Health
Sydney
Local Health District

IMPORTANT INFORMATION REGARDING SCREENING & VACCINATION ASSESSMENT

Please ensure that you READ the information provided on the following pages before completing the questionnaire.
NSW Health has released a Policy Directive PD2022_030 *'Occupational Assessment, Screening & Vaccination against Specified Infectious Diseases'.* This policy is about protecting our most valuable resource, our staff. The benefits to you of being 'protected' are:

- You will be safe in the event of an outbreak of any of these diseases,
- You will play an important role in minimising the spread of these diseases to your family and friends,
- You will assist in the wider control of these diseases in not only your local community, but across the state, throughout Australia and internationally as well.

This policy mandates that all new and existing employees are 'protected' against the specified infectious diseases. NSW Health is required and committed to ensure that all prospective employees satisfy the requirements of this policy.

The form **"*Evidence Required to Demonstrate Protection Against Specified Infectious Diseases*"** requires you to **provide documentation** that you are 'protected' against the following diseases:

- Diphtheria
- Tetanus
- Pertussis (whooping cough)
- Hepatitis B
- Annual Influenza Vaccination
- Mumps
- Rubella
- Varicella (chickenpox)
- Measles
- Covid-19

Tuberculosis (TB): You will need to submit any evidence of previous screening and/or vaccination against tuberculosis. Your Staff Vaccination Coordinator/Staff Health Clinic will also ask you to complete a tuberculosis questionnaire and you may be required to undergo TB screening if indicated.

Risk categorisation refers to the process of assessing a person or position according to the risk of transmission of the specified infectious diseases. Persons are categorised as either Category A or Category B:

- **Category A –** denotes direct physical contact with patients/clients, deceased persons, blood, body substances or infectious material or surfaces/equipment that might contain these or contact that would allow acquisition and/or transmission of a specified infectious disease by respiratory means. Failure to complete outstanding Hepatitis B, TB or COVID-19 vaccination requirements within the appropriate timeframe(s) will result in suspension from further clinical placements/duties and may jeopardise their course of study/ work/ employment.

- **Category B** – denotes no direct physical contact with patients/clients, deceased persons, blood, body substances or infectious material or surfaces/equipment that might contain these and no greater risk of acquisition and/or transmission of a specified infectious disease than for the general community. Category B workers will only be permitted to commence employment/attend placements if they have evidence of COVID-19 protection as specified in Appendix 1 of the policy directive Evidence of protection.

Applicants both internal and external must be compliant with PD2022_030 or may not be considered for employment. It is important if you are considering applying for a new position that you immediately act on ensuring you are compliant. This will help prevent any delay in the recruitment process should you be the preferred candidate.

Should you wish to read the policy document, it can be found on the NSW Health website:
https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2022_030.pdf

If you are the **Preferred Applicant** you will be required to:

1. Provide **vaccination & serological evidence of immunity.** If you do not have the required evidence, please take the form called *Advice Sheet Regarding the Evidence Required to Demonstrate Protection against Specified Infectious Diseases* to your doctor or vaccination provider. They will arrange vaccination and/or a blood test for you.
2. Complete the following forms:
   a) **Form 1:** New Recruit Undertaking/Declaration – Return this form to your convener/contact person
   b) **Form 2:** Tuberculosis (TB) assessment tool
   c) **Form 3:** Personal Details section only of the *Screening & Vaccination Compliance Assessment* – submit Form 1 & 2 along with your vaccination & serological evidence to the facility's Staff Vaccination Coordinator/Staff Clinic for assessment. Your convener/contact person will provide you with contact details.

Please Note: **The information provided will be treated in the strictest confidence.**

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ADVICE SHEET FOR CATEGORY A APPLICANTS REGARDING EVIDENCE REQUIRED TO DEMONSTRATE PROTECTION AGAINST SPECIFIED INFECTIOUS DISEASES

Please take this form to your doctor or service provider to assist with provision of the required evidence.

1. Acceptable evidence of protection against specified infectious diseases includes:
   a) A written record of vaccination (i.e. Adult vaccination record card or general practitioner letter) signed by the medical practitioner, and/or
   b) Serological confirmation of protection, and/or
   c) Other evidence, as specified in the table below

The vaccination record card MUST contain:

- ❒ Vaccine name, batch number and date given.
- ❒ Official certification from vaccination provider (e.g. clinic/practice stamp and signature).
- ❒ Serology results recorded on the card requires a signature and stamp. A copy of the original pathology results is preferred.
- ❒ Evidence must be legible and written in English.

2. TST screening is required if the person was born in a country with a high incidence of TB, or has resided for a cumulative time of 3 months or longer in a country with a high incidence of TB, as listed at: http://www.health.nsw.gov.au/Infectious/tuberculosis/Documents,countries-incidence.pdf

In certain specialised clinical settings, the health facility *may* require serological evidence of protection (in addition to evidence of vaccination or other evidence) to ensure that the risk to vulnerable patients is minimised.

Disease	Evidence of vaccination	Documented serology results	Other acceptable evidence
Diphtheria, Tetanus AND Pertussis (whooping cough) (dTpa)	One dose of **ADULT** type dTpa within the last 10 years. (Boostrix or Adacel)	Serology will not be accepted.	Not applicable.
	******PLEASE CONFIRM****** WITH YOUR GP THAT YOU ARE RECEIVING EITHER BOOSTRIX OR ADACEL (dTpa) AND **NOT ADT**		
Hepatitis B	Documented Evidence of Anti-HBc (core antibodies) indicating past infection or HBsAg+. **OR**	Anti-HBs (surface antibodies) greater than or equal to 10mIU/ml. **AND**	History of completed age-appropriate course of Hepatitis B vaccine. A completed Hepatitis B Vaccination Declaration are acceptable if all attempts fail to obtain the vaccination record.
Measles, Mumps, Rubella (MMR)	2 doses of MMR vaccine - at least one month apart. **OR**	Positive IgG for measles, mumps and Rubella. Rubella immunity is provided as a numeral value with immunity status as per lab report. (The interpretation of the result given in the laboratory's report must be followed). **OR**	Birth date before 1966.
Varicella (chickenpox)	2 doses of varicella vaccine at least one month apart. *Evidence of one dose is sufficient if the person was vaccinated before 14 years of age* **OR**	Positive IgG for varicella.	Australian Immunisation Register (AIR) History Statement that records natural immunity to chickenpox.
Tuberculosis (TB) Assessment	Please complete FORM 2 Tuberculosis (TB) Assessment Tool and you might be required to provide one of the below documents: ■ BCG Vaccination ■ Tuberculin skin test *(TST)* ■ Interferon gamma release immunoassay *(IGRA)* ■ Recent Chest X-ray ■ Clinical review discharge letter from a TB service (Chest Clinic)		
Influenza	One dose of current southern hemisphere influenza vaccination is a requirement for all positions by 1 June each year.		
COVID-19	Three doses of a TGA approved or recognised COVID-19 vaccine (in accordance with ATAGI minimum intervals) * **OR** Two doses of a TGA approved or recognised COVID-19 vaccine (in accordance with ATAGI minimum intervals), and the third dose: (i) Within eight weeks from the date of issue of this Policy if it is more than thirteen weeks since they received their second dose; or (ii) Within six weeks from the due date for the worker's third dose of a TGA approved or recognised COVID-19 vaccine, whichever is later.		

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Undertaking/Declaration Form

Occupational Assessment, Screening and Vaccination Against Specified Infectious Diseases

Part Undertaking/Declaration (tick the applicable option)		✓
1	I have read, understand and agree to abide by the requirements of the NSW Health *Occupational Assessment, Screening and Vaccination against Specified Infectious Diseases Policy*	☐
2	a. I consent to assessment and I undertake to participate in the assessment, screening and vaccination process and I am not aware of any personal circumstances that would prevent me from completing these requirements, (OR)	☐
	b. (For existing workers only) I consent to assessment and I undertake to participate in the assessment, screening and vaccination process; however I am aware of medical contraindications that may prevent me from fully completing these requirements and am able to provide documentation of these medical contraindications. I request consideration of my circumstances.	☐
3	I have provided evidence of protection for hepatitis B as follows (Category A workers only): a. history of an age-appropriate vaccination course, and serology result Anti-HBs ≥10mIU/mL OR	☐
	b. history of an age-appropriate vaccination course and additional hepatitis B vaccine doses, however my serology result Anti-HBs is <10mIU/mL (non-responder to hepatitis B vaccination) OR	☐
	c. documented evidence of anti-HBc (indicating past hepatitis B infection) or HBsAg+ OR	☐
	d. I have received at least the first dose of hepatitis B vaccine (documentation provided) and undertake to complete the hepatitis B vaccine course (as recommended in *The Australian Immunisation Handbook*, current edition) and provide a post- vaccination serology result within six months of my initial verification process OR.	☐
	e. I have provided evidence of a medical contraindication to hepatitis B vaccine (e.g. letter from a doctor); AND.	☐
	f. I have been informed of, and understand, the risks of infection, the consequences of infection and management in the event of exposure (refer Appendix 6 Specified Infectious Diseases: Risks and Consequences of Exposure) and agree to comply with the protective measures required by the health service and as defined by PD2017_013 Infection Prevention and Control Policy.	☐
4	I have provided COVID-19 vaccination evidence as follows (Category A workers only): a. Evidence of 3 doses of a Therapeutic Goods Administration (TGA) approved or recognised COVID-19 vaccine (in accordance with ATAGI minimum intervals); OR	☐
	b. Evidence that I have received at least two doses of a TGA approved or a recognised COVID-19 vaccine and will complete the required 3 dose schedule with a TGA approved COVID-19 vaccine, within the dosing time frame stipulated by the Australian Technical Advisory Group on Immunisation (ATAGI) and will provide evidence of completed vaccines within 6 weeks of the dose 3 due date; OR	☐
	c. I have provided evidence of a temporary or permanent medical contraindication to all the available TGA approved COVID-19 vaccines, in the form of an Australian Immunisation Register (AIR) - immunisation medical exemption form (IM011). I understand that if the medical contraindication is temporary, I must be reviewed by the date specified on the Medical Contraindication Form; OR	☐
5	I have provided COVID-19 vaccination evidence as follows (Category B workers only): a. Evidence of 2 doses of a Therapeutic Goods Administration (TGA) approved or recognised COVID-19 vaccine (in accordance with ATAGI minimum intervals); OR	☐
	b. I have provided evidence of a temporary or permanent medical contraindication to all the available TGA approved COVID-19 vaccines, in the form of an Australian Immunisation Register (AIR) - immunisation medical exemption form (IM011). I understand that if the medical contraindication is temporary, I must be reviewed by the date specified on the Medical Contraindication Form.	☐

Declaration: I, _____ declare that the information provided is correct

Full name _____ Worker cost centre (if available) _____

Parent/guardian name _____ Parent/guardian signature _____

(for workers/students under 18 years)

D.O.B _____ Worker/Student ID (if available): _____

Medicare number _____ Position on card _____ Expiry date _____

Email _____

NSW Health agency / Education provider _____

Signature _____ Date _____

NSW Health

Tuberculosis (TB) Assessment Tool

Occupational Assessment, Screening and Vaccination Against Specified Infectious Diseases

Your Personal Information

Family Name

Given Name(s)

Date of Birth

Phone Number

Medicare Number *[if eligible]*

Position on card *[number next to your name]*

Expiry Date

Address (street number and name, suburb and postcode)

Email

Employer/Education Provider

Stafflink/Student/Other ID

Course/Module of Study OR Place of Work

Signature

Date completed

Please complete all questions in Parts A, B and C.

Part A: Symptoms requiring investigation to exclude active TB disease

Do you currently have any of the following symptoms that are not related to an existing diagnosis or condition that is being managed with a doctor?	Yes	No
1. **Cough for more than 2 weeks?**	○	○
2. **Episodes of haemoptysis (coughing blood) in the past month?**	○	○
3. **Unexplained fevers, chills or night sweats in the past month?**	○	○
4. **Significant* unexpected weight loss over the past 3 months?** **loss of more than 5% of body weight*	○	○

Tuberculosis (TB) Assessment Tool

Occupational Assessment, Screening and Vaccination Against Specified Infectious Diseases

Family Name

Given Name(s)

Stafflink/Student/Other ID

Part B: Previous TB treatment or TB screening or increased susceptibility	Yes	No
1. **Have you ever been treated for active TB disease or latent TB infection (LTBI)?** *If Yes, please state the year and country where you were treated and provide documentation (if available)* **Year** **Country**	○	○
2. **Have you ever had a positive TB skin test (TST) or blood test (IGRA or QuantiFERON TB Gold+)?** *If Yes, please provide copies of TB test results.*	○	○
3. **Do you have any medical conditions that affect your immune system?** *e.g. cancer, HIV, auto-immune conditions such as rheumatoid arthritis, renal disease*	○	○
4. **Are you on any regular medications that suppress your immune system?** *e.g. TNF alpha inhibitors, high dose prednisone* *Please provide details here:*	○	○

Part C: TB exposure risk history		
The following questions explore possible previous exposure to TB		
1. **Have you had direct contact with a person with infectious pulmonary TB without adequate personal protective equipment and did not complete contact screening?**	**Yes** ○	**No** ○
2. **In what country were you born?** **If born overseas, when did you migrate to Australia?**		
3. **Is your country of birth on the list of high-TB-incidence countries?** *For the up-to-date list of high TB incidence countries, please go to https://www.health.nsw.gov.au/Infectious/tuberculosis/Pages/high-incidence-countries.aspx*	**Yes** ○	**No** ○
3a. **If Yes, as part of your visa medical assessment, did you have a negative TB skin test (TST) or blood test (IGRA or QuantiFERON TB Gold+)?** **If yes, please provide a copy of the result*	○	○
4. **Have you ever visited or lived in any country/ies with a high TB incidence in your life (first assessment) or since your last TB Assessment?** *If Yes, please list below the countries you have visited, the year of travel and duration of stay*	○	○

Country visited	Year of travel	Duration of stay *(please specify d/w/m)*	Country visited	Year of travel	Duration of stay *(please specify d/w/m)*

Tuberculosis (TB) Assessment Tool

Occupational Assessment, Screening and Vaccination Against Specified Infectious Diseases

Family Name

Given Name(s)

Stafflink/Student/Other ID

Other relevant information to assist with determining TB risk

E.g. pre-migration TB screening - CXR reported as normal and negative IGRA on

Date

All workers and students need to submit this form to their NSW health agency or education provider.
Education providers must forward this form to the NSW Health agency for assessment.
The **NSW Health agency** will assess this form and determine whether TB screening or TB clinical review is required.
NSW TB Services contact details:
https://www.health.nsw.gov.au/Infectious/tuberculosis/Pages/accessing-your-local-TB-service.aspx

Privacy Notice: *Personal information about students and employees collected by NSW Health is handled in accordance with the Health Records and Information Privacy Act 2002. NSW Health is collecting your personal information to meet its obligations to protect the public and to provide a safe workplace as per the current Occupational Assessment Screening and Vaccination Against Specified Infectious Diseases Policy Directive. All personal information will be securely stored, and reasonable steps will be taken to keep it accurate, complete and up to date. Personal information recorded on this form will not be disclosed to NSW Health officers or third parties unless the disclosure is authorised or required by or under law. If you choose not to provide your personal information, you will not meet the condition of placement. For further information about how NSW Health protects your personal information, or to learn about your right to access your own personal information, please see our website at www.health.nsw.gov.au*

For Official Use of NSW Health Agency or NSW TB Service

Please refer to *Appendix 3 - TB Assessment Decision Support Tool* for guidance on documenting outcomes from this TB Assessment:

- ◯ TB Compliant
- ◯ Advice sought from local TB service/chest clinic
- ◯ TB Screening required – referred to GP or local TB service/chest clinic
- ◯ TB Clinical Review required – referred to local TB service/chest clinic
- ◯ Other

Name of assessor and role

Contact Number

Health Agency/District/Network

Date of assessment

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FORM 3

SCREENING & VACCINATION COMPLIANCE ASSESSMENT

PERSONAL DETAILS

Submit this form with your vaccination documentation to the Staff Health/Vaccination Nurse

Title (please tick ✓)	**Mr** [ ]	**Mrs** [ ]	**Miss** [ ]	**Ms** [ ]	**Dr** [ ]
Surname:			**Former Names:** (if applicable)		
Given Names:					
Date Of Birth:			**Gender:**		
Contact Phone Number(s):					
Email Address:					
Existing SLHD Employee? YES [ ] NO [ ]			**Employee No:**		
Other Existing NSW Health Employee? YES [ ] NO [ ]					
Position Applied For:			**ROB REQ:**(if applicable)		
Convenor / Contact Person:			**Contact No.**:		
Department:			**Facility:**		

STAFF HEALTH/ VACCINATION CLINIC USE ONLY:

[Please tick ✓ where applicable]

CATEGORY *(circle)* **A** **B**

❑ **COVID VACCINATION COMPLIANT**

❑ **SUITABLE FOR EMPLOYMENT**:

- ❑ **COMPLIANT**: Meets screening/vaccination requirements of the NSW Health Policy Directive *'Occupational Screening and Vaccination Against Specified Infectious Diseases* Policy Directive PD2022_030.
- ❑ **CONDITIONAL**: Applicant meets the mandatory requirements of the policy directive and can be employed under the condition that they complete the remaining screening and vaccination requirements within the required timeframe.

❑ **NOT SUITABLE FOR EMPLOYMENT:** Does not meet the minimum screening/vaccination requirements for employment according to the NSW Health Policy Directive *'Occupational Screening and Vaccination Against Specified Infectious Diseases* Policy Directive PD2022_030.

One (1) provider is **required** to authorise compliance:

(1) Name of Provider …… Signature …… Date ……

(Only an authorised vaccination provider from the employing health care facility can sign this section)

Facility ……

Note to Convenor: The New Recruit Undertaking/Declaration and this form ONLY is to be uploaded into ROB or returned with Recruitment Paperwork if offline.

Please forward any vaccination health records to the Staff Vaccination Coordinator or return them to the applicant.

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Hepatitis B Vaccination Declaration

This form is to be used where a hepatitis B vaccination record is not available.

Stafflink/candidate ID

Section A: All sections to be completed by the Declarant in conjunction with an appropriately trained assessor

I, _____ declare that

[print name of declarant in CAPITAL LETTERS]

I have received an age-appropriate course of hepatitis B vaccine consisting of _____ *(insert number)* vaccine doses.

The approximate year I was vaccinated against hepatitis B was _____

I do not have the record of vaccination because:

I make this declaration believing it to be true

Declared on: _____ *[date]* _____

[signature of declarant]

Section B: To be completed by the Assessor

An Assessor includes: a doctor, accredited nurse immuniser, paramedic, registered nurse or enrolled nurse, who has training on the policy directive, interpretation of immunological test results and vaccination schedules.

Applying my clinical judgement, I am satisfied that the declarant's hepatitis B vaccination history and serology demonstrate compliance and long term protection.

Assessor name

Assessor qualification

Assessor signature

Date