

OCCUPATIONAL HISTORY

ACCIDENT HISTORY

NO ACCIDENT HISTORY

DATE	INJURY/ILLNESS	WORK-RELATED YES NO	WORKER'S COMPENSATION BENEFITS

INFECTIOUS DISEASE & IMMUNIZATION HISTORY

WRITTEN DOCUMENTATION OF IMMUNIZATIONS MUST BE PROVIDED AT THE TIME OF HEALTH SCREENING

	HAD DISEASE YES NO	HAD VACCINATION YES NO	NURSE ONLY DOCUMENT PROVIDED Y-N	ORDERED
	Rubella (German Measles)			
Rubeola (Measles)				
Mumps				
Varicella (Chicken Pox)				
Tetanus Booster				
Hepatitis B			Hep B AB	
			Hep B Ag	
			Hep B Core	
			RAST	

TUBERCULOSIS RISK ASSESSMENT SCREENING

If you had a TB test in the past please answer the following:

When was your last TB test?	
Was it negative or positive?	
Where was it done? Do you have documentation of the result?	
Was a CXR done? Was the result normal?	
Did you ever have a vaccine (BCG) for tuberculosis? What year?	
Did you take medication for a positive TB test?	
How long did you take the medicine?	
If you were born outside the U.S., how long have you been in the U.S.?	
Have you had any known contact with active TB	
Have you had a NEGATIVE TB skin test in the past 2 years	
Do you take Steroid medication?	

PRE-PLACEMENT OCCUPATIONAL HEALTH EVALUATION
ALL INFORMATION IS CONFIDENTIAL

Special Accommodations:

- A. Do you have any health condition(s) that may interfere with your ability to perform your basic job duties in a healthy and safe manner?
Yes____ No____ If yes, please explain:

- B. Have you ever been told to restrict your physical activity at work?
Yes _____ No _____ If yes, please explain:

- C. Will you require any special equipment or assistive devices to perform your job?
Yes_____ No_____ If yes, please explain:

I understand all medical information obtained from this assessment is considered confidential and cannot be released without my written consent.

I have been advised that I must complete all infection control requirements including:

- Lab testing.
- Immunizations.
- Decisions regarding Hepatitis B vaccine, if appropriate.
- Screening for tuberculosis.

I understand that failure to meet all employment requirements will result in postponement of my date of hire or suspension and/or termination of my employment.

I hereby declare that my answers to the above health assessment questions are complete and true to the best of my knowledge.

Employee signature

Date



Beth Israel Deaconess Medical Center
Employee/Occupational Health Service
West Campus, Lowry Medical Office Building, Suite 6C
Hours: Monday-Friday: 7:30am to 4 pm
Phone: (617) 632-0710 FAX: (617)-632-0906

To: All BIDMC Applicants (Paid and Non-Paid), as well as all HMFP members.

From: Employee Occupational Health and Dieter Affeln, M.D.
Medical Director, Employee/Occupational Health
Beth Israel Deaconess Medical Center

In order for your application to be finalized, the following information is required to meet BIDMC requirements, which are based on the following: state and federal regulations; Joint Commission Standards; and Infection Control policies. Your application will not be processed until all required documentation listed below is received and approved by Employee/Occupational Health. This information is necessary in order so that we may protect both our patient population and you from potential infections of public health significance.

Official documentation (i.e. completed by your medical provider/clinic OR laboratory results) of your immunizations must be PROVIDED to the Employee/Occupational Health Services prior to your start date at the Medical Center and shall include the following:

- 1. Tuberculosis (TB) test: Official documentation within past three months of your start date, as well as a prior documented skin test within the year. If you cannot provide this documentation, you will be required to complete 2-step TB testing (baseline skin testing and repeat testing in 1-3 weeks). If you are here for less than three months, documentation of one TB test within the past three months is sufficient.
-Those with history of BCG are required to have TB testing.
-Those with history of positive TB test must submit both:
-Official documentation of the positive result in MM of induration
-Report of chest x-ray performed within past year
2. Rubella (German measles): Official documentation of vaccine or positive blood test result
3. Rubeola (Measles): Official documentation of two vaccines or positive blood test
4. Mumps: Official documentation of two vaccines or a positive blood test
5. Tetanus-Diphtheria Booster: Official documentation of vaccine with in the last 10 years
6. Varicella: Official documentation of two varicella vaccines or positive blood test if no hx of disease

FOR ALL THOSE WHO WILL HAVE DIRECT PATIENT AND/OR BLOOD /BODY FLUID CONTACT:

- 7. Hepatitis B Vaccine: Official documentation of positive Hepatitis B vaccine surface antibody titer. If you are here for less than three months, documentation of just the vaccine series is sufficient.

Please have this sheet accompany the required immunization information listed above, and fax to Employee/Occupational Health at 617-632-0906. Please print the following information:

Name: _____ Date of Birth: _____ Social Security: _____
Address: _____ City: _____ State: _____ Zip Code _____
Telephone: _____
Department/Position: _____ Start Date _____ End Date _____
Department Contact Person phone/fax _____
Signature: _____ Date _____

TO BE COMPLETED BY EMPLOYEE/OCCUPATIONAL HEALTH

[] HOLD, Date: _____
Pending: _____
[] CLEARED, Signature RN: _____ Date: _____

**Beth Israel Deaconess Medical Center
Employee/ Occupational Health Services (EOHS)
Health Screening for Respirator Fit Test**

Employee Information

Name: _____
 DOB: _____
 Telephone ext/pager ID: _____
 Department/Location: _____

Medical History

Angina	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Asthma	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Diabetes treated w/insulin	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Emphysema	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Epilepsy or Seizures	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Heart Attack	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Heart Disease	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
High Blood Pressure	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Latex Allergy	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Lung Disease	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Review of Symptoms

Are you short of breath at rest?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you get short of breath walking?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you get short of breath at work?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you get chest pain with certain activities?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you get chest pain at work?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Have you ever experienced dizziness at work?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you wear contact lenses at work?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you have any medical problems that might interfere with respirator use?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

List any medications you are currently taking (prescription & OTC): _____

List any allergies: _____

If you answered "yes" to any question above, please explain: _____

Smoking History

Smoker	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	If yes, how many packs per day? ____
Ex-smoker	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	If yes, when did you last smoke? ____

**This point on filled out by EOHS
Return completed form to EOHS LMOB 6 or Fax 2-0906**

Occupational Health Department Evaluation

Physical exertion during respirator use is: Light Moderate Heavy
 Length of time respirator will be worn during shift: <1 hour 1-4 hours 4-12 hours

Approved to use respirator Yes No
 If answer is no, give reason. _____

Approved with restrictions Yes No
 If answer is yes, list restrictions. _____

Further evaluation required Yes No
 Comments: _____

Signature Occ. Health Representative: _____ Date: _____

BIDMC
EMPLOYEE OCCUPATIONAL HEALTH SERVICE
TB COMPLIANCE PROGRAM

NAME _____

DATE OF BIRTH _____

DEPARTMENT _____

JOB TITLE _____

DATE _____

In order to comply with employee health guidelines for the prevention of tuberculosis, employees who cannot be screened for tuberculosis with PPD testing must undergo a “symptom check” for pulmonary tuberculosis on a YEARLY basis or following a possible exposure.

You have been identified as an employee who needs to undergo a “symptom check”. Please respond to the following questions. Positive answers suggest the possibility of tuberculosis infection and you will be evaluated further in Employee Health Services.

In the past year have you experienced any of the following symptoms?

Cough lasting longer than 14 days _____ NO YES

Unexplained loss of greater than 10% of your weight _____ NO YES

Unexplained fever for more than 14 days _____ NO YES

Unexplained fever at night _____ NO YES

Sweats while sleeping that require a change of clothing _____ NO YES

Unexplained cough with bloody discharge _____ NO YES

In the past year, have you been exposed to anyone who has been diagnosed with or strongly suspected of having an active infection with tuberculosis?

NO YES

Thank you very much for completing this form.

Please return this form to Employee Health Services at BIDMC.

Our Fax number is 617-632-0906. You will be contacted if further evaluation is required.