CREATED: 3/2/16
ARCHIVED: N/A
OWNER: Employee Health
PURPOSE: New Hire Assessment

Employee Health Screening Questionnaire

Name: _____ **Date of Birth**: _____**Today's Date:** _____
Position/Dept: _____ **Email:** _____
***I authorize JH Employee Health Department to retrieve any vaccination records from the Washington State Immunization Information System.**
SIGNATURE:_____
Allergies and description of reactions: _____□**NONE**
Current Medications: _____□**NONE**
Latex Sensitivity Allergy: ☐ Yes ☐ No

Do you have a history of:	**YES**	**NO**	**If yes, please explain**
Asthma, Shortness of Breath, or Lung problems	☐	☐	
Heart, blood pressure problems	☐	☐	
Seizures	☐	☐	
Hepatitis; if yes type: _____	☐	☐	
Diabetes	☐	☐	
Allergic reactions that interfere with breathing.	☐	☐	
Claustrophobia	☐	☐	

Work Related Injury/Exposures

A previous workers' compensation claim or disability WILL NOT prevent you from working at Jefferson Healthcare if you are able to perform the essential functions of the job with or without reasonable accommodations.

1. Do you currently have Preferred Worker status or an open Workers' Compensation claim? ☐ Yes ☐ No
If Yes, please explain_____
2. Have you ever had a blood borne pathogen exposure? ☐ Yes ☐ No
If Yes, please explain: _____

HEPATITIS B VACCINATION DECLINATION FORM
OSHA REGULATION (Standard- 29 CFR 1910.1030 App A)

FOR JOBS WITH POTENTIAL EXPOSURE TO BLOOD AND BODY FLUIDS

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I **decline** hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

I **decline** the Hepatitis B vaccination at this time, due to:

- Have had vaccination series and will be awaiting titer results
- Have full vaccination series & positive titer
- Position does not expose me to blood or infectious material
- Allergic
- Starting series

_____ _____
Employee Signature Date

_____ _____
EH Nurse Signature Date

RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE
(Required and Adapted from WISHA/OSHA Respiratory Protection Program 29 CFR 1910.134)

TO THE EMPLOYEE:

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your director or supervisor must not look at or review your answers. This is kept in your occupational health record in Employee Health which is separate from your personnel file kept in Human Resources.

PART 1

Section 1 (Mandatory): The following information must be provided by every employee who has been selected to use any type of respirator (please PRINT).

NAME_____ **DOB**_____ **BADGE NUMBER**_____

DEPT_____ **TODAY'S DATE**_____ **GENDER** ☐Male ☐ Female

HEIGHT_____ft _____in **WEIGHT**_____ **JOB TITLE**_____

A phone number where you can be reached by the health care professional who reviews this questionnaire (include Area Code)_____

WHAT TYPE OF RESPIRATOR(S) WILL YOU BE USING? (you can check more than one)

☐N95 disposable respirator (filter mask, non-cartridge only) ☐Other type (half/full face mask, PAPR, SCBA, Surgical)

Have you ever worn a respirator? ☐No ☐Yes, what type(s) _____

Part 2 (Mandatory): QUESTIONS 1- 9 BELOW MUST BE ANSWERED BY EVERY EMPLOYEE WHO HAS BEEN SELECTED TO USE ANY TYPE OF RESPIRATOR.

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? **Yes** ☐ **No** ☐

2. Have you ever had any of the following conditions?
   ☐ Seizures (fits) ☐ Diabetes (sugar disease) ☐ Allergic reactions that interfere with your breathing ☐ Trouble smelling odors
   ☐ Claustrophobia (fear of closed-in places)
   ☐ **NONE OF THE ABOVE**

3. Have you ever had any of the following pulmonary or lung problems?
   ☐ Asbestosis ☐ Asthma ☐ Chronic bronchitis ☐ Emphysema ☐ Pneumonia ☐ Tuberculosis (TB) ☐ Silicosis
   ☐ Pneumothorax (collapsed lung) ☐ Lung cancer ☐ Broken ribs ☐ Any chest injuries or surgeries
   ☐ Any other lung problems you've been told about_____
   ☐ **NONE OF THE ABOVE**

4. Do you currently have any of the following symptoms of pulmonary or lung illness?
   ☐ Shortness of breath ☐ Shortness of breath when walking on level ground or walking up a slight hill or incline
   ☐ Shortness of breath when walking with other people at an ordinary pace on level ground
   ☐ Have to stop for breath when walking at your own pace on level ground ☐ Shortness of breath when washing or dressing
   ☐ Shortness of breath that interferes with your job ☐ Coughing that produces phlegm (thick sputum)
   ☐ Coughing that wakes you early in the morning ☐ Coughing that occurs mostly when you are lying down
   ☐ Coughing up blood in the last month ☐ Wheezing ☐ Wheezing that interferes with your job
   ☐ Chest pain when you breathe deeply ☐ Any other symptoms that you think may be related to lung problems
   ☐ **NONE OF THE ABOVE**

5. Have you ever had any of the following cardiovascular or heart problems?
   ☐ Heart attack ☐ Stroke ☐ Angina ☐ Heart failure ☐ Swelling in your legs or feet (not caused by walking)
   ☐ Heart arrhythmia (irregular heartbeat) ☐ High blood pressure ☐ Any other heart problems you've been told about
   ☐ **NONE OF THE ABOVE**

6. Have you ever had any of the following cardiovascular or heart symptoms?
   ☐ Frequent pain or tightness in your chest ☐ Pain or tightness in your chest during physical activity
   ☐ Pain or tightness in your chest that interferes with your job ☐ past two years, noticed your heart skipping or missing a beat
   ☐ Heartburn or indigestion not related to eating ☐ Any other symptoms that you think may be related to heart problems
   ☐ **NONE OF THE ABOVE**

7. Do you currently take medication for any of the following problems?
   ☐ Breathing or lung problems ☐ Heart trouble ☐ Blood pressure ☐ Seizures (fits)
   ☐ **NONE OF THE ABOVE**

8. If you have used a respirator, have you ever had any of the following?
   ☐ Eye irritation ☐ Skin allergies/rashes ☐ Anxiety ☐ General weakness/fatigue
   ☐ Any problem that interferes with your use of a respirator ☐ Any significant structural changes to your face/head
   ☐ **NONE OF THE ABOVE**

9. Would you like to talk with a healthcare professional who will review this questionnaire about your answers to this questionnaire?
   ☐ YES ☐ NO

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JEFFERSON HEALTHCARE EMPLOYEE HEALTH SERVICES

***I have been educated on *the instructions for use, reasons for usage, donning and doffing, storage, and replacement indicators for this respirator.* ***

Badge ID#:_____ Dept: _____

Name: _____ DOB: _____

Employee Signature: _____Date:_____

Mask fitted for: 3M 1860S/ 1804/ 1870+/ 1860/ 2322/ PAPR/ CAPR/ Surgical Mask

Fit Process: Qualitative Saccharin/Biterex or Quantitative Machine Fit Test

◯ **Voluntary N95 usage: OSHA Appendix D to Sec. 1910.134 form provided:** _____

Person reviewing this questionnaire/performing testing/educating employee:

(EH Nurse/ designee) _____ Date_____

Color Vision Screening

Employee Name: _____ Date: _____
Badge ID#: _____ Position/ Department: _____

Plate #1	**12**	
Plate #2	**8**	
Plate #3	**5**	
Plate #4	**29**	
Plate#5	**74**	
Plate#6	**7**	
Plate#7	**45**	
Plate#8	**2**	
Plate# 9	**None**	
Plate#10	**16**	
Plate#11	**Line**	
Plate#12	**35**	
Plate#13	**96**	
Plate#14	**Line**	

◯ **PASS** ◯ **FAIL**

***If I did not pass, I agree, for the safety of my patients, to allow another co-worker to read, interpret, and document on any Point of Care Testing or color changing tests (i.e. color changing tests) that I might perform.**

Employee Signature:_____
Employee Health Nurse: _____
*Mgr. notified by email if employee did not pass (Initials/date) _____

ISHIHARAS TESTS FOR COLOUR DEFICIENCY INTERPRETATION

*If 10 or more plates are read normally, the color vision is regarded as normal.
* If only 7 or less than 7 plates are read normally, the color vision is regarded as deficient. However, in reference to plate 9, only those who read the numerals 2 and read it easier than those on plate 8 are recorded as abnormal. Employee acknowledges that he/she has color blindness and must not interpret results of point of care testing (POCT). Employee agrees to have another co-worker who is not color blind interpret POCT results for accuracy. Employee will notify his/her manager of being color blind so a co-worker will be able to assist in interpreting the POCT results.

Jefferson Healthcare

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TB SYMPTOM SCREENING SAFETY PROGRAM
MEDICAL QUESTIONNAIRE SURVEILLANCE

PURPOSE:
Tuberculosis (TB) screening through use of this medical questionnaire is required for all employees as an assessment tool who are a new hire or have had a prior positive TB skin test or positive Interferon Gamma Release Assay (IGRA) lab test. An annual chest x-ray is not recommended by the Centers for Disease Control unless employee is symptomatic. TB is transmitted by people with active TB who cough, sneeze, talks, or sings in the vicinity of others. Latent tuberculosis has the potential to activate in times of stress or when the body is immunocompromised and spread disease to others, including friends, family, and patients. Latent TB is treatable! If you have been diagnosed with latent TB It is highly recommended to see your medical provider if you have not been treated for latent TB infection (LTBI).

YOU MAY FAX THIS FORM TO 360-344-1006, BRING IN, OR SEND ORIGINAL IN INTEROFFICE MAIL.

NAME:_____ BADGE#:_____ DATE:_____

DEPT: _____SIGNATURE_____

Have you ever had or do you now have any of the following:

		*YES	NO
1.	Persistent cough longer than 3 weeks	o	o
2.	Night sweats	o	o
3.	Unexplained weight loss	o	o
4.	Unusual fatigue	o	o
5.	Anorexia (loss of appetite) for more than two months	o	o
6.	Hemoptysis (coughing up blood)	o	o
7.	Persistent temperature elevations over the past few months	o	o
8.	History of active TB within the past year or recently diagnosed TB and no subsequent disease inactivity	o	o
9.	Exposure to person with active TB in the past 2 years without personal protection equipment	o	o
10.	Abnormal chest x-ray (upper lobe infiltrates, cavitation, other infiltrates - if no other cause)	o	o
11.	History BCG vaccination (vaccine against TB)	o	o
12.	History of positive Quantiferon Gold or T-Spot (blood test confirming TB)	o	o
13.	Current use of immunosuppressive medications	o	o
14.	Have you ever had past 3-9 months of INH antibiotic therapy for TB **(If Yes- please send in record of INH treatment completion)**	o	o

***Please explain YES answers:** _____

*Please complete and return this form to Employee Health Services. If you have any questions or if you have any of the above symptoms at anytime, please notify your medical provider and Employee Health as soon as possible at # **360-385-2200 ext 2084.** Thank you for your cooperation.