New Employee Health Assessment

Post-offer health assessments are performed at two locations: Employee Health at Floyd Medical Center in Rome and Employee Health at Polk Medical Center in Cedartown.

For ***both*** Floyd Medical Center and Polk Medical Center, please bring the following packet and completed forms (to follow this page) to your assessment. *If the completed new hire paperwork is not with you when you arrive at your appropriate Employee Health department, your appointment may need to be rescheduled, delaying your start date.*

While you ***do not need to pay out of pocket*** to have the following vaccinations performed before your appointment, we ***do*** ask that you make an effort to locate and bring the following records with you to the appointment:

- MMR and Varicella (chickenpox)
    - Provide record of immunization or proof of lab titer results
- Hepatitis B
    - Provide record of immunization or proof of lab titer results; the vaccination series can also be started at your appointment
- Influenza
    - Between October 1 and March 31, bring proof of influenza vaccination

Directions to Floyd Medical Center Employee Health Department: Parking is available in the main campus parking lot.

- Enter the hospital at the main entrance next to the fountain.
- Walk to the right side of the lobby toward the South Elevators. There will be a black piano next to these elevators.
- Take the elevator to the first floor.
- After exiting the elevator, *take a few steps forward;* then go **right** at the first hallway. There will be a sign for Employee Health; take a **left** at this hallway. **Continue straight.** Make a **right** at the next hallway. We are the first door on the **right −** Epidemiology/Employee Health.

Directions to Polk Medical Center Employee Health Department: Enter the main hospital lobby, and go to your left to the Guest Relations Desk. Ask for Employee Health to be called announcing your arrival. Someone from Employee Health will come and escort you to the department.

Employee Health Assessment- Initial Preplacement

The purpose of this evaluation is to screen for communicable diseases and to determine if there are any physical, mental, or emotional impairments that could affect your ability to perform the job that you have been offered. Whenever such impairment is identified, we will attempt to specify restrictions that may allow you to perform the job safely while still successfully performing the essential functions of the job. This evaluation is not a comprehensive health review to identify hidden disease or to offer medical treatment.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Name (Print) *first name, middle initial, last name*	Preferred Name:
Address:	Cell/Home phone:
City, State, Zip Code:	Birth Date:
Previous job title/work location:	Email Address:
Title of the job you have been offered:	Do you require licensing? **Y** ☐ **N** ☐
Dept./work area:	Proposed Start Date:
Supervisor/Manager:	Hospital Campus: ☐ FMC ☐ FBH ☐ PMC

Employment Information

Will you work with: ☐ **Blood Body Fluid Exposure** ☐ **Patient Contact**

Do you have any current disability or physical condition requiring restricted activity? ☐ Yes ☐ No

Do you have any lifting restrictions? ☐ Yes ☐ No

If yes, state restrictions:

If yes, are these restrictions:
☐ Permanent ☐ Temporary until

Do you have decreased ability to lift, carry, push/ pull, and transfer patients and/or equipment/ materials as described in your employment interview and/or health assessment.
Y ☐ **N** ☐

Have the physical demands of the job been described to you?
☐ Yes ☐ No ☐ Uncertain

Please state your understanding of the amount of weight and frequency of lifting required in this job:
_____ lbs. (*ex. Up to 10, 25, 30, 50, 75, or over 75 lbs.)*
_____ frequency *(ex. Up to 1/3, 2/3,or whole shift)*

Can you perform the essential functions of this job?
☐ Yes ☐ No ☐ Uncertain

If no, will you require a job modification to accommodate a disability?
☐ Yes ☐ No ☐ Uncertain

If yes, please explain:

Occupational History – List your last three positions, starting with the most recent.

	TITLE	BRIEF JOB DESCRIPTION	DUTIES PERFORMED
1			
2			
3			

I certify *that the following information is true to the best of my knowledge. I understand and agree to authorize Employee Health to review any information (including, but not limited to, information relating to psychiatric/psychological and alcohol and substance abuse diagnosis and treatment, if any such information exists) at Floyd or other health care providers for purposes related to my fitness for employment. I agree to any reasonable subsequent testing or evaluation deemed necessary to determine my fitness to perform this job, and I authorize the examining provider to forward pertinent information to those who would perform such testing or evaluation. I understand that Floyd is relying upon my representations contained herein and they are substantial employment factors. I further understand that misrepresenting the facts may result in forfeiture of this employment opportunity. I understand that this information will become part of my confidential Employee Health record and is not shared with management.*

Signature of applicant	**Date**

Functional Self-Assessment **Name:**_____

(*Check all that apply)*

1. Have you developed any of the following?

Y ☐ **N** ☐ Loss of vision in either eye that cannot be corrected

Y ☐ **N** ☐ Loss of vision requiring correction
select type of correction needed (if applicable):

☐ Near Correction ☐ Far Correction

☐ Eyeglasses ☐ Lasik ☐ Contact Lenses

Y ☐ **N** ☐ Loss of hearing that is corrected.
Y ☐ **N** ☐ Loss of hearing that is not corrected.

2. Do you have decreased function in any of the following?

Y ☐ **N** ☐ Either arm/hand, including grip/reach, use of fingers

Y ☐ **N** ☐ Neck, or lower back (such as arthritis, or pinched nerve)

Y ☐ **N** ☐ Hips, knees, ankles, or feet

3. Do you have decreased ability in any of the following?

Y ☐ **N** ☐ To stay awake or maintain consciousness (due to such causes as seizures, diabetes, or sleep disorder)

Y ☐ **N** ☐ To breathe or maintain endurance (due to such causes as asthma, emphysema, or angina)

Y ☐ **N** ☐ To fight off infection (due to such causes as immune deficiency, diabetes, HIV infection, drugs for Rheumatoid arthritis, cancer, and other illnesses).

If yes to any of the prior, provide comments:

Continue if needed:

4. Do you have physical problems (such as seizure disorder, diabetes, allergies) or mental/emotional problems (such as anxiety, attention deficit disorder, or claustrophobia) that could interfere with any of the following?

Y ☐ **N** ☐ Working with soaps, detergents

Y ☐ **N** ☐ Wearing gloves

Y ☐ **N** ☐ Using a respirator

Y ☐ **N** ☐ Using latex products

Y ☐ **N** ☐ Working rotating shifts (nights, evenings)

Y ☐ **N** ☐ Working with radiation or chemotherapy agents

Y ☐ **N** ☐ Managing multiple tasks at one time

Y ☐ **N** ☐ Focusing on job tasks

If yes to any of the above, provide comments:

Y ☐ **N** ☐ 5. Have you been vaccinated against varicella?

Y ☐ **N** ☐ 6. Have you had the Hepatitis B vaccine series?

Year Completed Series _____

Y ☐ **N** ☐ 7. Do you have questions regarding general health, Reproductive health, or other safety issues at work?

8. List ALL current medications/treatments (including non prescription), the condition treated, and date begun.

Medication	Dosage	Condition	Date

9. ☐ Yes ☐ No Do you now or have you ever had a substance abuse/dependence problem?

10. ☐ Yes ☐ No Do you now or have you ever had an alcohol abuse/dependency problem?

Reviewer's Signature	Date of signature - *mm/dd/yy*

Employee Compliancy Screening

Name: _____ **Employee #:** _____ **Date:** _____

Mailing Address: _____**City:** _____ **State:** ____ **Zip:** _____

Email Address: _____ **Age:** _____ **DOB:** _____

Department: _____ **Job Title:** _____ **Phone #:** _____

Please answer the following questions:

1. Are you currently taking any of the following medications: Prednisone, Enbrel, Humira or Remicade? Yes _____ No _____
2. Have you had a cough for longer than 3 weeks? Yes _____ No _____; Are you coughing up blood? Yes _____ No _____
3. Do you have night sweats (non-hormonal)? Yes _____ No _____
4. Weight loss >10 pounds in one month without trying? Yes _____ No _____
5. Have you been tired or weak (more so than usual)? Yes _____ No _____ if yes, how long?_____
6. Have you had a fever? Yes _____ No _____
7. If you have **radiation exposure on the job**, have you experienced: __ joint pain __ weakness __ fatigue __ loss of appetite __ lymph node enlargement __ unexplained weight loss __ **None**
8. If you have **antineoplastic drug exposure on the job**, have you experienced: __ lightheadedness __ dizziness __ hair loss __ infertility __ spontaneous abortions __ fetal malformations __ **None**
9. If you have **formaldehyde exposure on the job**, have you experienced: __ itching __ shortness of breath __ chest tightness __ wheezing __ coughing up phlegm __ **None**
10. Do you have direct patient contact? Yes _____ No _____
11. Do you wear artificial nails? Yes _____ No _____
12. Have you traveled outside of the United States in the past 12 months? __ Yes __ **No** If yes, what country? _____
13. Were you born outside of the United States? __ Yes __ **No** If yes, have you ever had a BCG vaccination? __ Yes __ **No**

Hand Hygiene Statement of Commitment

Hand hygiene is an expected and mandatory requirement of all Floyd employees. Failure to meet this requirement will result in disciplinary action up to and including termination. By signing this "Statement of Commitment", I pledge to follow the Floyd Medical Center policy about hand hygiene. That policy includes the following:

1. **I have read and understand the hand hygiene policy of Floyd Medical Center.**
2. **I promise to perform hand hygiene before and after each patient contact.**
3. **I promise to perform hand hygiene before I perform an aseptic task.**
4. **I promise to wash my hands/use hand sanitizer before and after putting on gloves when used for patient care.**
5. **I promise to wash my hands after contact with blood/body fluids or my hands are visibly soiled.**
6. **I promise to perform hand hygiene after contact with the patient's physical environment.**
7. **I promise to be a hand hygiene role model for my co-workers.**
8. **I promise to verbally encourage all of my co-workers to always follow hand hygiene good practices.**

Employee Statement: The information provided is true and complete to the best of my knowledge. I understand falsification of the information provided may be grounds for dismissal.

Employee Signature: _____ **Date:** _____

To be completed ONLY if you have or will have direct patient contact

This questionnaire is used in accordance with OSHA standard 1910.134 (e) (2) (i) to determine whether or not you have a medical condition that may affect your ability to safely wear a N95 respirator mask. All information is confidential.

Annual fit testing is an OSHA mandated procedure.

Medical Evaluation:

Name:				Employee #:		
Department:				Date:		
1. When using respirator, work is: ☐ Light ☐ Moderate ☐ Heavy	2. Shifts per week respirator is worn: ☐ < than 1hr ☐ 1-4 hrs ☐ Almost every shift			3. Length of time respirator is worn during a shift: ☐ Less than 1 hr ☐ 1-5 hrs ☐ 5-12 hrs		
Medical History	Has a doctor ever told you that you have any of the following?	**Yes**	**No**		**Yes**	**No**
	1. Cardiac problems:			5. Lung Disease: asthma, emphysema		
	Angina, heart attack, CHF			6. Hypertension		
	2. Epilepsy or Seizures			7. **Are you allergic to natural rubber latex?**		
	3. Smoking history: __pk/day / ___yrs Quit ___yrs Never smoked ___			Please explain "yes" answers:		
	4. Please list all medications:				**Yes**	**No**
Review of Systems	8. Are you short of breath at rest?					
	9. Do you get short of breath when walking?					
	10. Do you get chest pain with certain activities?					
	11. Do you have medical problems that might interfere with respirator use?					
	12. Have you ever had problems wearing a respirator?					
	13. Are you allergic to saccharin?					
	Please explain "yes" answers:					

Employee Education & Training:

- Explanation of airborne precautions and OSHA requirements
- How to put on, remove, inspect and check the seal of the respirator
- Necessity and care of the N95 respirator
- Identification of the program administrator

I have participated in fit testing and training of the OSHA Fit test under respiratory Protection 1910.134 (f) requirement. I understand I am to notify Employee Health and/or my immediate supervisor if I experience any problems or have questions.

Employee Signature: _____ **Date:** _____

The results (below) will be completed by Employee Health

Fit Testing: (For Employee Health Documentation)

Your evaluation revealed the following:

[ ] A. You are approved to wear a particulate respirator **without restrictions.**

[ ] B. You are approved to wear the respirator with the following **restriction(s):**

_____ Do not wear the respirator if wheezing or short of breath;

_____ Notify supervisor if you have difficulty wearing the respirator.

[ ] C. _____ You are **not approved** to wear a particulate respirator.

The supervisor _____ and the employee were notified of the results of this evaluation and of any further evaluation or treatment recommended.

Respirator: Brand and Model Number:
[ ] 3M 1860 [ ] Gershon Other: _____

Size:
[ ] Small [ ] Regular [ ] One Size

Evaluator Signature: _____ **Date:** _____

Appendix A

OSHA Respirator Medical Evaluation Questionnaire
Mandatory – New Employee

Name:_____ Date: _____
Address:_____ Telephone: _____
SSN:_____ Date of Birth: _____
Occupation: _____

The following information must be provided by every employee where job duties may require the use of any type of respirator (please print).

Part A (Mandatory)

1. Sex (circle one) Male Female
2. Height _____ft. _____in
3. Weight _____lbs.
4. Job title _____ Department _____

5. Have you ever worn a type of respirator (circle one):	Yes	No
If yes, what type(s): _____		
6. Do you *currently* smoke tobacco or have you smoked tobacco in the last month:	Yes	No
7. Have you ever had any of the flowing conditions?		
a. Seizures (fits):	Yes	No
b. Diabetes (sugar disease):	Yes	No
c. Allergic reactions that interfere with your breathing:	Yes	No
d. Claustrophobia (fear of closed-in places):	Yes	No
e. Trouble smelling odors:	Yes	No
8. Have you ever had any of the following pulmonary or lung problems?		
a. Asbestosis:	Yes	No
b. Asthma:	Yes	No
c. Chronic bronchitis:	Yes	No
d. Emphysema:	Yes	No
e. Pneumonia:	Yes	No
f. Tuberculosis:	Yes	No
g. Silicosis:	Yes	No
h. Pneumothorax (collapsed lung):	Yes	No
i. Lung cancer:	Yes	No
j. Broken ribs:	Yes	No
k.Any chest injuries or surgeries:	Yes	No
l. Any other lung problems that you've been told about:	Yes	No
9. Do you *currently* have any of the following symptoms of pulmonary or lung illness?		
a. Shortness of breath:	Yes	No
b. Shortness of breath when walking fast on level ground or up a slight hill or incline:	Yes	No
c. Shortness of breath when walking and talking at an ordinary pace on level ground:	Yes	No
d. Have to stop for breath when walking at your own pace on level ground:	Yes	No
e. Shortness of breath when washing or dressing yourself:	Yes	No
f. Shortness of breath that interferes with your job:	Yes	No
g. Coughing that produces phlegm (thick sputum):	Yes	No
h. Coughing that wakes you early in the morning:	Yes	No
i. coughing that occurs mostly when you are lying down:	Yes	No
j. Coughing up blood in the last month:	Yes	No
k. Wheezing:	Yes	No
l. Wheezing that interferes with your job:	Yes	No
m. Chest pain when you breathe deeply:	Yes	No
n. Any other symptoms that you think may be related to lung problems:	Yes	No
10. Have you *ever had* any of the following cardiovascular or heart problems?		

a. Heart attack: Yes No
b. Stroke: Yes No
c. Angina: Yes No
d. Heart failure: Yes No
e. Swelling in your legs or feet (not caused by walking): Yes No
f. Heart arrhythmia 9heart beating irregularly): Yes No
g. Any other heart problem that you've been told about: Yes No

11. Have you *ever had* any of the following cardiovascular or heart symptoms?
a. Frequent pain or tightness in your chest: Yes No
b. Pain or tightness in your chest during physical activity: Yes No
c. Pain or tightness in your chest that interferes with your job: Yes No
d. In the past two years, have you noticed your heart skipping or missing a beat: Yes No
e. Heartburn or indigestion that is not related to eating: Yes No
f. Any other symptoms that you think may be related to heart or circulation problems: Yes No

12. Do you *currently* take medication for any of the following problems?
a. Breathing or lung problems: Yes No
b. Heart trouble: Yes No
c. Blood pressure: Yes No
d. Seizures (fits): Yes No

13. If you've used a respirator, have you *ever had* any of the following problems?
If you've never used a respirator, check the following space _____
a. eye irritation: Yes No
b. Skin allergies or rashes: Yes No
c. Anxiety: Yes No
d. General weakness or fatigue: Yes No
e. Any other problem that interferes with your use of a respirator: Yes No

14. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? Yes No

Part B (Optional)

1. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g. gases, fumes, or dust), or have you come into skin contact with hazardous chemicals: Yes No
If "yes", name the chemical(s) if you know them: _____

2. Have you ever worked with any of the materials, or under any of the conditions listed below?
a. Asbestos: Yes No
b. Silica (e.g. in sandblasting): Yes No
c. Tungsten/cobalt (e.g., grinding or welding this material): Yes No
d. Beryllium: Yes No
e. Aluminum: Yes No
f. Coal (for example, mining) Yes No
g. Iron: Yes No
h. Tin: Yes No
i. Dusty environment: Yes No
j. Any other hazardous exposures: Yes No

For any "yes" answers, please describe exposures: _____

3. List any second jobs or side business you have: _____

4. List your current and previous hobbies: _____

_____ _____
Employee Signature Date