

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 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.

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 a positive immunity to measles, mumps and rubella.
- Documentation of 2 varicella (chicken pox) vaccinations or a blood test result indicating positive immunity to varicella or physician documented chicken pox disease.
- Documentation of 3 doses of Hepatitis B vaccine, if previously vaccinated.
- A blood test result indicating the presence of Hepatitis B antibodies (if done).
- Provide written documentation of Quantiferon-Tb Gold (QFT) Blood test within the past 3 months. If previous Quantiferon-Tb Gold (QFT) test is positive, documentation of a chest x-ray within the past 3 months is needed.
- If history of latent Tuberculosis disease (+ PPD or + QFT), 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 to measles, mumps or rubella, you will be required to be immunized, free of charge through Employee Health Services, **BEFORE** you start employment. If you are not immune to Varicella, all those with patient contact will be required to be immunized, free of charge, through Employee Health Services, **BEFORE** you start employment

*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 or during your health assessment appointment.

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

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 at your health assessment (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 may be rescheduled and/ or your clearance will be held until employee health receives and reviews 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- Pocono Medical Center

Phone: 570-476-3779 Fax: 570-420-2493

285 Prospect Street
East Stroudsburg, PA

Hours of Operation: Mon/Fri: 9:00a – 5:00p

**Employee Health is Paperless! Complete Your Health Assessment
Paperwork Online at ReadySet.com.**

Follow the instructions below. Complete all Health Surveys.

**You must complete the on-line surveys prior to your scheduled appointment with
Employee Health.**

**1. Click the link below to access your secure and private My Health webpage
online on the ReadySet web page.**

Follow the instructions to create a username and password. The login information will be required for you to access all of your personal Employee Health information in the future (i.e. vaccinations, TB skin test, etc.). You can use the space below to record your confidential login information.

- <https://poconohealthsystem.readysetsecure.com>
- Click "New User? Click Here to Begin" and follow the instructions. You will need the following information:
 - Access Code: **1212**
 - Program Type:
 - Pre-Placement (Please choose this Program Type unless otherwise instructed)
 - Pre-Placement Food Handler
 - Pre-Placement Plant Services
 - Pre-Placement Volunteers
 - Location:
 - PMC
 - FCC
 - NEMP
 - Population Type: Please choose **Pre-Employment**

2. Complete the Health Assessment Surveys.

- After logging in to ReadySet, you will have several surveys to complete.
- Please note, only the questions with a red asterisk (*) are required to be answered. All other questions are optional.
- When a survey is complete, click Submit Final.
- If you receive a message that a question is not complete, scroll through the survey and look for the red box around the incomplete response.
- All completed survey statuses will have a green checkmark under status after you click Submit Final.

Thank you,

Victoria Castaldi, RN Employee Health

User Name: _____

Password: _____

Pocono Health System
Employee Health
206 East Brown Street
East Stroudsburg, PA 18301
570-476-3779

 go
paperless!



OCCUPATIONAL MEDICINE
2838 PA 611, Tannersville, Pa 18372 PHONE: (570) 476-3336
FAX: (570) 839-7210

EMPLOYEE HEALTH, POCONO
285 Prospect Street, East Stroudsburg, Pa 18301
PHONE: (570) 476-3779
FAX: (570) 420-2493

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 and urine to screen for the presence of drugs, 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 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 # _____

LVHN.ORG
(610)-402-CARE

Pre-placement Assessment and Subsequent Physical Examination Record

Name, SSN

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 Current Medical Provider's Name, Address & Phone #

Sex Marital Status
M F S M W D

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

Start Date: _____ Termination Date: _____ 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: _____

Pre-placement Assessment and Subsequent Physical Examination Record

Name / SSN

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? _____

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 ***(needs screening tool) | | | |
| 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 / ADDICTION:

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? - If YES, specify type of treatment..... | | | |
| 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 professional health monitoring program? | | | |
| 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)

| | 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

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 | <input type="checkbox"/> | <input type="checkbox"/> → draw Rubella titer | <input type="checkbox"/> |
| Rubeola | Documented proof of 2 MMR vaccines or 2 doses Rubeola or + titer | <input type="checkbox"/> | <input type="checkbox"/> → draw Rubeola titer | <input type="checkbox"/> |
| Mumps | Documented proof of 2 MMR vaccines or 2 doses Mumps or + titer | <input type="checkbox"/> | <input type="checkbox"/> → draw Mumps titer | <input type="checkbox"/> |
| Varicella | Documented proof of 2 doses of Varicella vaccine, + titer or history of chicken pox verified by a healthcare provider.* | Physician hx | <input type="checkbox"/> → draw Varicella titer | <input type="checkbox"/> |
| | | <input type="checkbox"/> | | |
| | | OR | | |
| | | Documented 2 doses vaccine | | |
| | | <input type="checkbox"/> | | |
| OR | | | | |
| Documented positive Titer | | | | |
| <input type="checkbox"/> | | | | |

*All residents **MUST** have varicella titer drawn

II.

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

III.

| | | | | |
|---------|---|----------------|---|--|
| Tetanus | Date of last Tetanus Booser 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 <input type="checkbox"/> |
|---------|---|----------------|---|--|

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 <input type="checkbox"/> Contacts <input type="checkbox"/> | | COLOR VISION TESTING | Pass <input type="checkbox"/> Fail <input type="checkbox"/> |
|---------------------|------|--|------|----------------------|---|
| 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

RN signature Date _____

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

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.

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? <i>If yes, identify city, country and timeframe:</i> |
| | Were you born in the United States? <i>If no, identify the country you were born in:</i> |

Employee

Medical Staff

Volunteer

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 – 29CFR)

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?

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, Pocono
285 Prospect Street
East Stroudsburg, Pa 18301
Phone: (570)-476-3779
Fax: (570)-420-2493

Date

Licensed Health Care Professional

Signature



WORKERS' COMPENSATION INFORMATION

In Pennsylvania, the workers' compensation law provides wage loss and medical benefits to employees who cannot work and/or who need medical care because of a work-related injury.

Benefits are required to be paid by your employer when self-insured or through insurance provided by your employer. Your employer is required to post the name of the company responsible for paying worker's compensation benefits at its primary place of business and at its sites of employment in a prominent and easily accessible place, including, without limitation, areas used for the treatment of injured employees or for the administration of first aid.

You should report immediately any injury or work-related illness to your employer/supervisor. Your workers' compensation benefits could be delayed or denied if you do not notify your employer/supervisor immediately. Your Workers' Compensation Coordinator is located within Employee Health Services, Lehigh Valley Health Network, 285 Prospect Street, East Stroudsburg, 570-476-3779.

If your work-related injury claim is denied, you have the right to file a petition and request a hearing before a workers' compensation judge.

The Bureau of Workers' Compensation cannot provide legal advice. However, you may contact the Bureau of Workers' Compensation for additional general information at:

Bureau of Workers' Compensation 1171 South
Cameron Street, Room 103
Harrisburg, Pennsylvania 17104-2501
Telephone number within Pennsylvania (800) 482-2383 Telephone
number outside of Pennsylvania (717) 772-4447 TTY (800) 362-4228
(for hearing and speech impaired only) www.state.pa.us - PA
Keyword: workers comp

EMPLOYEE ACKNOWLEDGMENT:

I, _____, employee of Lehigh Valley Health Network, hereby certify that I was provided with the above statement on _____/_____/20____. By signing and dating, this certifies that I have received, read and understood the information provided above. (Retain one copy for your personal records and return the original with your pre-employment medical assessment at the time of your physical).

Employee Signature