I. AUTHORITY: TCA 4-3-603 and TCA 4-3-606.

II. PURPOSE: To ensure that all new non-security employees of the Tennessee Department of Correction (TDOC) receive a pre-assignment medical screening prior to job placement to ensure a basic level of health.

III. APPLICATION: Director of Human Resources, human resources staff, new institution non-security employees, health services staff, contracted employees, interns, Major Maintenance, Electronic Security/Information Technology, Tennessee Correction Academy (TCA), and Tennessee Rehabilitative Initiative in Correction (TRICOR) employees.

IV. DEFINITIONS:

A. Institutional Non-Security Employees: For the purpose of this policy only, all employees of the TDOC that are assigned to non-security positions in the correctional institutions and transition centers, health services staff, institutional positions with contract vendors, institutional intern positions, major maintenance, institutional electronic security services, Tennessee Correction Academy, and institutional TRICOR positions.

B. Contract Staff: Employees that work for the employer contracted by the state to provide medical, mental health, food service, or other specific services to the TDOC and are assigned to the correctional institution on a regular basis.

C. Qualified Medical Provider: For the purpose of this policy only, a licensed physician, nurse practitioner, physician assistant, registered nurse, or licensed practical nurse.

V. POLICY: All new TDOC institutional non-security employees shall receive a medical screening prior to their job assignment.

VI. PROCEDURES:

A. The human resources staff shall arrange for all new institutional non-security employees to receive a medical screening. The results of the screening shall not be used to determine an employee's ability to perform a specific work responsibility or task and not used to disqualify individuals from employment.

B. The screening shall be authorized by the human resources staff and provided by the contract medical services vendor in keeping with ACA Standard 5-ACI-1C-15.

C. The screening shall be conducted by a qualified licensed medical provider licensed in the state where the service is provided.

D. The medical screening shall consist of pulse, respiration, blood pressure, and Tuberculin Skin Test (TST) unless otherwise clinically indicated per Policy #113.44. If an employee was previously vaccinated with BCG, they should receive the IGRA blood test. The contract vendor shall not perform any services for any new employee beyond the initial medical screening, except as defined in Policy #113.13.

E. A record (including Inmate/Employee Tuberculosis Screening Tool, CR-3628, and Employee Medical Screening, CR-3300), of the medical screening shall be maintained in the employee's confidential institutional file. Documentation shall include the date(s), screening results, and full legal signature and title of the health services provider. The health records must be kept confidential at all times.

F. If any problems are noted during this screening, the employee will be referred to his/her own private physician for examination/treatment.

G. All institutional non-security employees must be screened for tuberculosis at the time of employment using Employee Medical Screening, CR-3300, and thereafter on an annual basis using Inmate/Employee Tuberculosis Screening Tool, CR-3628, as required by Policy #113.44.

H. Employees hired for a 120-day appointment will be required to complete the medical screening at the time of their first appointment. If the employee returns for additional 120-day appointments within six months of the expiration of their last appointment, additional medical screenings will not be required. Tuberculosis Screenings will be required as described in "G" above.

I. All employees who are identified as having potential for exposure to bloodborne pathogens during the performance of their duties will be offered the Hepatitis B vaccination series in accordance with the *TDOC Exposure Control Plan* to prevent occupational exposure to bloodborne pathogens.

J. Security employees will receive a physical examination in accordance with Policy #305.06 and non-security employees required to carry firearms will receive a physical examination in accordance with Policy #110.06.

VII. ACA STANDARDS: 5-ACI-1C-15 and 5-ACI-6B-05.

VIII. EXPIRATION DATE: June 1, 2025

TENNESSEE DEPARTMENT OF CORRECTION

# EMPLOYEE MEDICAL SCREENING

**TDOC WORK LOCATION:** _____

Print Employee's Full Name: _____
*Last* *First* *Middle*

_____ _____
*LAST **4-DIGITS** OF SS NUMBER* *DATE OF BIRTH*

Please check "√" all conditions that apply to your current health and briefly explain in the space provided below.

| | | | | | |
|---|---|---|---|---|---|
| **1.** | Asthma | ☐ | **12.** | Kidney Infection/Stones/Disease | ☐ |
| **2.** | Back problems | ☐ | **13.** | Peptic Ulcers | ☐ |
| **3.** | Cancer | ☐ | **14.** | Rheumatic Fever | ☐ |
| **4.** | Seizures, narcolepsy | ☐ | **15.** | Do you volunteer at a homeless shelter on a regular basis? | ☐ |
| **5.** | Diabetes | ☐ | **16.** | Tuberculosis (TB): Persistent/ productive cough, weight. loss, night sweats, fever, loss of appetite, bloody sputum | ☐ |
| **6.** | Foot problems | ☐ | **17.** | Have you ever had a positive TB skin test? | ☐ |
| **7.** | Headaches | ☐ | **18.** | Have you ever been told you have Tuberculosis? | ☐ |
| **8.** | Heart attack or heart disease | ☐ | **19.** | Have you ever taken medication for Tuberculosis? | ☐ |
| **9.** | Hernia | ☐ | **20.** | Were you ever given BCG? | ☐ |
| **10.** | High Blood Pressure | ☐ | **21.** | Do you have any allergies? | ☐ |
| **11.** | Indigestion | ☐ | **22.** | Are you under the care of a physician for a chronic illness of injury? | ☐ |

Explain the above checked conditions and list all medications, illnesses, injuries, and operations.

_____

_____

_____

_____

_____

TB Tests:
IGRA Blood Test: Date: _____ Result: _____ Date: _____

| DATE | ANTIGEN | LOT# | SITE | DATE READ | REACTION IN MM | CHEST X RAY DATE/RESULT | NURSE |
|---|---|---|---|---|---|---|---|
| | TUBERSOL | | FA | | | | |
| | TUBERSOL | | FA | | | | |

Blood Pressure: _____ Pulse: _____ Respiration: _____

I certify that to the best of my knowledge that I am not affected with any form of disease or disability which would interfere with the performance of the duties of the position for which I am applying. I authorize the release to and use by the Tennessee Department of Correction any medical records needed to verify the answers given.

| Employee Signature | Date | Examining Medical Professional Signature | Date |
|---|---|---|---|
| _____ | _____ | _____ | _____ |

Authorized by: _____ Phone: _____
Human Resources Manager/Designee

Date: _____ Fax: _____

TENNESSEE DEPARTMENT OF CORRECTION

# INMATE/EMPLOYEE TUBERCULOSIS SCREENING TOOL

INSTITUTION

☐ Employee ☐ Inmate

Inmate Name (Printed) | TDOC ID

Employee Name (Printed) | Last four (4) digits of Employee SS#

*Tennessee Department of Correction (TDOC) Policy requires annual screening for tuberculosis. This tool is to be used annually and whenever tuberculosis is suspected.*

Have you experienced any of the following symptoms within the last year?

| | | YES | NO |
|---|---|---|---|
| 1. | Prolonged cough (*lasting 3 weeks or longer*) | ☐ | ☐ |
| 2. | Productive cough (*if yes, state color*) | ☐ | ☐ |
| 3. | Coughing up blood | ☐ | ☐ |
| 4. | Chest pain | ☐ | ☐ |
| 5. | Get tired easily | ☐ | ☐ |
| 6. | Weight loss (*if yes, how many lbs._____, time period _____*) | ☐ | ☐ |
| 7. | Loss of appetite | ☐ | ☐ |
| 8. | Night sweats | ☐ | ☐ |
| 9. | Fever or chills | ☐ | ☐ |

| | | |
|---|---|---|
| Are you immunocompromised? (Diabetes, End stage renal disease, cancer, HIV, prolonged corticosteroid therapy, gastric bypass or immunosuppressive arthritic therapy) | ☐ | ☐ |
| Were you given BCG at any time? | ☐ | ☐ |
| Have you traveled to Asia, the Caribbean, South America, or Africa within the last year? (***employee only***) | ☐ | ☐ |
| Have you ever had a positive TB skin test or positive TB blood test? | ☐ | ☐ |
| Have you ever been told that you had tuberculosis? | ☐ | ☐ |
| Do you Volunteer to a homeless shelter on a regular basis? (***employee only***) | ☐ | ☐ |
| Have you ever taken medication for TB? | ☐ | ☐ |

List medications: _____ Treatment date(s): _____

Most recent TST/IGRA Date: _____ Result: _____ mm: _____

Most recent Chest-X-ray Date: _____ Result: _____

Current Test PPD (Brand): _____ Lot#: _____ Exp Date: _____

Date placed: _____ Site: _____ Nurse: _____

Date read: _____ Result: _____ mm Nurse: _____

Date of IGRA _____ Result: _____ Nurse: _____

**Exposure Control Methods Implemented**

| | |
|---|---|
| ☐ No action required | ☐ Physician/Mid-Level Referral; |
| ☐ Segregated from population | ☐ Immediate physician referral |
| ☐ Surgical mask on patient | ☐ Prepare for transfer to All facility |
| ☐ Placed in All | ☐ Recommend Quanti-FERON Blood Test |

Physician review required for all positive findings:

Employee/Inmate Signature | Date

Reviewing Physician/Mid-Level Referral Signature | Date

Health Care Provider Signature | Date