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Policy Number: 86100-MS-089
Providence St. Peter Hospital

Health Requirements for PSPH Medical Staff Providers

PURPOSE: To provide a safe and healthy working environment at Providence St. Peter Hospital (PSPH).

APPLIES TO: All PSPH credentialed providers with privileges. Not applicable to non-members performing only telehealth services at PSPH.

POLICY STATEMENT: It is the provider's responsibility to submit documentation of all necessary health requirements at the time of initial appointment and reappointment. Medical Staff Services will monitor privileged providers for adherence to this policy. All changes to health requirements will be applied prospectively after Community Ministry Board approval has been granted.

PROCEDURE:

1. All privileged providers will meet medical staff health requirements at initial appointment and reappointment. A provider's privileges will not be activated until health requirements' documentation has been received and verified.

2. The following are included in the PSPH Health Requirements for privileged providers

A. TB surveillance required of privileged providers at initial appointment.
   1) Recent two step PPD placement or QuantiFERON-TB Gold blood test for TB.
   2) If positive, chest x-ray report (CXR) and TB symptom questionnaire are required.
      a) CXR must be completed within the last 2 years
      b) If CXR is consistent with pulmonary tuberculosis, a medical clearance will be required prior to activation of privileges.

B. Rubeola, Rubella and Mumps (MMR) required of privileged providers at initial appointment.
   1) Document two doses of MMR vaccine or immunity by positive titer.
   2) Providers that are unable to take the MMR vaccine due to health reasons must sign a declination. By signing a declination, they agree that in the event they are involved in an exposure to Rubella, Rubeola or Mumps infection, they will refrain from exercising their privileges at the hospital for the duration of the incubation period (Rubella 7-23 days post exposure; Rubeola or measles 5-21 days post exposure and Mumps 12-25 days post exposure or 5 days after onset of parotitis.)

C. Varicella required of privileged providers at initial appointment.
   1) Document two doses of Varicella vaccine or immunity by positive titer.
   2) Providers that are unable to take the Varicella vaccine due to health reasons must sign a declination. By signing a declination, they agree that in the event they are involved in an exposure to the varicella infection, they will refrain from exercising their privileges at the hospital for the duration of the incubation period (day 8-21 post exposure).

D. Tetanus, Diphtheria, Pertussis Vaccine (Tdap) required of privileged providers at initial appointment and reappointment, if not previously on file.
   1) Providers are required to document vaccination with tetanus diphtheria and acellular pertussis vaccine (Tdap). Vaccinations received during childhood **are not sufficient** to meet this requirement.
      a) Providers that are unable to document vaccination with tetanus toxoid, reduced diphtheria toxoid and acellular pertussis vaccine (Tdap) due to health reasons must sign a declination. By signing a declination, they will refrain from exercising their privileges at the hospital for the duration of the incubation period (21 days post exposure).

b) If a Tdap record or declination is not on file at reappointment, the provider's reappointment will be incomplete and the provider's privileges will be not be activated. If a Tdap record or declination is not received within 90 days of the reappointment date an automatic expiration will be processed.

E. Hepatitis B required of privileged providers at initial appointment.
1) Providers are required to document 3 shot vaccinations and titers.
2) Providers who are unable to document 3 shot vaccinations and titers are required to document initiation of vaccine protocol or sign a declination.

F. Influenza
1) Providers must obtain seasonal influenza vaccination annually.
2) Providers that are unable to receive refrain from having a seasonal an influenza vaccination must sign a declination.

Key Words: Immunity; TB surveillance; Rubeola; Rubella; Varicella; Hepatitis, MMR, Vaccination; Tdap, PPD, QuantiFERON-TB Gold

Owner: Credentials Committee
Contributing Department/Committee Approval: Medical Executive Committee, Infection Control Committee

Attachment: Medical Staff Tuberculosis Questionnaire

Administrative Approval:

Francois M. Cady, MD, Medical Staff President

Jennifer Groberg, Community Ministry Board Chair

PROVIDENCE Health & Services

Tuberculosis Screening Questionnaire

Name: _____ Date of Birth: _____
Last First Middle

Do you currently have symptoms of:		**If yes, please explain:**
Productive cough for more than three weeks?	❑ Yes ❑ No	
Fever associated with cough for more than one week?	❑ Yes ❑ No	
Blood present in sputum?	❑ Yes ❑ No	
Night sweats?	❑ Yes ❑ No	
Unusual fatigue for more than two weeks?	❑ Yes ❑ No	
Loss of appetite for more than two weeks?	❑ Yes ❑ No	
Unexplained weight loss (of five pounds or more)?	❑ Yes ❑ No	
Current health status		**If yes, please explain:**
Do you have an acute viral infection or febrile illness?	❑ Yes ❑ No	
Have you had a live-virus vaccine in the past six weeks?	❑ Yes ❑ No	
Are you currently taking steroids (cortisone)?	❑ Yes ❑ No	
Are you currently undergoing radiation therapy, chemotherapy or immunosuppressive therapy?	❑ Yes ❑ No	
History		**If yes, please explain:**
Are you foreign-born?	❑ Yes ❑ No	Country:
Have you been out of the country within the last six months?	❑ Yes ❑ No	Country:
Have you ever had a TB skin or blood test?	❑ Yes ❑ No	
Have you ever had a positive reaction?	❑ Yes ❑ No	Date:
Have you had a recent chest x-ray?	❑ Yes ❑ No	Date:
Is there anyone in your family with TB?	❑ Yes ❑ No	Relationship:
Have you ever had close contact with active TB (including health care exposure)?	❑ Yes ❑ No	
Have you ever been treated with TB medications?	❑ Yes ❑ No	
Have you received the BCG vaccination?	❑ Yes ❑ No	
Do you have diabetes?	❑ Yes ❑ No	

To my knowledge, the above information is correct.

Signature:_____ **Date:** _____

MEDICAL STAFF VACCINATION DECLINATION STATEMENTS (Check all that apply.)

☐ I am unable to take the Measles/Mumps/Rubella vaccine due to health reasons. I agree that in the event I am involved in an exposure situation to the Rubella or Rubeola infection, I am required to stay out of the hospital for the duration of the incubation period (Rubella 7-23 days post exposure; Rubeola or measles 5-21 days post exposure and Mumps 12-25 days.)

☐ I am declining the tetanus toxoid, reduced diphtheria toxoid and acellular pertussis vaccine (Tdap) vaccination. I agree to stay out of the hospital for the duration of the incubation period (21 days post exposure).

☐ I am unable to take the Varicella vaccine due to health reasons. I agree that in the event I am involved in an exposure to chicken pox, I am required to stay out of the hospital for the duration of the incubation period (day 8-21 post exposure).

☐ I am refraining from taking the Annual Flu Vaccine. I agree that in the event I am involved in an exposure to flu, I am required to stay out of the hospital for the duration of the incubation period (day 8-21 post exposure).

Signature:_____ **Date:**_____

Print Name Here:_____