UVA Health

UVA Occupational Health & Wellness Screening Form

Name: _____ Social Security #: _____ Birth Date: _____

Personal Email: _____ Home/Cell Phone: _____

Home Address: _____
Street State ZIP

Date of Employment: _____ Job Title: _____ Department: _____

Please indicate if you have ever had any of the following:
(If you indicate "Yes" to having received a vaccination or titer, you must provide support documentation)

	Yes	No	Unknown	If Yes:
Varicella (Chickenpox) Vaccine or Titer*				Vaccine or Titer Date:
MMR (Measles (Rubeola), Mumps, Rubella) Vaccine or Titers*				Vaccine or Titer Date:
Tetanus (TD) Vaccine*				Vaccine or Titer Date:
Tetanus, Diptheria, Acellular Pertussis (Tdap) Vaccine*				Vaccine or Titer Date:
Positive Tuberculin Skin Test*				Dates of treatment received:
Suspected or Positive Tuberculosis Diagnosis*				Dates of treatment received:
Hepatitis B Vaccine Series*				Vaccine Dates:
Hepatitis B Titer*				Titer Date:
COVID-19 Initial Vaccine Series				Vaccine Date(s):
COVID-19 Booster				Vaccine Date(s):
Diagnosed or Suspected HIV*				
Yellow Jaundice/Hepatitis*				
Liver Disease*				

** = required*

Please indicate if you currently have any of the following:

	Yes	No	Unknown
A reportable disease that might pose a risk to patients you'll be caring for during your job functions?*			
MRSA (methicillin-resistant *Staph aureus*)*			
VRE (vancomycin-resistant enterococcus)*			
Seizures in the past 6 months*			
Latex Allergy*			
Trouble Identifying Colors*			

** = required*

_____ _____
Signature Date