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 Healthworks or Occupational Medicine as part of the new hire onboarding process. Your assessment appointment will be scheduled by your Talent Team member. If you need to change your appointment date or time, please contact your Talent Team member for assistance. ***Please be aware that pre-employment assessments scheduled less than TEN (10) days before your anticipated start date may cause your start date to be delayed.***

Location for Physicals	Address	Phone Number
Healthworks Allentown	1243 S Cedar Crest Blvd	610-402-9285
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
Occupational Medicine - Pocono	2838 PA 611, Tannersville	570-476-3336
Occupational Medicine - Schuylkill	100 Schuylkill Medical Plaza, Suite 103	570-621-5067
LVHN, Station Circle	26 Station Circle, Hazle Township	610-861-8080 Ext 36051 – Heather Ext 36329 - Erin
LVHN- 511 VNA Road	East Stroudsburg	610-861-8080 Ext 23550
LVHN – Highland Avenue	2300 Highland Ave., Bethlehem	610-861-8080

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 with you to your medical assessment:

1. Proof of Measles, Mumps and Rubella Immunity:
    a. Documentation of 2 MMR vaccines (both given after your 1st birthday) or a blood test result indicating immunity to measles, mumps and rubella.
    b. If you do not have documentation of MMR vaccines or laboratory evidence of immunity, your blood will be drawn during your physical to determine your immunity status.
    c. ***If you are not immune, you will be required to be immunized, free of charge through Employee Health Services, BEFORE you start employment.***
2. Proof of Chickenpox (Varicella) Immunity:
    a. Documentation of 2 varicella (chicken pox) vaccinations or a blood test indicating immunity to varicella
    b. Physician documented chicken pox disease with date of disease noted.
    c. If you do not have documentation of Varicella vaccines or laboratory evidence of immunity, your blood will be drawn during your physical to determine your immunity status.
    d. ***If you are not immune, you will be required to be immunized, free of charge through Employee Health Services, BEFORE you start employment.***
3. Proof of Hepatitis B Immunity:
    a. Documentation of 3 doses of Hepatitis B vaccine, if previously vaccinated and/or a blood test indicating a positive Hepatitis B antibody.
    b. This vaccine is not required but strongly recommended for anyone at risk for blood or body fluid exposures.
4. Documentation of 1 dose of single dose COVID vaccine or proof of 2 doses of 2 dose COVID vaccine with date and manufacturer listed. ***COVID vaccination is a requirement of employment***.

5. If you have ever tested positive to TB (Tuberculosis) or you have a history of latent Tuberculosis disease, documentation of a chest x-ray **within the past 3 months and documentation of prophylactic treatment is requested**. If you have not had one, you will be given a script to obtain a Chest x-ray as part of your medical clearance. If you have not been treated, you may be referred to you local Department of Health for an evaluation.
6. Documentation of influenza vaccine, if you start employment during the months of September through May is ***required PRIOR to your starting employment***. You can be immunized, free of charge by Employee Health Services.
7. Proof of most recent Tetanus or Tdap vaccine. If you are not up to date with this vaccine, the vaccine will be offered free of charge at your physical
8. The original **prescription medication bottles** for any and all prescription medications and supplements you take
9. If you have a disability, please be ready to specify what your limitations are.
10. 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.
11. If you have a medical marijuana card, you must bring the card and the name of the certifying physician.
    a. Applicants possessing medical marijuana cards who are hired for positions which include tasks or duties which could result in a public health or safety risk, or could be life-threatening to either the employee or any of the other employees or patients under your care, while under the influence of medical marijuana will not be medically qualified for the position pursuant to 35 PS § 10231.510. Applicants are notified of this policy on the job postings and in their offer letter.

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 **(*original prescription medication bottles for any and all prescription medications and supplements*).**
- Receipt of MMR or Varicella vaccine if titers drawn do not indicate immunity to the disease.
- If any additional information is requested at the time of your physical, the requested information must be provided to the Employee Health office ***no later than the Monday prior to your anticipated start date.*** Information received after that Monday may delay your clearance for your start date.
- 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.

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 Services Hours and Locations

Employee Health – LVHN-CC

Phone: 610-402-1880 Fax: 610-402-1203

Employee Health – LVHN-M

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

Employee Health – LVHN – Pocono

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

Employee Health – LVHN – Schuylkill-East Norwegian Street

Phone: 570-621-4351 Fax: 570-621-4257

Employee Health - LVHN Hazleton

Phone: 570-501-4788 Fax: 570-501-4721

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

Name: _____ SSN: _____

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 to screen for the presence of drugs/alcohol, and meeting the rubeola, varicella, rubella, mumps influenza and covid 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 at the time of my evaluation. If the laboratory test determines I am not immune to one of the required communicable diseases, 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 Employee Health free of charge when indicated.

I also understand, as defined in the LVHN Universal COVID and Influenza Vaccination policies, I will be required to be immunized against covid and influenza unless I request and am granted an exemption because of a valid medical reason or bonafide religious reason. Influenza vaccine is free of charge to all employees.

Hepatitis B vaccine is offered free of charge to all employees who are at 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 fitness for duty to perform essential job functions 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.

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

Print Full Name

Acknowledgement of Lehigh Valley Health Network COVID and Influenza Policy *

I understand that LVHN has a Universal COVID and Influenza Vaccination Policy. I will be required to be immunized against COVID and influenza as a condition of employment unless I have experienced a severe reaction to a previous dose of the vaccine or have a bonafide religious reason for not taking the vaccine.

Influenza Vaccine:

☐ - I have received the flu vaccine for this flu season and am providing proof.

☐ - I have had a severe reaction to the flu vaccine that required treatment. I have provided the documentation of the reaction and treatment needed for the reaction along with any testing results that were recommended by my personal physician. I am requesting a medical exemption from the influenza vaccine.

☐ - I have a bonafide religious reason for not taking the influenza vaccine. I am requesting a religious exemption from the influenza vaccine.

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

COVID-19 – Please check all that apply: (*The COVID-19 vaccine is required for all employee's and is a condition of employment)*

☐ - I have received one dose of the J&J COVID-19 vaccine or other single dose COVID vaccine and I am providing proof

☐ - I have received two doses of the COVID-19 vaccine and I am providing proof.

☐ - I have not yet received the COVID-19 vaccine and will be scheduling an appointment to obtain my first dose by calling 484-750-4951. I will notify Employee Health of my appointment date.

☐ - I have received one dose of the COVID -19 vaccine and had a severe allergic reaction requiring treatment. I am requesting a medical exemption from receiving the second dose.

☐ - I have a bonafide religious reason for not taking the covid vaccine. I am requesting a religious exemption from talking the covid vaccine.

I am aware that I cannot be medically cleared to start employment until I have provided proof of my vaccination status to Employee Health no later than 2 weeks before my start date or have completed and been approved for an exemption.
I further understand that it is my responsibility to complete the COVID vaccination series within the timeframes outlined for each vaccine (Pfizer 2nd dose in 3 weeks, Moderna 2nd dose in 28 days). Failure on my part to complete the series will result in my removal from the workplace until such time I as have satisfied this requirement.

I understand the Influenza and COVID Vaccine requirements and have provided all needed information at the time of my pre-employment physical.

Signature Date

Pre-placement Assessment and Subsequent Physical Examination Record (PLEASE PRINT)

Last Name	First Name	
Date of Birth	Social Security Number	
Home Address:		
City	State	Zip Code
Phone Number:	Personal Email Address:	
Position hired for:	Department:	Anticipated start date:

I Identify as a ☐ Male ☐ Female	My preferred name is:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Personal Healthcare Provider

Name:	Phone Number:
Address:	

Employment History

Have you ever worked for any Lehigh Valley Health Network entity (Lehigh Valley Hospital, Lehigh Valley Hospital-Muhlenberg, Pocono, Schuylkill or Hazelton, Coordinated Health, Spectrum Administrators, Lehigh Valley Hospice/Homecare, Lehigh Valley Physician Group, Health Spectrum Pharmacy, or Health Network Labs) ?		
☐ NO ☐ YES	Which Entity:	When:

Current/Last Place of Employment:	Employed From:	Employed To:

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, hookah, chew, nicotine spray, patches or gum, etc.) **in the last three (3) months?**		
☐ YES ☐ NO	If yes, explain what/when you last smoked:	

Note - *You will be tested for nicotine metabolites, and any discrepancy in your response to these questions and the laboratory test result may result in the job offer being rescinded*

_____
Print Full Name

SOCIAL HISTORY-continued

Do you drink alcohol?	☐ YES ☐ NO	If YES, how many drinks at a time?	How often?
What do you usually drink?	☐ Wine ☐ Beer ☐ Hard Liquor ☐ Mixed drinks ☐ Other		

This information remains confidential

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?

FAMILY HISTORY

Has anyone in your family or close household ever had: If YES, who?	☐ Tuberculosis	☐ Hepatitis B or C	☐ Other Infectious disease

SURGERIES/OPERATIONS ***IF YES, GIVE DETAILS***

Past surgery to your back or neck?	☐ YES ☐ NO	
Past surgery to your upper extremity or lower extremity?	☐ YES ☐ NO	
Past surgery to other parts of the body? Please list with dates	☐ YES ☐ NO	
Hernia repair – Umbilical, Abdominal, Inguinal	☐ YES ☐ NO	
Have you ever been hospitalized over night? Why?	☐ YES ☐ NO	

Notes:

Pre-placement Assessment and Subsequent Physical Examination Record _____

Print Full Name

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

GENERAL MEDICAL HISTORY: ***IF YES, GIVE DETAILS***

Diabetes – Type I Type II	☐ YES ☐ NO	Date Diagnosed: Treatment:
Stroke, ministroke, TIA, aneurysm	☐ YES ☐ NO	
Cancer, leukemia, lymphoma	☐ YES ☐ NO	Diagnosed: ☐ Radiation ☐ Chemotherapy Last treated:
Hepatitis B	☐ YES ☐ NO	Treatment: Date of last viral load measurement: Current Viral load measurement:
Hepatitis C	☐ YES ☐ NO	Treatment: Date of last viral load measurement: Current Viral load measurement:
HIV	☐ YES ☐ NO	Treatment: Date of last viral load measurement: Current Viral load measurement:
Liver disease, liver failure, jaundice	☐ YES ☐ NO	
Eye problems – decreasing vision, eye pain, double vision, loss of vision, eye infection, photophobia, eye injury or disease?	☐ YES ☐ NO	
Hearing problems – decreased hearing, pain in ears, ringing or throbbing in ears, hearing aids, cochlear implants?	☐ YES ☐ NO	
History of Convulsions or seizures?	☐ YES ☐ NO	Date of last seizure?
Brain trauma/concussion, head injury of any type?	☐ YES ☐ NO	
Migraines, cluster headaches, trigeminal neuralgia?	☐ YES ☐ NO	
Serious accident/injuries sustained?	☐ YES ☐ NO	
Blood transfusion, needle stick or splash of blood or body fluid?	☐ YES ☐ NO	
Bleeding or clotting disorder, anemia, Sickle Cell disease, leukemia or lymphoma?	☐ YES ☐ NO	
Anorexia, loss of appetite, difficulty swallowing, chronic indigestion, nausea, vomiting, abdominal pain, chronic diarrhea, chronic constipation, Irritable bowel syndrome, Crohns disease?	☐ YES ☐ NO	

Notes:

Pre-placement Assessment and Subsequent Physical Examination Record _____

Print Full Name

DO YOU HAVE or HAVE YOU EVER HAD the following:

OCCUPATIONAL HEALTH HISTORY		***IF YES, GIVE DETAILS***
Exposure in your past or present work to the following: excessive noise, fumes, chemicals, brick/stone or sand dust?	☐ YES ☐ NO	
Have you ever been injured on the job or in the course of any current or previous employment? • Treatment received: • Current treatment: • Current restrictions: • Still in Treatment? ☐YES ☐NO	☐ YES ☐ NO	Nature of Injury: Date of Injury: Time out from work: From _____ To _____
Filed a workers compensation claim?	☐ YES ☐ NO	Provide details:
Received a workers compensation settlement? ***** If YES, you must provide a record of your <u>permanent restrictions</u>. The pre-employment assessment cannot be completed without this information.***	☐ YES ☐ NO	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)	☐ YES ☐ NO	
Have you received an "other than Honorable" or dishonorable discharge from the Armed Forces?	☐ YES ☐ NO	
Have you been rejected or denied insurance, employment, or acceptance into the Armed Forces?	☐ YES ☐ NO	
Are you receiving SSDI or Veterans disability benefits?	☐ YES ☐ NO	
Have you worked in a stone quarry, foundry, farm, pottery, cotton, flex hemp mill, mine, chemical or cement plant?	☐ YES ☐ NO	
Have you been exposed to asbestos or worked with asbestos?	☐ YES ☐ NO	
Worked as a plumber, dry waller or worked in construction?	☐ YES ☐ NO	
Worked with X-ray or radioactive materials?	☐ YES ☐ NO	
Any hobby that exposed you to wood and other dust, gas or fumes such as paints, glues and solvents, metals?	☐ YES ☐ NO	
Handled or worked with cytotoxic drugs, such as chemotherapy drugs used to treat cancer?	☐ YES ☐ NO	# of preparations or administrations per week: Years of handling:

Notes:

Pre-placement Assessment and Subsequent Physical Examination Record _____

Print Full Name

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

MENTAL HEALTH / ADDICTION: ***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?	☐ YES ☐ NO	
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?	☐ YES ☐ NO	
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? ☐ YES ☐ NO	☐ YES ☐ NO	Specify substance involved? Dates of treatment? Treatment received?
Have you ever Attempted suicide?	☐ YES ☐ NO	
Have you or do you have a Mental or emotional illness? Depression, anxiety, schizophrenia, bipolar, panic attacks, eating disorder, etc.	☐ YES ☐ NO	
Are you at the present time taking any medication for a Mental or emotional illness?	☐ YES ☐ NO	
If licensed, have you ever been or are you currently enrolled in the voluntary recovery program or a professional health monitoring program?	☐ YES ☐ NO	√ All that apply: ☐ PHMP ☐ SARPH ☐ VRP ☐ PHP ☐ DMU ☐ PNAP ☐ OTHER _____
Have you ever been diagnosed with a learning disability, Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Autism?	☐ YES ☐ NO	

HEART ***IF YES, GIVE DETAILS***

Heart disease, heart attack or MI, heart infection, heart surgery or other heart condition	☐ YES ☐ NO	
High blood pressure	☐ YES ☐ NO	
Rheumatic fever or heart murmur	☐ YES ☐ NO	
Chest, neck or arm discomfort, pain or pressure during exercise	☐ YES ☐ NO	
Irregular heart beats, rapid heart beats or skipped beats	☐ YES ☐ NO	
Passed out or nearly passed out during or after exercise?	☐ YES ☐ NO	
Have you ever had an echo cardiogram, stress test or heart catheterization?	☐ YES ☐ NO	
Phlebitis, blood clots, deep vein thrombosis, pulmonary embolism or poor circulation?	☐ YES ☐ NO	

Notes:

Pre-placement Assessment and Subsequent Physical Examination Record _____

Print Full Name

DO YOU HAVE or HAVE YOU EVER HAD the following:

LUNGS ***IF YES, GIVE DETAILS***

Asthma, wheezing, or reactive airways disease and receiving treatment?	☐ YES ☐ NO	
Cystic Fibrosis?	☐ YES ☐ NO	
Positive skin test for tuberculosis (TB)?	☐ YES ☐ NO	When?
Treatment for + TB test?	☐ YES ☐ NO	***Provide documentation of completion of treatment***
Productive cough, bloody sputum, excessive sweating at night, chills, fever?	☐ YES ☐ NO	
Have you been exposed to someone who has TB?	☐ YES ☐ NO	
Any other problem with your lungs / breathing?	☐ YES ☐ NO	

MUSCLE-SKELETAL ***IF YES, GIVE DETAILS***

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

Notes:

Pre-placement Assessment and Subsequent Physical Examination Record _____

Print Full Name

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

FOR WOMEN ONLY*

		IF YES, GIVE DETAILS
Date of last normal menstrual period	☐ YES ☐ NO	
Are your menstrual periods regular?	☐ YES ☐ NO	
Ever unable to work due to menstrual pain?	☐ YES ☐ NO	
Are you pregnant at the present time? Do you have any restrictions at present? YES NO Is this considered a High Risk Pregnancy? YES NO	☐ YES ☐ NO	
Fertility problems or undergoing or planning to undergo fertility treatments within the next 3 months?	☐ YES ☐ NO	
Any miscarriages?	☐ YES ☐ NO	
Any children? - If YES, ages of children	☐ YES ☐ NO	
Age of menopause	☐ YES ☐ NO	

*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

ADA / AMERICANS WITH DISABILITIES

Do you have any condition (physical, medical or psychological) that would require special accommodations in order for you to perform your essential job duties?	☐ YES ☐ NO
If YES, please explain what accommdations you will need:	

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

Seasonal Allergies, Hay fever	☐ YES ☐ NO	
Reaction to any substance which resulted in hives, swelling, itching, trouble swallowing or breathing	☐ YES ☐ NO	
Reaction to rubber products (balloons, condoms, diaphragms, dental procedures)	☐ YES ☐ NO	
Reaction to latex products	☐ YES ☐ NO	
Reaction to vinyl gloves	☐ YES ☐ NO	If yes, complete latex screening questonnaire
Skin rash or history of eczema	☐ YES ☐ NO	
Foods – please list with reaction	☐ YES ☐ NO	
Drugs – please list with reaction	☐ YES ☐ NO	

Notes:

Pre-placement Assessment and Subsequent Physical Examination Record _____

Print Full Name

MEDICATIONS

☐ I do not take any prescription medications, on an 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.**

☐ I have listed all of the medications I take below. (Use additional paper if needed)

	Drug Name	Dose	How Often	Reason	Prescriber	Date Filled	Prescription #	Prescription verified by:
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								

☐ I do **not** have a Medical Marijuana Card ☐ I have a Medical Marijuana card and have provided a copy

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

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.

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.

Print Name: _____ Sign: _____

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

APPLICANT, PLEASE WRITE YOUR NAME AND SSN ON THE TOP OF THE REMAINING PAGES OF THE FORMS. THIS IS FOR LVHN EMPLOYEE HEALTH/OCCUPATIONAL MEDICINE USE ONLY.

Pre-placement Assessment and Subsequent Physical Examination Record _____

Print Full Name

FOR LVHN EMPLOYEE HEALTH/OCCUPATIONAL HEALTH USE ONLY

NURSE/TECHNICIAN EXAM:

HEIGHT	WEIGHT	BLOOD PRESSURE	PULSE	RESPIRATIONS

VISION

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

VACCINES:

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

Hepatitis B	Initiate Hepatitis B series ***IF never had series and will have patient contact***	Vaccine dose #1 given ☐

TUBERCULOSIS SCREENING HISTORY:

Past history of positive Tb skin test or positive QFT? ☐ NO ☐ YES

If YES –

- ☐ New Hire Tb Sign and Symptom Questionnaire completed
- ☐ Chest xray PA and Lateral done at physical
- ☐ Script given to obtain Chest xray PA and Lateral at any LVHN facility
- ☐ **Draw QFT**

*****acceptable proof of Chest xray - completed within 3 months of start date. Need hard copy with the file.***

LABS TO BE DRAWN: 1. ☐ **Everyone - Hbsab, Hbsag, HepCab, Rubeola, Mumps, Rubella, Varicella ab, QFT**

2. ☐ **Cytotoxic/chemotherapy handlers: Urinalysis, CBC, CPMP plus above**

I completed: ☐ #1 labs ☐ #2 labs _____

Print name legibly

☐ RN/LPN review completed and **NO Physician or CRNP exam is required.**

_____ _____

Signature of reviewer Date

☐ Review by RN/LPN – exam by **Physician or CRNP** is required

_____ _____

Signature of reviewer Date

Print Full Name

FOR LVHN EMPLOYEE HEALTH/OCCUPATIONAL HEALTH USE ONLY

PHYSICIAN / PRACTITIONER FOCUSED EXAM

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

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

Pre-placement Assessment and Subsequent Physical Examination Record _____

Print Full Name

I. STEP 1 OF MEDICAL CLEARANCE - Exam date: _____

1. ☐ Has completed Step 1 of the medical clearance process and is qualified for unrestricted work pending lab results
2. ☐ Has completed Step 1 of medical clearance process but requires clearance from personal provider(s) for:

   ☐ _____ ☐ _____ ☐ _____

3. Is not qualified for work as a _____

   due to: _____

_____ _____

Practitioner Signature Date

☐ **EH Nurse chart review identified no concerns that were not addressed at time of exam: Initials -** _____

II. STEP 2 OF MEDICAL CLEARANCE – Review date: _____

1. ☐ Additional medical information reviewed. Candidate is qualified for unrestricted work
2. ☐ Candidates personal provider(s) have provided restrictions due to chronic medical concerns.

   _____

   _____

3. ☐ Candidate requires the following accommodations in order to perform their essential job functions:

   _____

   _____

_____ _____

Practitioner Signature Date

4. ☐ Is not qualified for work as a _____

   Based on review of the job description and the essential job functions for this role, the medical information obtained during the pre-hire assessment and the documentation the candidates provider made available, Employee Health or Occupational Medicine has determined that this candidate is not able to perform the functions of this position safely. This information will be communicated directly to the candidate and the Talent Team to assist the candidate in applying for alternative positions.

_____ _____

Practitioner Making Determination Signature Date

Candidate has been Notified of this determination by:

_____ _____

Practitioner Name Date

☐ **EH Nurse has notified Talent Team of this determination: Initials -** _____

Lehigh Valley Health Network
A PASSION FOR BETTER MEDICINE.

Name _____
(PLEASE PRINT FULL NAME)

Department _____

Employee ID OR SUI # _____
(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):_____

_____

Print Full Name

Part A. Section 2 (Mandatory)
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?

_____
_____

_____

Print Full Name

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?

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:

(Check one)

☐ Employee Health Services- CC
☐ Employee Health Services – Muhlenberg
☐ Employee Health Services – Pocono
☐ Employee Health Services – Schuylkill
☐ Employee Health Services - Hazelton

_____	_____	_____
Date	Licensed Health Care Professional	Signature

☐ Copy of Respirator Certification form given to new hire at time of physical

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