person Assessed for TB Risk Factors: _____

Assessment Date: _____ Date of Birth: _____

History of Tuberculosis Disease or Infection (Check appropriate box below)

☐ Yes
- If there is a documented history of positive TB test or TB disease, then a symptom review and chest x-ray (if none performed in the previous 6 months) should be performed at initial hire by a physician, physician assistant, or nurse practitioner. If the x-ray does not have evidence of TB, the person is no longer required to submit to a TB risk assessment or repeat chest x-rays.

☐ No (Assess for Risk Factors for Tuberculosis using box below)

TB testing is recommended if any of the 3 boxes below are checked

☐ One or more sign(s) or symptom(s) of TB disease
- TB symptoms include prolonged cough, coughing up blood, fever, night sweats, weight loss, or excessive fatigue.

☐ Birth, travel, or residence in a country with an elevated TB rate for at least 1 month
- Includes countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries.
- Interferon gamma release assay (IGRA) is preferred over tuberculin skin test (TST) for non-US-born persons.

☐ Close contact to someone with infectious TB disease during lifetime

Treat for LTBI if TB test result is positive and active TB disease is ruled out

^The law requires that a health care provider administer this questionnaire. A health care provider, as defined for this purpose, is any organization, facility, institution or person licensed, certified or otherwise authorized or permitted by state law to deliver or furnish health services. A Certificate of Completion should be completed after screening is completed (page 3).

Certificate of Completion
Tuberculosis Risk Assessment and/or Examination

*To satisfy **job-related requirements** in the California Education Code, Sections 49406 and 87408.6 and the California Health and Safety Code, Sections 1597.055, 121525, 121545 and 121555.*

First and Last Name of the person assessed and/or examined:

_____

Date of assessment and/or examination: _____mo./_____day/_____yr.

Date of Birth: _____mo./_____day/_____yr.

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

X_____

Signature of Health Care Provider completing the risk assessment and/or examination

Please print, place label or stamp with Health Care Provider Name and Address (include Number, Street, City, State, and Zip Code):

SHARP® Rees-Stealy Medical Centers

Health Questionnaire Patient Registration

PLEASE COMPLETE ALL FIELDS

Last Name: _____

First Name: _____

Social Security Number or Last 4 digits: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Primary Language: _____

Home Mailing Address: _____

City: _____ State: _____ Zip Code _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Country of Birth: _____

Employer: _____

Employer Address: _____

City: _____ State _____ Zip Code _____

Signature: _____ Date _____

SHARP Rees-Stealy Medical Group
Health Information Management Department
5651 Copley Dr., Suite A, San Diego, CA 92111
(Mailing address only. No patient access.)
Phone: (858) 262-6422 Fax: (858) 636-2424
E-mail: SRS.ROIRequest@sharp.com

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

All sections on page two of this authorization must be completely filled out before Sharp Rees-Stealy (SRS) is permitted to disclose or receive your protected health information (PHI).

EXPLANATION: This form authorizes the use or disclosure of PHI in the manner described below and is voluntary. Refusal to sign will not affect your ability to obtain treatment from Sharp Rees-Stealy. Please be aware that once your information leaves Sharp Rees-Stealy, we will no longer be able to protect that information, and the recipients of your information may not be legally required to protect your information.

AUTHORIZATION TO DISCLOSE SPECIFIC PROTECTED HEALTH INFORMATION (PHI): Federal and State laws require us to obtain specific authorization from patients to release especially sensitive information. Sensitive information is defined as treatment or documentation related to Human Immunodeficiency Virus (HIV) and AIDS test results; psychiatric care, and treatment for alcohol or drug abuse. Be aware that we will automatically exclude these types of information unless you specifically identify them for release.

RECEIVING RECORDS ELECTRONICALLY: This option is available for patient or patient representative requests; not businesses, medical providers or third parties. If you prefer this option provide an email address in number 4 and select whether you would like to receive the records encrypted or unencrypted. Please do this in addition to your mailing address in number 3.

RESTRICTIONS: I understand that Sharp Rees-Stealy may not further use or disclose the information described on page two of this form unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. I hereby release Sharp Rees-Stealy from any/all liability that may arise from the release of this information to the party named on this form.

ADDITIONAL COPY: I further understand that I have a right to receive a copy of this authorization upon my request.

REVOCATION: I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken.

CHARGES: The requestor may be responsible for payment of a reasonable, cost based processing fee. The fee covers clerical costs as well as any/all costs associated with copying of the information. Unless stated otherwise only amounts above $25 or higher will require fee-approval before copying.

NON-SRS RECORDS: Sharp Rees-Stealy may not retain all records received from outside providers. Please contact your non-Sharp Rees-Stealy provider for complete copies of those records.

Office use	☐ ID checked
Recd by/Site:	
Date/Time:	
SHC:	
MRN:	

1. **Name of patient:** _____
   Telephone: (_____) _____ Date of birth: _____
2. **I authorize:** Sharp Rees-Stealy Medical Group
   Address: _____ Telephone: (___) _____
3. **To disclose to:** SD Community College Telephone: (619) 388-6579
   Address: 3375 Camino del Rio South, Suite 330, San Diego, CA 92108
4. **Email address to receive records electronically:** _____
   Choose security option for email delivery:
   ☐ Encrypted (Recipient will be required to create an account with Cisco envelope to access.)
   ☐ Unencrypted (I understand that there is some risk that my identifiable health information and other confidential information may be misdirected, read or intercepted by unauthorized parties.)
5. **Use of information:** The recipient identified above is permitted to use my PHI for the following purpose (choose one):
   ☐ Continuing Medical Care ☐ Personal ☐ Second Opinion
   ☐ Provider/Insurance Change ☐ Insurance (Life, Claims, etc.) ☐ Legal
6. **Dates of service:** From _____ To _____
7. **Only records pertaining to (optional):** _____
8. **Type of information to be released** (Check all that apply):
   ☐ Office Notes
   ☐ Operative/Procedure Reports
   ☐ Immunization Records
   ☐ Laboratory (Excludes HIV test results)
   ☐ Radiology Reports Only
   ☐ PT/OT/Speech Therapy Notes
   ☐ Eye Notes
   Initial ☐ Occupational Medicine
   ☐ Radiology Images with Reports
   ☐ Billing
   Initial ___ Other: TB Assessment Review / PPD / X-RAY

Records released as part of this authorization may include mention of HIV, mental health and alcohol or drug use. Mental health and/or alcohol/drug treatment facilities and/or results of HIV tests will not be disclosed unless you ***initial*** next to the specific information below.
☐ HIV Test Results ☐ Mental Health Treatment Records ☐ Alcohol/Drug Treatment Records

9. **Expiration:** This authorization will expire one year from the date of signature below unless you indicate an earlier expiration date here _____. If the purpose of this request may require future treatment notes to be disclosed to the same recipient named above, you may initial here allowing SRS to release future treatment dates ____.
10. By signing below, I acknowledge I have read and understand pages one and two of this authorization.

Print Name: _____ **Signature:** _____
Date: _____ **Witness (optional):** _____
If you are not the patient, indicate relationship to patient: _____

Office use Completed by:	Date:	DOS released:	Total pages:
Doc Types Released/ Comments:			