Welcome to Lehigh Valley Health Network! Employee Health Services is dedicated to protecting you and our patients from infectious diseases and providing a safe and healthy environment for all for both patients and LVHN colleagues.

All newly hired colleagues are required to complete a health assessment and drug and alcohol screen prior to employment. The health assessment and any resulting requirements are based on LVHN policies, Occupational Safety and Health Administration Standards (OSHA) and Centers for Disease Control (CDC) recommendations. The assessment and any required immunizations and tests must be completed before beginning employment and orientation. The forms in this section must be completed for the pre-employment medical assessment. To expedite your assessment, we ask that you download and print all the forms and have them completed prior to your scheduled appointment.

Pre-employment assessments are scheduled through Talent Acquisition as part of the new hire onboarding process. If you do not have your pre-employment assessment scheduled, please contact your recruiter. If you need to change your appointment date or time, please contact the Health Works location directly (phone numbers are below). Please be aware that pre-employment assessments scheduled less than five (5) days before your assigned start date may cause your start date to be delayed.

Location	Address	Phone Number
Healthworks Allentown	1243 S Cedar Crest Blvd	610-402-9230
Healthworks Bethlehem	1770 Bathgate Rd, Suite 200	484-884-2249
Healthworks Easton	2101 Emrick Blvd	610-866-9675
Healthworks Trexlertown	6900 Hamilton Blvd	610-402-0047

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II 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.

Please bring the following documents with you to your medical assessment*:

- Documentation of 2 MMR vaccines (both given after your 1st birthday) or a blood test result indicating immunity to measles, mumps and rubella.
- Documentation of 2 varicella (chicken pox) vaccinations or a blood test indicating immunity to varicella or physician documented chicken pox disease.
- Documentation of 3 doses of Hepatitis B vaccine, if previously vaccinated.
- A blood test indicating the presence of Hepatitis B antibodies (if done).
- Provide written documentation of two tuberculin skin test results during the 12 months prior to beginning practice, one of which needs to be within the past 3 months, or a IGRA blood test done within the past 3 months. If previous tuberculin skin test result or IGRA blood test is positive, documentation of a chest xray within the past 3 months is needed.
- If history of latent Tuberculosis disease (a □PPD or + IGRA), documentation of prophylactic treatment is requested. A copy of a recent chest x-ray reading, if you had a chest x-ray within the past three months.
- Documentation of influenza vaccine, if you start employment during the months of September through April.

*If you do not have documentation of MMR and varicella vaccines or laboratory evidence of immunity, your blood will be drawn during your physical to determine your immunity status. If you are not immune, you will be

required to be immunized, free of charge through Employee Health Services, **BEFORE** you start employment. See employee health information below.

*If you have not received a flu vaccination and are starting employment during the months of September through April, you must be vaccinated **BEFORE** you start employment. You can be immunized, free of charge by Employee Health Services: See employee health information below.

*If you have not been vaccinated for Hepatitis B, and you may be exposed to blood or body fluid, the vaccine will to be offered to you free of charge at the time of your assessment. It is strongly encouraged for anyone at risk of a blood or body fluid exposure.

The following requirements must be met in order to obtain medical clearance to start employment:

- A negative urine drug screen. If you take prescription medications, please be prepared to present proof of your prescriptions (the prescription bottle with prescription label on it).
- If you have a disability, please be ready to specify what your limitations are.
- If you have restrictions related to a workers compensation injury (you have permanent restrictions if you received any settlement money), you must bring documentation of these restrictions. If you do not bring this documentation, your physical cannot be completed and you cannot start employment. Your physical will be rescheduled and/ or you clearance will be held until employee health receives the restrictions.

If you have questions, please call Employee Health Services at the number below. Thank you for your interest in Lehigh Valley Health Network. We look forward to working with you for a safe and healthful workplace.

Employee Health – LVHN-CC

Phone: 610-402-8869 Fax: 610-402-1203

1200 S Cedar Crest Boulevard, Allentown, PA 18103

3rd Floor Anderson Wing, (Main entrance, take purple elevators next to main Cafeteria, follow signs)

Hours of Operation: Mon/Fri: 7:00a – 4:00p; Tue/Wed/Thurs 7:30a – 4:00p

Walk-In Hours (No appt necessary for routine occupational health services such as immunizations or TB testing):

Mon 7a - 8a, 1:30p – 3:30p	**Tue** 1p - 3p	**Wed** 7:30a - 8:30a	**Thurs** 1:30p – 3:30p	**Fri** 7a - 8a

Physician Appointments: Please call 610-402-8869

Employee Health – LVHN-M

Phone: 484-884-7098 Fax: 484-884-7324

2545 Schoenersville Road, Bethlehem

South Entrance (Good Shepherd Rehab Entrance), thru lobby to the back elevator, turn right, 3rd door on right

Hours of Operation: Mon/Tues/Wed/Fri: 7:30a – 4:00p; Thurs 7:00a – 3:30p

Walk-In Hours (No appt necessary for routine occupational health services such as immunizations or TB testing):

Mon 1:30p – 3:30p	**Tue** 7:30a -10a	**Wed** 2p – 3:30p	**Thurs** 7a - 10a	**Fri** 8a - 10a

Physician Appointments: Please call 484-884-7098

***Tuberculosis skin testing will NOT be done on Thursdays, as tests must be read in 48 -72 hours.**

EMPLOYEE HEALTH SERVICES
Cedar Crest Blvd & I-78 PHONE: (610) 402-8869
FAX: (610) 402-1203

Muhlenberg Campus
PHONE: (484) 884-7098
FAX: (484) 884-7324

LVH.org
610-402-CARE

PRE-EMPLOYMENT/POST OFFER MEDICAL HISTORY AUTHORIZATION AND SUBSEQUENT PHYSICAL FORM

Name: _____SSN: _____ Position Hired For_____

I have reviewed this pre-employment post offer medical evaluation form and I agree to submit to a medical evaluation, laboratory studies, and possible physical examination and laboratory studies as a condition of employment at a Lehigh Valley Health Network subsidiary**. I understand that my employment is contingent upon successfully passing the medical evaluation including laboratory studies; the collection of blood, urine and saliva to screen for the presence of drugs/alcohol, and meeting the rubeola, varicella, rubella, mumps and influenza immunization requirements.** I acknowledge and understand that if I do not meet the standards established, I will be disqualified as an applicant for employment. I understand that if I am asked to provide additional medical documentation at the time of the evaluation, my evaluation cannot be completed until the requested documentation is received and evaluated. I understand that my employment cannot commence until my evaluation is completed.

I understand that if the laboratory reports the drug test positive, the information will be sent to the Medical Review Officer (MRO) for review and interpretation. MRO findings will be discussed with Human Resources.

I understand that my urine will be screened for cotinine, a nicotine metabolite, for the purposes of certifying my tobacco use status, should I elect to take LHVN benefits I understand that the results of the cotinine screening will be shared with the Benefits Counselors in Human Resources, for the sole purpose of benefits administration.

I understand I will be tested for communicable diseases, including tuberculosis, Hepatitis B and Hepatitis C. If the result indicates infection, an assessment of my job duties will be made to determine if I can perform the essential functions of my position with or without reasonable accommodation.

I understand I may be screened for immunity to several communicable diseases, depending upon the documentation I provide at the time of my evaluation. I understand that if acceptable documentation of disease or vaccination is not provided at the time of assessment, my blood will be drawn to determine immunity. If the laboratory test determines I am not immune, I understand I must be immunized **PRIOR** to my start date. I will not be permitted to start employment without the required immunizations. **I understand that ALL network employees are required to be immune to rubella, rubeola and mumps. Varicella immunity is required for network employees with patient contact. MMR & Varicella vaccines will be provided by the hospital free of charge when indicated. Annual tuberculosis screening may be required of some employees. Influenza vaccine is required of all employees with patient contact. Influenza vaccine is free of charge to all employees. I also understand that if I have patient contact, as defined in the LVHN Influenza Vaccination policy, I will be required to be immunized against influenza unless I request and am granted an exemption because of a valid medical reason or bonafide religious reason.** Hepatitis B vaccine is offered free of charge to all employees who are risk for blood and body fluid exposure. I understand that results of my pre-employment evaluation may be shared with my direct supervisor if it affects my work duty responsibilities.

I understand that any Pre-placement or Work Physical examination is for the determination of work status or ability to perform duties at a Lehigh Valley Health Network subsidiary only. It is not for new diagnosis of medical conditions or routine medical care. This examination and other information contained in my Employee Health file is not intended to be used or relied upon by third parties for their own purposes. This does not take the place of a personal/primary care physician's health care examination or treatment plan and I understand that I must return to my personal/primary care physician for this care.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II 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.

For Employee Health Use Only: **MR#_____**

Acknowledgement of Lehigh Valley Health Network Influenza Policy *

I understand that if I have patient contact as defined in the LVHN Influenza policy, I will be required to be immunized against influenza on an annual basis as a condition of employment unless I request and am granted an exemption because of a valid medical reason or bonafide religious reason.

Check one:

☐ I have a religious ☐ or medical ☐ reason preventing me from taking the influenza vaccine.

☐ I do not have a religious or medical reason preventing me from taking the influenza vaccine.

Signed: _____ Print Name: _____

If minor (under 18): _____
(Parent or Guardian Signature)

Date: _____

*** Vaccination (or proof of vaccination if immunized elsewhere) is required if employed during/between October – April**

Pre-placement Assessment and Subsequent Physical Examination Record

_____ _____
(Name) LAST, FIRST, M.I. DATE OF BIRTH

_____ _____
Street or Box Social Security Number

_____ _____
City State Zip Code Personal Email Address

Sex Marital Status
M ☐ F ☐ S ☐ M ☐ W ☐ D ☐

Current Medical Provider's Name, Address & Phone #

_____

_____

Have you ever worked for Lehigh Valley Health Network entities (Lehigh Valley Hospital, Lehigh Valley Hospital-Muhlenberg, Spectrum Administrators, Lehigh Valley Hospice/Homecare, Lehigh Valley Physician Group, Health Spectrum Pharmacy, or Health Network Labs) before? ☐ YES ☐ NO

When? _____ Which Entity? _____

Last Place of Employment: _____

Length of Time Employed: **From**____/____/____ **To**____/____/____

Do you have any condition (physical, medical or psychological) that would require special accommodations in order for you to perform your job duties? ☐ YES ☐ NO

--If YES, please explain: _____

_____

COMMUNICABLE DISEASE EXPOSURES

Have you or anyone in your family or close household ever had:
☐ Tuberculosis ☐ Hepatitis ☐ Other Infectious Disease ☐ No, None
-- If YES, please give details: _____
_____

PAST MEDICAL SURGICAL HISTORY

Have you had any medical illnesses such as diabetes, cancer, heart disease, thyroid problem etc., serious injuries or surgery (operations) or medical procedures?

-- If YES, please note treatment date, physician's name and place of treatment: _____

_____

_____

If NO treatment was sought or provided, please explain: _____

_____

SOCIAL HISTORY

Have you ever smoked cigarettes, cigars, or a pipe? ☐ YES ☐ NO

If YES, how much _____

If you no longer smoke, when did you quit? _____

Have you smoked cigarettes, cigar, or pipe OR used any nicotine containing products (chewing tobacco, snuff, e-cigarettes, vape, hooka, chew, nicotine spray, patches or gum, etc.) in the last three (3) months?
☐ YES ☐ NO

If YES, please explain. _____

(*You will be tested for nicotine metabolites, and any discrepancy in your response to this question and the laboratory test result may result in the job offer being rescinded.)

Do you drink alcohol? ☐ YES ☐ NO

If YES, how many drinks at a time? _____ How many days per week? _____

What do you drink? ☐ Wine ☐ Beer ☐ Hard liquor ☐ Other _____

Do you feel safe in your current relationship? ☐ YES ☐ NO

If NO, please explain. _____

Is someone making you feel bad about yourself? ☐ YES ☐ NO

If YES, by whom? _____

Within the last year, have you been hit, kicked, punched or otherwise hurt by someone you know? ☐ YES ☐ NO

Is there someone making you feel unsafe now? ☐ YES ☐ NO

If YES, do you need assistance? _____

Pre-placement Assessment and Subsequent Physical Examination Record _____

Name, SSN

DO YOU HAVE or HAVE YOU EVER HAD the following:

ALLERGIES:	**YES**	**NO**	***IF YES, GIVE DETAILS***
Hay fever			
Reaction to any substance which resulted in hives, swelling, itching, trouble swallowing or breathing			
Reaction to rubber products (balloons, condoms, diaphragms, dental procedures)			
Reaction to latex gloves			
Reaction to vinyl gloves			
Foods			
Skin rash or history of eczema			
Drug allergies			

GENERAL:	**YES**	**NO**	***IF YES, GIVE DETAILS***
Diabetes			
Stroke, ministroke, TIA			
Tumor, cancer, leukemia, lymphoma			
Hepatitis B			Treatment: Date of last viral load measurement: Viral load measurement:
Hepatitis C			Treatment: Date of last viral load measurement: Viral load measurement:
HIV			Treatment: Date of last viral load measurement: Viral load measurement:
Liver disease, jaundice			
Serious accident			
Operations, surgeries, medical procedures			
Eye problems – decreasing vision, eye pain, double vision, loss of vision, eye infection, photophobia, eye injury or disease?			
Hearing problems – decreased hearing, pain in ears, ringing or throbbing in ears?			
A hernia or rupture?			
Convulsions or seizure and/or taken medication for seizures?			
Brain trauma/concussion, head injury of any type?			
Received radiation or chemotherapy as a treatment?			
Migraine headaches?			
Skin Problems – Eczema, Psoriasis, Rashes			

Pre-placement Assessment and Subsequent Physical Examination Record _____

Name, SSN

DO YOU HAVE or HAVE YOU EVER HAD the following:

OCCUPATIONAL HEALTH HISTORY	**YES**	**NO**	***IF YES, GIVE DETAILS***
Exposure in your past or present work to the following: excessive noise, fumes, chemicals, brick/stone or sand dust?			
Are you receiving any disability income? (SSDI, through the VA or Armed Forces?)			
Have you ever been injured on the job or in the course of any current or previous employment? -If YES, indicate date of injury, and any current or past treatment…….. (Use additional paper if needed)			Nature of Injury: Date of Injury: Company/Employer: Time out from work: From_____ To _____ Treatment: Still in Treatment?
Filed a workers compensation claim? -If YES, please describe……			
Received a workers compensation settlement? -If YES, you must provide a record of your permanent restrictions. The pre-employment assessment cannot be completed without this information.			Restrictions at time of settlement: (documents must be provided)
Are you receiving workers compensation disability payments at this time? (partial or total disability, medical benefits)			
Have you been rejected or denied insurance, employment, or acceptance in the Armed Forces?			
Have you received an "other than Honorable" or dishonorable discharge from the Armed Forces?			
Worked in a stone quarry, foundry, farm, pottery, cotton, flex hemp mill, mine, chemical or cement plant?			
Have you been exposed to asbestos or worked with asbestos?			
Worked as a plumber, dry waller or worked in construction?			
Worked with X-ray or radioactive materials?			
Any hobby that exposed you to wood and other dust, gas or fumes such as paints, glues and solvents, metals? - If YES, state the situation…….			
Handled or worked with cytotoxic drugs, such as chemotherapy drugs used to treat cancer?			# of preparations or administrations per week: Years of handling:

Pre-placement Assessment and Subsequent Physical Examination Record _____

Name, SSN

DO YOU EVER HAVE or HAVE YOU EVER HAD the following:

MENTAL HEALTH / ADDICATION:	**YES**	**NO**	***IF YES, GIVE DETAILS***
Have you ever felt that you had a problem with addiction or substance use disorder (e.g., drugs/alcohol), but you did not seek treatment?			
Have you ever had and/or have a history of substance abuse (e.g., drugs/alcohol) or ever been recognized as having substance abuse problem?			
Have you ever been treated for substance abuse or drug/alcohol addiction or abuse, including any mandated program related to DUI? Are you currently abstinent from this substance and other potentially addictive substances? Explain			Specify substance involved and treatment received:
Attempted suicide?			
Mental or emotional illness? Depression, anxiety, schizophrenia, bipolar, panic attacks, eating disorder, etc.			
Are you at the present time taking any medication for an emotional or psychiatric illness?			
If licensed, have you ever been or are you currently enrolled in the voluntary recovery program or a professional health monitoring program?			√ All that apply: PHMP ( ) SARPH ( ) VRP ( ) PHP ( ) DMU ( ) OTHER ( )
Have you ever been diagnosed with a learning disability or Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD)?			

HEART	**YES**	**NO**	***IF YES, GIVE DETAILS***
Heart disease or heart attack			
High blood pressure			
Treatment for any other heart conditions			
Rheumatic fever or heart murmur			
Passed out or nearly passed out during or after exercise?			
Discomfort, pain or pressure in your chest/neck or arm during exercise?			
Does your heart race or skip beats? Have arrhythmia?			
High cholesterol			
Heart infection			
Has your doctor ever ordered a test for your heart? (e.g., EKG, echo cardiogram, stress test, heart catheterization)			
Phlebitis, varicose veins or blood clots/poor circulation?			
Have you ever refused any medical treatment for any heart-related problems?			

Pre-placement Assessment and Subsequent Physical Examination Record _____

Name, SSN

DO YOU HAVE or HAVE YOU EVER HAD the following:

LUNGS	**YES**	**NO**	***IF YES, GIVE DETAILS***
Cystic Fibrosis?			
Asthma, wheezing, or reactive airways disease?			
Positive skin test for tuberculosis (TB)?			
Treatments for + TB test? - If YES, documentation must be submitted to LVHN-Employee Health Services @ the time of physical			
Have you been exposed to someone who has TB?			
Have you ever refused medical treatment for any lung-related disorder? (asthma, bronchitis, pneumonia)			
Productive cough, bloody sputum, excessive sweating at night, chills, fever?			
Any other problem with your lungs?			

MUSCLE-SKELETAL	**YES**	**NO**	***IF YES, GIVE DETAILS***
Arthritis, rheumatism, neck, back, spine injury or disease?			
Fibromyalgia, rheumatoid arthritis, systemic lupus, nerve disorder, or any neurological problems causing weakness or pain?			
Herniated disc? Bulging disc? Slipped disc?			
Treatment for any back or neck problems?			
Recurrent stiffness or pain in back or neck?			
Bursitis, tendonitis?			
Recurrent pulled muscles or sprains?			
Hand, wrist, elbow injury or problems, including carpal tunnel?			
Any discomfort, pain or numbness or tingling in hands?			
Hip or knee injury or problems?			
Ankle or foot injury or problems?			
Shoulder injury or problems?			
Job requiring heavy lifting or standing/sitting for long periods of time?			
Any broken bones? - If YES, please list……..			
Muscular or neuromuscular disease?			

SURGERIES/OPERATIONS	**YES**	**NO**	***IF YES, GIVE DETAILS***
On your back, neck, upper extremity or lower extremity?			
To treat a hernia?			
Varicose veins?			
Other operations?			
Have you ever been hospitalized?			

Pre-placement Assessment and Subsequent Physical Examination Record _____

Name, SSN

DO YOU HAVE or HAVE YOU EVER HAD the following:

BLOOD, OTHER	**YES**	**NO**	***IF YES, GIVE DETAILS***
Blood transfusion, needle stick or splash of blood or body fluid? – If YES, when……			
Bleeding or clotting disorder or anemia, leukemia or lymphoma?			
Difficulty urinating, blood in urine, burning, irritation?			
Anorexia, loss of appetite, difficulty swallowing, chronic indigestion, nausea, vomiting, abdominal pain, chronic diarrhea, chronic constipation, bloody or black bowel movements?			
Deep vein thrombosis, blood clots, pulmonary embolism?			

FOR WOMEN ONLY*	**YES**	**NO**	***IF YES, GIVE DETAILS***
Are your menstrual periods regular?			
Ever unable to work due to menstrual pain? - If YES, for how long……			
Any miscarriages?			
Any children? - If YES, ages of children……...			
Date of last normal menstrual period			
Are you pregnant at the present time?			
Fertility problems or undergoing or planning to undergo fertility treatments within the next 3 months?			
Age of menopause			

*These questions are intended to provide baseline information regarding reproductive health that may be important should you ever be exposed to reproductive health hazards in the course of your job(s) at LVHN

Food, Drug or Dye ALLERGIES ☐ Yes – List allergies below ☐ No, I have no allergies

Drug/Food/Dye	**Reaction**

Pre-placement Assessment and Subsequent Physical Examination Record _____

Name, SSN

MEDICATIONS ***(CHECK ONE)***

☐ I do not take any prescription medications, as needed or on a regular basis including any pills, eye drops, liquids, inhalers, medication patches, vitamins, herbal or nutritional supplements or over the counter medications _____ (signature of hire)

☐ I have listed all of the medications I take below. (ask for additional form if needed)

☐ I do ☐ I do not ☐ have a medical marijuana card

	Drug Name	Dose		How Often	Reason	Prescriber	Date Filled	PROOF of Rx – **EH/HW complete this column** Check if bottles Provided and Write Rx#	
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

I, THE UNDERSIGNED, DO HEREBY CERTIFY THAT TO THE BEST OF MY KNOWLEDGE, THE ANSWERS I HAVE GIVEN TO THE QUESTIONS ABOVE ARE TRUE AND THAT I HAVE NO PHYSICAL IMPAIRMENTS, CONDITIONS OR CONCERNS EXCEPT AS STATED ABOVE.

I UNDERSTAND THAT FAILURE TO PROVIDE ACCURATE AND COMPLETE INFORMATION, INCLUDING ANY PRESCRIPTION MEDICATIONS I MAY BE TAKING, ON A DAILY OR AS NEEDED BASIS, MAY RESULT IN TERMINATION OF MY OFFER OF EMPLOYMENT OR EMPLOYMENT IF DISCOVERED AFTER I BEGIN WORKING

Signed: _____Print Name: _____

If minor (under 18): _____
(Parent or Guardian Signature)

Social Security #: _____ Home Phone #:_____ Cell Phone #:_____

Position Applied For: _____ Dept.: _____

Date: _____ Date Scheduled for Orientation: _____

I hereby authorize Employee Health Services to release any information regarding my health or physical condition to my designated treating physician(s). I understand Employee Health Services will not notify my personal physician of abnormalities and that I am responsible for following up with my own treating physicians if provided with any abnormal findings that arise during the pre-employment assessment. I understand that LVHN will not provide follow-up treatment for any such findings.

Signed: _____ Print Name: _____

If minor (under 18): _____ Date: _____
(Parent or Guardian Signature)

APPLICANT, PLEASE WRITE YOUR NAME AND SSN ON THE TOP OF THE REMAINING PAGES OF THIS FORM. OTHERWISE, DO NOT COMPLETE ANY OTHER AREAS OF THE REMAINING FORM. THIS IS FOR LVHN EMPLOYEE HEALTH/OCCUPATIONAL HEALTH USE ONLY

Pre-placement Assessment and Subsequent Physical Examination Record _____
Name, SSN

FOR LVHN EMPLOYEE HEALTH/OCCUPATIONAL HEALTH USE ONLY

-- Documentation MUST be presented at time of the evaluation. If NO documentation, titers must be drawn. IF DOCUMENTATION PROVIDED, PLEASE ATTACH TO THIS FORM AND SEND TO EMPLOYEE HEALTH

I.

IMMUNITY TO COMMUNICABLE DISEASE				
DISEASE	***IF NO ACCEPTABLE PROOF OF IMMUNITY PRESENT AT TIME OF PHYSICAL, DRAW BLOOD**	**YES**	**NO**	**Titer Drawn**
Rubella	Documented proof of MMR vaccine or 1 dose Rubella or + titer	☐	☐ → draw Rubella titer	☐
Rubeola	Documented proof of 2 MMR vaccines or 2 doses Rubeola or + titer	☐	☐ → draw Rubeola titer	☐
Mumps	Documented proof of 2 MMR vaccines or 2 doses Mumps or + titer	☐	☐ → draw Mumps titer	☐
Varicella	Documented proof of 2 doses of Varicella vaccine, + titer or history of chicken pox verified by a healthcare provider.*	Physician hx ☐ OR Documented 2 doses vaccine ☐ OR Documented positive Titer ☐	☐ → draw Varicella titer	☐

All residents **MUST have varicella titer drawn*

II.

Occupational risk of blood and body fluid exposure?		**NO** ☐ (no action necessary, proceed to section III.)	**YES** ☐ → draw Hep. B antigen AND antibody	☐
Vaccinated with Hepatitis B Vaccine?		**YES** ☐ If no documentation provided, sign declination and write "vaccinated previously"	**NO, never vaccinated** ☐ **or not sure** ☐ If **NO**, give 1st dose of Hep. B vaccine ****MUST** sign declination if declining Hep. B vaccine*	Vaccine #1 given ☐
Hepatitis C Ab	Drawn ☐	**Yes** ☐	**No** ☐	

III.

Tetanus	Date of last Tetanus Booster or Tdap *(circle one)*	____/____/____	Offer Tdap regardless of last Td booster if hire will have patient contact. Do not give Tdap if previously received Tdap.	Vaccine given ☐

FOR LVHN EMPLOYEE HEALTH/OCCUPATIONAL HEALTH USE ONLY

IV. TUBERCULOSIS SCREENING HISTORY

1. **Draw QFT on all new hires** ☐ DRAWN

2. Past history of positive TST or QFT? ☐ YES ☐ NO – If no, proceed to Section V
   If yes:
   1. Complete S/S questionnaire ☐
   2. Date of positive test _____ ☐
   3. Give CXR prescription and directions for CXR ☐
      (if employee can provide cxr report done within last 3 months, skip cxr and enclose report)
   4. If yes, has employee received treatment? ☐ YES ☐ NO
   5. Specify treatment below and request documentation be sent to Employee Health Services – CC:

_____

_____

_____

V.

HEIGHT	WEIGHT	BLOOD PRESSURE	PULSE	RESPIRATIONS

VISION

WITHOUT CORRECTION:		WITH CORRECTION: Glasses ☐ Contacts ☐			COLOR VISION TESTING	Pass ☐ Fail ☐
L	20 /	L	20 /		**Comments:**	
R	20 /	R	20 /			
BOTH	20 /	BOTH	20 /			

VI. LABS DRAWN: _____

Technician/RN Signature
Completing Pages 11, 12: _____ Date _____

☐ RN review completed and **NO exam is required.**
☐ Review by RN – exam by **Physician or CRNP** is required

_____ Date _____
RN signature

OR

☐ No RN review – exam by **Physician or CRNP** is required.

Pre-placement Assessment and Subsequent Physical Examination Record _____
Name, SSN

FOR LVHN EMPLOYEE HEALTH/OCCUPATIONAL HEALTH USE ONLY

PHYSICIAN / PRACTITIONER EXAM

HEENT:	
Neck:	
Chest/Lungs:	
Heart:	
Abdomen:	
Musculoskeletal:	
Neurological:	
Skin:	
Other:	

Assessment: *(please note any pertinent information relating to YES answers):* _____

_____

_____

_____

As of today _____/_____/_____; applicant

1. ☐ Is qualified for unrestricted work
2. ☐ Is qualified for restricted work – List restrictions/accommodations, if applicable: _____

   _____

   _____
3. ☐ Cannot be qualified for work at this time pending receipt and review of medical information from personal provider(s).
4. ☐ Is not qualified for work as a _____

_____ _____
Practitioner Signature / Print Name Date

_____

Complete this section if #3 is checked above:

Review of additional information on _____/_____/_____; applicant

☐ Is qualified for unrestricted work

☐ Is qualified for restricted work – List restrictions/accommodations, if applicable: _____

_____

_____

☐ Is not qualified for work as a _____

_____ _____
Practitioner Signature / Print Name Date

EMPLOYEE HEALTH SERVICES
Cedar Crest Blvd & I-78, Allentown, PA 18105-1551
PHONE: (610) 402-8869
FAX: (610) 402-1203

Muhlenberg Campus
2545 Schoenersville Rd, Bethlehem, PA 18017
PHONE: (484) 884-7098
FAX: (484) 884-7324

QUANTIFERON GOLD TESTING QUESTIONNAIRE

Name _____ Date_____

SSN _____ DOB _____ Phone Number _____

*HIV infection and other medical conditions may cause a tuberculosis skin test to be negative, even though you may be infected with tuberculosis. Please consult your healthcare provider should you have any concern.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by 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.

[ ] Employee

[ ] Medical Staff

[ ] Volunteer

YES	NO	In the last year, have you had any of the following symptoms? (Please explain any "*YES*" answers).
		Have you ever had a positive TB test (PPD or QFT)?
		Have you ever been told by a doctor or other health care provider that you had active TB?
		Coughing up blood?
		Hoarseness lasting three weeks or more
		Persistent cough lasting three weeks or more
		Unexplained, excessive fatigue
		Unexplained, persistent fever lasting three weeks or more
		Unexplained, excessive sweating at night
		Unexplained weight loss
		Has a doctor or other healthcare provider ever told you that your immune system is not working right or that you cannot fight infection?
		Have you had pneumonia in the past year?
		Have you ever lived with or had close contact with someone who has/had active tuberculosis disease?
		Have you ever been told that you have an abnormal chest x-ray?
		Have you ever worked where patients with active tuberculosis disease receive care or services?
		Have you ever worked, volunteered or lived in any institution such as a jail, group home or homeless shelter?
		Have you traveled outside the United States in the last 12 months? ***If yes***, identify city, country and timeframe:
		Were you born in the United States? ***If no***, identify the country you were born in:

YES	NO	QFT Screening; (Draw QFT, but to be considered in interpreting results)
		Have you had a PPD/tuberculin skin test in the last 6 months? If yes, when: _____
		Are you diabetic?
		Do you have or have you had silicosis?
		Are you on immunosuppressive therapy (Steroids, chemo) or problem with immune system?
		Do you have chronic renal failure?
		Do you have or have you had any blood disorders/leukemia/lymphoma? Cancer or cancer treatment?
		Are you Pregnant?
		Are you less than 17 years old?

_____ _____

Patient/Client Signature Reviewed by Clinician

_____

Parent/Legal Guardian Signature, if client under 18 years of age

Name _____
(PLEASE PRINT)

Department _____

Social Security _____
OR
Employee ID # _____
(At Least One of These Is Required)

Regulations (Standard – 29CFP)
OSHA Respirator Medical Evaluation Questionnaire (Mandatory). – 1910.134 App C

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II 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.

Can you read (circle one): Yes No?

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 employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

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

1. Today's date:_____
2. Your name:_____
3. Your age (to nearest year):_____
4. Sex (circle one): Male/Female
5. Your height:_____ft._____in.
6. Your weight:_____lbs.
7. Your job title: _____
8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): Work:_____Home: _____
9. The best time to phone you at this number: _____
10. Has your employer told you how to contact the health care professional who will review this questionnaire? (circle one): Yes No
11. Check the type of respirator you will use (you can check more than one category):
    a. __√____N, R, or P disposable respirator (filter-mask, non- cartridge type only).
    b. _____Other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).
12. Have you worn a respirator (circle one): Yes No

If "yes," what type(s):_____
_____

Part A. Section 2 (Mandatory) Name, SSN

Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please circle "yes" or "no").

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?
   a. Seizures (fits): Yes No
   b. Diabetes (sugar disease) Yes No
   c. Allergic reactions that interfere with your breathing: Yes No
   d. Claustrophobic (fear of closed in places): Yes No
   e. Trouble smelling odors: Yes No

If any yes answers please explain: is it current or past condition? Is condition controlled by treatment and/or medication?

_____
_____
_____

3. 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 problem that you've been told about: Yes No

If any yes answers please explain: is it current or past condition? Is condition controlled by treatment and/or medication?

_____
_____
_____

4. 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 walking up a slight hill or incline: Yes No
   c. Shortness of breath when walking with other people 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

If any yes answers please explain: is it current or past condition? Is condition controlled by treatment and/or medication?

_____
_____

Name, SSN

5. 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 (heart beating irregularly): Yes No
   g. High blood pressure: Yes No
   h. Any other heart problem that you've been told about: Yes No

If any yes answers please explain: is it current or past condition? Is condition controlled by treatment and/or medication?

_____
_____

6. 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

If any yes answers please explain: is it current or past condition? Is condition controlled by treatment and/or medication?

_____
_____
_____

7. 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

8. 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 and go to question 9 :)

   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

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

FOR EMPLOYEE HEALTH USE ONLY

RESPIRATOR CERTIFICATION FORM

I certify that I have examined _____ in accordance with the applicable OSHA Respiratory Protection Standard (29 CFR 1910.134) and, through:

☐ the medical questionnaire only/ ☐ an examination only / ☐ the medical questionnaire and examination, ☐ Have / ☐ Have Not detected medical conditions which would place the employee at increased risk of material impairment of health from respirator use.

Recommended work limitations (if indicated):_____

_____

_____

The employee has been informed of the results of the medical review and/or examination and of any conditions requiring further evaluation. The complete questionnaire and examination form for the employee is on file at:

Employee Health Services
Lehigh Valley Hospital –CC
1200 S. Cedar Crest Blvd.
Allentown, PA 18105-1556

Employee Health Services
Lehigh Valley Hospital
2545 Schoenersville Road
Bethlehem, PA 18017

(Circle one)

_____ _____ _____

Date Licensed Health Care Professional Signature

Notification to Employees of Their Rights and Duties Under the PA Workers' Compensation Act

Section 306 (f.1)(1)(i)

If you are injured while on duty, you are responsible for notifying Employee Health Services within 24 hours.

The Pennsylvania Workers' Compensation Act requires that employees be given written notice of their rights and duties under Sec. 306 (f.1)(1)(i) of the Act if a list of designated health care providers is established by the employer.

If you are viewing this electronically, your electronic signature will be your acknowledgement that you have been provided with your rights and duties; otherwise, you must acknowledge this with your signature and return it to the Employer Health Dept. You may keep a copy for your records.

Rights and Duties

As an employee of the Commonwealth working at a location where a list of designated health care providers has been established and posted, you have the right to seek emergency medical treatment from any provider; for post-emergency and other injuries, you must obtain treatment for work-related injuries and illnesses from a designated health care provider for 90 days. The penalty for not using a designated health care provider is that the commonwealth is not liable for the medical bill incurred. Specific rights and duties are:

- The duty to obtain treatment for work-related injuries and illnesses from one or more of the designated health care providers for 90 days from the date of the first visit to a designated provider. Your employer has selected a list of 6 or more physicians and other health care providers who are available to treat your work-related injuries and illnesses during the first 90 days of treatment. This list is posted on the LVH CRC for you to view.
- The right to seek emergency medical treatment from any provider, but subsequent non-emergency treatment shall be by a designated provider for the remainder of the 90-day period. Unauthorized, non-emergency treatment with non-panel health-care providers during the first ninety (90) days of treatment may not be considered for payment under Workers' Compensation.
- The right to have all reasonable medical supplies and treatment related to the injury paid for by your employer as long as treatment is obtained from a designated provider during the 90-day period.
- The right, during this 90-day period, to switch from one designated health care provider to another designated provider.
- The right to seek treatment from a provider if you are referred to that provider by a designated provider.
- The right to an additional opinion from a provider of your choice when invasive surgery is prescribed by the designated provider.
- The right to seek treatment or medical consultation from a non-designated provider during the 90-day period, but services shall be **at your expense** for the applicable 90 days.
- The right to seek treatment from any health care provider after the 90-day period has ended.
- The duty to **notify your employer of treatment by a non-designated provider (after the 90 day period) within 5 days of the first visit to that provider.** The employer may not be required to pay for treatment rendered by a non-designated provider prior to receiving this notification.

I acknowledge that I have been informed of my rights and duties under Sec. 306 (f.1)(1)(i) and that I understand them to the extent they are explained above.

_____	_____	_____
Employee's Printed Name	Employee's Signature	Date