E2

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES

NON-DHS/NON-COUNTY WORKFORCE MEMBER HEALTH CLEARANCE CERTIFICATION

Instructions:

- **Section A** shall be completed by the non-DHS/non-County workforce member's (WFM) physician or licensed health care professional including completing Department of Health Services (DHS) forms. Once complete, return this certificate along with DHS forms to the non-DHS/non-County WFM.
- **Section B** shall be completed by the non-DHS/non-County WFM authorizing the release of medical information contained on DHS forms as listed in Section A to his/her School/Employer and DHS, Employee Health Services (EHS). Non-DHS/non-County WFM shall return this certificate and DHS forms to his/her School/Employer.
- **Section C** shall be completed by the non-DHS/non-County WFM's School/Employer. School/Employer shall verify completion of DHS forms in Section A, sign and return this certificate (Form E2) including supporting documentation(s) as applicable to DHS-EHS. DHS forms shall be kept at non-DHS/non-County WFM's School/Employer.

A. TO BE COMPLETED BY A PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	DATE OF HEALTH CLEARANCE:

I certify that the individual identified above has met the Los Angeles County Department of Health Services Pre-placement/Annual health screening requirements AND verified completion of the following DHS forms*:

☐ B-NC Tuberculosis History and Evidence of Immunity *(ONE TIME use for initial pre-placement only)*
 ☐ Workforce member declined vaccination(s): ______________________
 NOTE: If workforce member declined vaccination(s), must attach medical documentation and clearance to work in a health care environment and submit to DHS-EHS. *Declination for Measles, Mumps, Rubella, & Varicella must specify reason for declination on Form K-NC.*

☐ E-NC Annual Health Screening** *(Thereafter, use annually)*
 NOTE: For new TB Conversion, must attach Form E-NC and submit to DHS-EHS.

☐ K-NC Declination Form, as applicable *(Submit to DHS-EHS)*

☐ N-NC FIT Test *(only if respirator is needed for job assignment)*
 ☐ O-NC Respirator Medical Questionnaire *(for respirators greater than N-95 respirator)* **OR**
 ☐ P-NC Appendix B – ATD Respirator Medical Evaluation Questionnaire *(for N-95 respirator)*

PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL SIGNATURE:	DATE:
PRINT NAME:	LICENSE NO.:
FACILITY NAME/ADDRESS:	PHONE NO.:

B. TO BE COMPLETED BY THE NON-DHS/NON-COUNTY WFM

I authorize the release of my medical information as listed above in Section A to my School/Employer and to DHS-EHS, and upon request by DHS-EHS for regulatory requirements and auditing purposes. The purpose of releasing my medical information is to meet DHS pre-placement/annual health screening requirements. DHS forms shall be maintained and filed at my School/Employer, and at

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LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	IDENTIFICATION NO.:

DHS-EHS as applicable. I understand that my School/Employer and DHS-EHS may not use or disclose my medical information unless another authorization is obtained from me or unless such use or disclosure is specially required or permitted by law. By signing this, I am authorizing the release of my medical information.

PRINT NAME:	SIGNATURE:	DATE:

C. TO BE COMPLETED BY THE SCHOOL/EMPLOYER

*DHS forms of non-DHS/non-County WFM's medical information shall be maintained and filed at non-DHS/non-County WFM's School/Employer. The School/Employer shall ensure confidentiality and meet all privacy regulations of non-DHS/non-County WFM's medical information.

Annual health screening is a requirement in accordance to DHS policy No. 705.001, Health Screening, Non-County Workforce Members. The School/Employer shall ensure the above WFM completes a health screening annually **by the end of the month of last health screening. Failure to provide documentation of timely health screening/clearance will result in immediate termination of assignment and placement in a "Do Not Send" status until compliant.

Medical surveillance/post-exposure regulations are the responsibility of non-DHS/non-County WFM's School/Employer. If the School/Employer chooses to have DHS-EHS to perform such surveillance/post-exposure services, the non-DHS/non-County WFM's School/Employer will be billed accordingly.

The School/Employer have verified completion of DHS forms and have ensure the health clearance requirements are accurate, and upon DHS request, supply supporting document(s) within four (4) hours to DHS-EHS.

PRINT NAME:	SIGNATURE:		DATE:
E-MAIL ADDRESS:	NAME OF SCHOOL/EMPLOYER:		PHONE NO.:
ADDRESS:		STATE:	ZIP CODE:

PLEASE MAKE A COPY FOR YOUR RECORDS
SUBMIT ORIGINAL FORM E2 INCLUDING SUPPORTING DOCUMENTATION(S) TO DHS-EHS

All medical records of non-DHS/non-County WFM submitted to DHS-Employee Health Services are confidential in accordance with federal, state and regulatory requirements.

DHS-EHS STAFF ONLY		
DATE CLEARED BY EHS:	SIGNATURE:	PRINT NAME: