NSW Ambulance

excellence in care

FORM: 188
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Occupational Assessment, Screening & Vaccination Program Verification Form

Name:	**Date of Birth:**	**Home Phone Number:**
Country of Birth:	**Email Address:**	**Mobile Phone Number:**
Residential Address:	**Medicare Number:** **(Medicare Number required by NSW Health PD2018_009, for the recording of new vaccinations on the Australian Immunisation Register (AIR))**	

NSW health care workers must be protected against some specific infectious diseases because of both occupational and patient safety risks. The requirements listed below are NSW Health policy. All Health Care Worker Category A employees, volunteers and clinical placement applicants must provide evidence of compliance with the listed criteria. Compliance with these requirements also provides additional public health benefit. Please complete the questionnaire below and provide all evidence as an attachment.

Acceptable evidence is a completed Vaccination Record Card. This card must be completed by a Doctor or a Registered Nurse Immuniser, be signed and have the practice stamp applied. Batch numbers should be recorded where available. Attach the evidence to this form. Blood test results and vaccination details may also be supplied in addition, but not as a substitute.

Statutory declarations will not be accepted.

You may need to visit your GP to complete all aspects of this program.

Diseases	Vaccination Evidence	Serology Evidence	Other Acceptable Evidence
Diphtheria, Tetanus & Pertussis	☐ One adult dose of dTpa vaccine within the last 10 years	N/A Serology will not be accepted	NIL
Hepatitis B	☐ History of age-appropriate Hepatitis B vaccination course	☐ **AND** Anti-HBs ≥10 mIU/ml	☐ **OR** Documented evidence of anti-HBc, indicating past Hepatitis B infection, or HBsAg+
Measles, Mumps & Rubella (MMR)	☐ 2 doses of MMR vaccine at least one month apart	☐ **OR** Positive IgG for measles, mumps and rubella	☐ **OR** Birth date before 1966
Varicella	☐ 2 doses of Varicella vaccine at least one month apart or 1 dose of Varicella vaccine before 14 years of age	☐ **OR** Positive IgG for varicella	N/A
Influenza	Influenza vaccination is strongly recommended for all health care workers including volunteers.		

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Tuberculosis (TB) Risk Assessment Tool

Part A		
1.	Do you currently have a cough that has lasted longer than 2 weeks?	Yes ☐ No ☐
2.	If yes, have you had any episode of haemoptysis (coughing up blood)?	Yes ☐ No ☐
3.	Have you had unexplained fever, chills or night sweats in the past month?	Yes ☐ No ☐
4.	Have you had any unexplained weight loss in the past month?	Yes ☐ No ☐

If you answered yes to any of the above questions, please attach relevant details on a separate page, including all results of any investigations or medical assessments you may have had, to this form.

Part B

1. Have you ever lived or travelled overseas? Yes ☐ No ☐

Country	Duration of stay	Approximate dates/year
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(attach a separate page if necessary)

2. Have you ever had contact with a person known to have TB? Yes ☐ No ☐
   If yes, detail the nature of the contact (attach separate page if necessary):

3. Have you ever been tested for TB before? Yes ☐ No ☐

If you answered yes to any of the above questions, please attach further information on a separate page, including the date and results of any previous tests for TB (including TST, IGRA, sputum culture, chest x-ray) and attach it to this form.

Applicant/Student Declaration: I declare that the information provided on this form is correct:		
Name:	**Signature**:	**Date:**

Final Instructions – please carefully check the listed requirements and your attachments. Ensure that all criteria are addressed and that evidence is provided where required. **Ensure your name is on all attachments.** (Provide copies only and keep your originals.)

Employee applicants - forward this form with attachments to Recruitment

Clinical Placement Applicants - forward this form and attachments to the relevant Sector Deployment staff.