

Vaccine preventable diseases evidence form

To be completed by the applicant with evidence attached

This form is to be used only if you (the applicant) have acceptable forms of evidence as per the list of acceptable forms in the table below of a completed course of vaccination or that you are not susceptible to the specified vaccine preventable diseases for your position.

Please complete the details on the form – **one (1) box must be ticked for each disease.**

You must **attach a copy of the evidence** relating to each vaccine preventable disease (each row of the table). Statutory declarations from applicants will not be accepted.

You will not be able to meet the conditions of employment if evidence is not attached for the specified VPDs specific to your role as listed below. If you do not have evidence for each disease listed, please take the "[Vaccine preventable diseases evidence certification form](#): To be completed by the applicant's health care provider" to a General Practitioner (GP) or a vaccine service provider (such as an immunisation clinic) to have the required vaccination/s or blood test/s in order to provide evidence.

Surname:				
First name:				
Date of birth:			Phone number:	
Address:				
Email:				
Job Reference No.:				
Disease	Evidence of vaccination	Documented serology results	Other acceptable evidence	Clinical Assessment
Measles, Mumps, and Rubella	<input type="checkbox"/> ATTACH EVIDENCE of two documented doses of MMR vaccine at least one month apart Date dose 1: ____/____/____ Date dose 2: ____/____/____	<input type="checkbox"/> ATTACH EVIDENCE of OR blood test results showing immunity (positive IgG) for each of measles, mumps, and rubella ¹	<input type="checkbox"/> Birth date before 1966 <input type="checkbox"/> Partial course of MMR vaccine ² Date of dose 1: ____/____/____	Compliant (circle): Yes / No Initial: _____ OR <input type="checkbox"/> Partially compliant
Pertussis	<input type="checkbox"/> ATTACH EVIDENCE of documented history of one adult dose of dTpa within the past ten years Date of dose: ____/____/____	Not applicable	Not applicable	Compliant (circle): Yes / No Initial: _____



Disease	Evidence of vaccinations	Documented serology results	Other acceptable evidence	Clinical Assessment
Varicella	<input type="checkbox"/> ATTACH EVIDENCE of documented history of age appropriate course of varicella vaccination ³ (including zoster) Date dose 1: ____/____/____ Date dose 2*: ____/____/____ (*if course is initiated after age 14).	<input type="checkbox"/> ATTACH EVIDENCE of blood test showing positive IgG for varicella ¹	<input type="checkbox"/> ATTACH EVIDENCE of documented history of physician-diagnosed chickenpox or shingles ⁴ <input type="checkbox"/> Partial course of varicella vaccine ⁵ Date of dose 1: ____/____/____	Compliant (circle): Yes / No Initial: _____ OR <input type="checkbox"/> Partially compliant
Hepatitis B	<input type="checkbox"/> ATTACH EVIDENCE of documented history of two or three age appropriate course of hepatitis B vaccine ⁶ Date dose 1: ____/____/____ Date dose 2: ____/____/____ Date dose 3: ____/____/____	<input type="checkbox"/> ATTACH EVIDENCE of blood test results showing immunity to hepatitis B (Anti-HBs greater than or equal to 10 IU/mL ⁷)	<input type="checkbox"/> ATTACH EVIDENCE that the individual is not susceptible to hepatitis B ⁸ <input type="checkbox"/> Partial course of Hepatitis B vaccine ⁹ Date of dose 1: ____/____/____ Date of dose 2: ____/____/____	Compliant (circle): Yes / No Initial: _____ OR <input type="checkbox"/> Partially compliant

Privacy Notice

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Your personal information will not be disclosed to any other third parties without consent, unless required by law. If you choose not to provide your personal information, you will not meet the condition of employment.

For information about how Queensland Health protects your personal information, or to learn about your right to access your own personal information, please see our website at www.health.qld.gov.au

Consent

I consent to the recruitment panel/human resources department giving personal information in this form to other areas within the Queensland public sector health system (including the Department of Health and Hospital and Health Services) for workforce planning and for outbreak management planning and response. This may include line managers and infection control units.

Applicant please complete:

Name: _____

Date: _____

Signature: _____

**The Australian Immunisation Handbook
10th Edition (updated June 2015) brand
names of vaccines are as follows:**

Hepatitis B

Brand names of hepatitis B vaccines are:

- H-B-Vax II (adult or paediatric formulation)
- Engerix-B (adult or paediatric formulation)

Brand names of combination vaccines containing hepatitis B vaccine are:

- Infanrix hexa (diphtheria, tetanus, pertussis, Haemophilus influenzae type b, Hepatitis B, polio)Twinrix/Twinrix Junior (hepatitis A, hepatitis B)
- ComVax (Haemophilus influenza type B, hepatitis B)¹⁰
- Infanrix hep B (diphtheria, tetanus, pertussis, acellular, hep B)¹⁰

Measles, Mumps, Rubella

Brand names of MMR vaccine are:

- M-M-R-II
- Priorix

Vaccines that contain measles, mumps, rubella and varicella (chickenpox) vaccines are:

- Priorix-tetra
- ProQuad

Varicella

- Varilrix
- Varivax

Brand names of combination vaccine containing varicella vaccine are:

- Priorix-tetra
- ProQuad

Brand name of zoster vaccine:

- Zostavax.

Footnotes and further information:

1. Positive IgG (Immunoglobulin G) indicates evidence of serological immunity, which may result from either natural infection or immunisation
2. Pre offer of employment requires minimum of one dose of Measles, mumps, rubella (MMR) vaccine course and second dose to be administered within three months of commencement. The applicant will be required to commit to completing the full course.
3. Two doses of varicella vaccine at least one month apart (evidence of one dose is sufficient if the person received their first dose before 14 years of age).
4. Letters from medical practitioners or other vaccine service providers should state the date chickenpox or shingles was diagnosed and should be on practice/facility letterhead, signed by the

provider/practitioner including professional designation and service provider number (if applicable).

5. Pre offer of employment requires minimum of one dose of Varicella (chickenpox) vaccine course and second dose (if required) to be administered within three months of commencement. The applicant will be required to commit to completing the full course.
6. Hepatitis B vaccine is usually given as a 3 dose course with 1 month minimum interval between 1st and 2nd dose, 2 months minimum interval between 2nd and 3rd dose and 4 months minimum interval between 1st and 3rd dose. For adolescents between the ages of 11-15 hepatitis B vaccine may be given as a two dose course, with the two doses 4-6 months apart.
7. Anti-HBs (hepatitis B surface antibody) greater than or equal to 10 IU/mL indicates immunity. If the result is less than 10 IU/mL (<10 IU/mL), this indicates lack of immunity
8. Letter from a medical practitioner, vaccine service provider or other health professional acceptable to the HHS or the Department with a statement that the individual is not susceptible to hepatitis B. Such a letter should be on practice/facility letterhead, signed by the provider/practitioner, and including their professional designation, service provider number (if applicable) and practice stamp. Other documented evidence that an individual is not susceptible to hepatitis B infection may include serology testing indicating a hepatitis B core antibody (Anti-HBc /HBcAb), or a documented history of past hepatitis B infection. Applicants (including students and volunteers) who are hepatitis B antigen positive do not have to disclose their hepatitis B infection status unless they perform exposure-prone procedures (see Guideline for the management of Human Immunodeficiency Virus (HIV), hepatitis B virus, and hepatitis C virus infected healthcare workers).
9. Pre offer of employment requires minimum of two doses of Hepatitis B vaccine course and third dose to be administered within six months of commencement. The applicant will be required to commit to completing the full course.
10. ComVax and Infanrix hexa are brand names of vaccine not in the updated Australian Immunisation Handbook 10th Edition (updated June 2015). These are vaccines that were included in previous immunisation schedules. Internationally administered vaccine may have a different brand name.

Tuberculosis Risk Assessment Questionnaire for Workers in Hospital and Health Service Facilities

Worker Information

Surname		Date of Birth	
Given name/s:		Phone-Home	
Address: Number/Street		Mobile	
Suburb/Town/City	Postcode	Sex:	<input type="checkbox"/> M <input type="checkbox"/> F
Proposed commencement date		e-mail	

Instructions:

- Please complete the following questions and provide (if available) any supporting documents and additional information as indicated to the Hospital and Health Service (HHS) prior to commencement of employment.
- Retain a copy of this assessment and any relevant documentation to take with you if any further assessment is required. The HHS will advise you if any additional assessment is required.
- NOTE there is no out-of-pocket expense for treatment of TB in public health facilities in Queensland.

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Part A: Signs of active TB - Do you currently have any the following symptoms?

1. Cough for more than 2 weeks (not related to an existing diagnosis or condition)	<input type="checkbox"/> No <input type="checkbox"/> Yes
2. Unexplained fever for more than 1 week	<input type="checkbox"/> No <input type="checkbox"/> Yes
3. Recent unexplained weight loss	<input type="checkbox"/> No <input type="checkbox"/> Yes
4. Coughing up blood	<input type="checkbox"/> No <input type="checkbox"/> Yes
5. Excessive sweating during the night for more than 1 week	<input type="checkbox"/> No <input type="checkbox"/> Yes
If you have answered YES to any questions from Part A :	
➔ You will require a clearance for signs of active TB prior to commencement of employment. Your HHS will provide further instruction.	

Part B: TB exposure risk history

1. Were you born in Australia?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If no, in what country were you born?	
2. Other than Australia or your country of birth, have you spent three (3) months or more in total within the past five (5) years visiting or living in any other country/ies? (For example, two months in country A and one month in country B is three months in total).	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, which countries?	
➔ Check the TB country incidence list (www.health.nsw.gov.au/Infectious/tuberculosis/Pages/high-incidence-countries.aspx) for each country you have listed in questions 1 and 2.	
3. Were you born, and/or have you spent three (3) months or more in total within the past five (5) years visiting or living in country/ies with a TB burden greater than 40 cases per 100 000 population? (see link above).	<input type="checkbox"/> No <input type="checkbox"/> Yes
4. Have you been in direct contact with a person with active TB disease, without using appropriate infection control precautions, within the past 2 years and you were not assessed for exposure to TB by hospital or public health authorities? (Contact may be work or non-work related).	<input type="checkbox"/> No <input type="checkbox"/> Yes
5. Have you previously worked (> 3 months) in any of the following settings: respiratory units; infectious disease units or other medical units caring for infectious TB patients; clinical procedure units conducting bronchoscopy and/or sputum induction; TB laboratories; mortuaries?	<input type="checkbox"/> No <input type="checkbox"/> Yes
6. Have you ever been diagnosed with active TB (i.e. not latent TB)?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, in what year did you complete treatment?	
7. Do you have any underlying health issues or take any medications that cause immunosuppression?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If you have answered YES to any of questions 3–7 from Part B , you require further assessment. Your HHS will provide instructions. If you have previously had an assessment for TB, please provide documentation as per Part C.	



Part C: Previous TB risk assessment procedures and BCG history:

If you have previously had a test for latent TB, to avoid unnecessary repetition of testing please provide (if available) any supporting documents and additional information as indicated below as instructed by your HHS.

Previous employment or immigration screening for TB	<input type="checkbox"/> No <input type="checkbox"/> Yes - Please attach evidence with results
Previous TB risk assessment on Staff Protect (Queensland Health Staff Health Application)	<input type="checkbox"/> No <input type="checkbox"/> Yes - Please attach evidence with results
Previous pathology result (Quantiferon test or T-spot test)	<input type="checkbox"/> No <input type="checkbox"/> Yes - Please attach evidence with results
Previous printed result of a tuberculin skin test result (also called Mantoux test)	<input type="checkbox"/> No <input type="checkbox"/> Yes - Please attach evidence with results
Have you ever received a BCG vaccine? (This leaves a raised scar, usually on your arm near the shoulder)	<input type="checkbox"/> No <input type="checkbox"/> Yes - at what age (approx.)? _____

Acknowledgement and Consent:

I certify that I have read and understand the [Queensland Health: Protocol for the control of tuberculosis— section 3.3.18 Workers and students in health care facilities risk assessment](#) on the Queensland Health Tuberculosis website, in preparation for my employment I agree to comply with the guidelines and all procedures in place at the Queensland Hospital and Health Service facility at which I am employed in respect of Queensland Health vaccination and infection control of health care workers.

I consent to my prospective employer giving personal information in this form to other areas within the Queensland public sector health system (including the Department of Health and Hospital and Health Services) for workforce and infection management planning and response. This may include line managers, infection control units and TB control units.

I certify that the information I have provided in this risk assessment is true and correct.

Full Name:

Signed:

Date:

Further information and Resources

- Tuberculosis Risk Assessment—Frequently Asked Questions (FAQ) for Workers in Queensland Health Facilities
- Tuberculosis Risk Assessment— Matrix and Explanatory Notes-for administration and/or clinician use (includes testing recommendations)
- Tuberculosis Risk Assessment— Guidance for HHS Administration