All newly hired colleagues are required to complete a health assessment with a certified negative 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 Employee Health 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
Employee Health, 1243 Cedar Crest	1243 S Cedar Crest Blvd suite 101
Employee Health, 1770	1770 Bathgate Rd, Suite 200
LVPG Occupational Medicine - Pocono	2838 PA 611, Tannersville
LVPG Occupational Medicine - Schuylkill	100 Schuylkill Medical Plaza, Suite 103
LVPG Occupational Medicine Hazelton- Station Circle	26 Station Circle, Hazelton

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 both patients and LVHN colleagues.

So that we can provide an excellent experience for you throughout the process, please bring the following to your medical assessment:

1. **Prescription bottles**
2. **Immunization Records- To include MMR, Varicella, Hepatitis B, TDAP, COVID, Current Season Influenza**
3. **Tuberculosis records if you ever tested positive or have history of latent Tuberculosis disease, provide documentation of chest X-ray within past 3 months and documentation of prophylactic consultation and treatment.**
4. **Please note: If additional information is requested by Employee Health, 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 the Monday prior to your anticipated start date may delay your start date. Additionally, failure or refusal to provide the requested information may result in your offer of employment being rescinded.**

In accordance with applicable federal, state, and local employment opportunity laws and regulations Lehigh Valley Health Network subsidiaries and affiliated entities provide employment opportunities to all persons without regard to protected classes as defined by law, that include, race, color, religion, sex, age, national origin, sexual orientation, genetic information, disability, gender identity or gender expression. Equal employment opportunity applies to all terms and conditions of employment, including hiring.

PRE-EMPLOYMENT/POST OFFER MEDICAL HISTORY & AUTHORIZATION FORM

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	My preferred name is:	

Employment History

Have you ever worked for any Lehigh Valley Health Network entity (Lehigh Vallely Health Network entities include, but are not limited to, the following: 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:

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, over the counter or other medications.**

☐ I have listed all of the medications I take below including **vitamins, herbal or nutritional supplements, over the counter or other medications**. (Use additional paper if needed)

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

SURGERIES/PROCEDURES INCLUDING DATES

OCCUPATIONAL HEALTH HISTORY

IF YES, GIVE DETAILS

Have you ever had an occupational injury/illness?	☐ YES ☐ NO	

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, other neurological problems	☐ YES ☐ NO	
Cancer, leukemia, lymphoma	☐ YES ☐ NO	Diagnosed: ☐ Radiation ☐ Chemotherapy Last treated:
Gastrointestinal disease, Liver disease, jaundice	☐ YES ☐ NO	
Lung/Respiratory Disease	☐ YES ☐ NO	
Heart Disease-including High blood pressure, heart attack	☐ YES ☐ NO	
Eye Concerns/Hearing concerns	☐ YES ☐ NO	
History of Convulsions or seizures?	☐ YES ☐ NO	Date of last seizure?
Headaches/Migraines Brain trauma/concussion, head injury of any type?	☐ YES ☐ NO	
Serious accident/injuries sustained?	☐ YES ☐ NO	
Bleeding or clotting disorder, anemia, Sickle Cell disease,?	☐ YES ☐ NO	
Kidney, bladder disease/complications	☐ YES ☐ NO	
ALLERGIES Food, Drug, Environment	☐ YES ☐ NO	

MENTAL HEALTH / ADDICTION: ***IF YES, GIVE DETAILS***

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 been diagnosed or do you have 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?	☐ NO ☐YES	√ All that apply: ☐ PHMP ☐ SARPH ☐ VRP ☐ PHP ☐ DMU ☐ PNAP ☐ OTHER _____

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

Arthritis, Fibromyalgia, rheumatoid arthritis, systemic lupus, nerve disorder	☐ YES ☐ NO	
Muscular or neuromuscular disease?	☐ YES ☐ NO	
Herniated disc? Bulging disc? Slipped disc?	☐ YES ☐ NO	
Any back or neck problems?	☐ YES ☐ NO	
Shoulder injury or problems?	☐ YES ☐ NO	
Bursitis, tendonitis?	☐ 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	
Any broken bones in past 6 months ?.	☐ YES ☐ NO	

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 accommodations you will need:	

_____
Print Full Name

I, the undersigned do hereby certify to the best of my knowledge have completed this post offer medical evaluation form, providing accurate and truthful information. I understand that failure to provide accurate, truthful, and complete information, including any prescription medications may impact my employment status.

By checking the boxes and signing I am certifying these statements and verifying my understanding of this medical clearance process.

☐ I agree to submit to a medical evaluation and understand that my employment is contingent upon successfully passing the medical evaluation, including laboratory studies reflective of immunity or disease and physical examination and understand LVHN follows universal immunization policies as well as infected health care policies. I am aware I may request an exemption for vaccinations for valid medical reasons or for a bona fide, sincerely held religious belief.

☐ 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. Failure or refusal to provide requested information may result in my offer of employment being rescinded.

☐ I understand that I must submit to urine screening for the presence of drugs/alcohol. I understand that if the laboratory reports the drug/alcohol test positive, the information will be sent to the Medical Review Officer (MRO) for review and interpretation. The MRO will review those results with you before final determination is made. 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 that results of my pre-employment evaluation may be shared with my direct supervisor if such information is needed to determine restrictions, ability to work, or reasonable accommodations.

☐ I understand that any Pre-Employment Physical examination is used for the determination of fitness for duty to perform essential job functions at a Lehigh Valley Health Network subsidiary. 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.

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)