Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

Employee Health
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Boston, MA 02215
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To: **BIDMC Applicants, Physicians, Volunteers, and External Personnel**
From: Daniel McTigue, RN
Clinical Ops Manager, Employee Health

Welcome to Beth Israel Deaconess Medical Center! In order to meet BIDMC Infection Control policies, official documentation (i.e. completed by your medical provider/clinic OR laboratory results) of **TB screening** and **immunizations** must be provided prior to your start date. **You will not be able to begin work at BIDMC until all required documentation listed below is received and approved.**

TB Screening		
TB Skin Testing	**IGRA Blood Test (Q-Gold, T-Spot)**	**History of Positive TB Screening**
One TB skin test done within past year of hire date; **a second TB** test within three months of hire date.	One test done within 3 months of hire	Report of Chest X-Ray, within 10 years of hire date, done specifically for TB evaluation; documentation of treatment; symptom review within three months of hire date.

Immunizations	
Measles (Rubeola)	Two (2) vaccines **or** a positive blood test result
Mumps	Two (2) vaccines **or** a positive blood test result
Rubella (German Measles)	One (1) vaccination **or** a positive blood test result
Varicella (Chickenpox)	Official documentation of two (2) vaccines **or** a positive blood test result
Tetanus-Diptheria-Pertussis*	Official documentation of one (1) vaccine within 10 years **(highly recommended)*
Hepatitis B	Official documentation of three vaccines and Hepatitis B surface antibody
Influenza	Official documentation of vaccination from most recent flu season
COVID-19	Official documentation of complete series

Please have this sheet accompany the requirements above, and either email or fax to Employee Health

Name: ____________________________ Date of Birth:_________ Phone Number: _________________ SSN (last 4):_____

Address: __________________________ City:_____________ State: _______ Zip code: _____________

BIDMC Department: __________________ BIDMC Position: ____________________ E-Mail: _______________

BIDMC Contact/Supervisor: _____________________ Start date:_________ End date:_______

Status (circle one): BIDMC HMFP APG Student Rotator Observer Agency Contractor Volunteer Collaborator

Signature: _______________________________________

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TO BE COMPLETED BY EMPLOYEE HEALTH

☐ **CLEARED**, Date: ______________ , Employee Health Designee: