Jackson HEALTH SYSTEM
PUBLIC HEALTH TRUST
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Occupational Health Services (OHS)

Pre-Placement Health Screen Instructions and Forms

New Residents and Fellows

PH: 786-466-8381
FAX: 305-355-5394
healthoffice@jhsmiami.org
Hour of Operations
Monday – Friday: 7:30am – 4:00pm
Excluding Holidays

Occupational Health Services
Jackson Medical Towers
1500 N.W. 12th Ave
11th Floor, Suite 1103
Miami, FL 33136

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OCCUPATIONAL HEALTH SERVICES

Phone: (786)466-8381 **Fax:** (305)355-5394

Email: HealthOffice@jhsmiami.org

Welcome to Jackson Health System!

Enclosed are the following forms required for OHS Health Screening:

a) *Registration and Consent Form*

b) *OHS Pre-Placement Health Screen*

c) *OHS Medical and Occupational History Statement*

d) *Respirator Medical Questionnaire*

Additional enclosures

e) *Pre-Placement Health Screening Instructions*

f) *JHS Campus Map*

Please read the "**PRE-PLACEMENT HEALTH SCREEN INSTRUCTIONS"** carefully. All forms must be completed, signed, dated, and return to OHS prior to scheduling appointment. Failure to follow the instructions as outlined in the documents may result in having to resubmit and consequently delay the scheduling process.

Should you have any questions please call or send email. We look forward to seeing you!

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University of Miami / Jackson Memorial Medical Center Campus

- P1 BLUE GARAGE (North)
- P2 YELLOW GARAGE (Highland)
- P3 RED GARAGE (Park Plaza East)
- P4 BLUE LOT (Lot 5)
- P5 ORANGE GARAGE (Jackson Medical Towers)
- P6 GREEN GARAGE (Park Plaza West)

C C C C C

ChipCoin Automated Payment Station

P5 DESTINATION

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PRE-PLACEMENT HEALTH SCREENING INSTRUCTIONS

All JHS employees must have a physical exam, have received immunizations and be tested for alcohol and drugs of abuse within 45 days of the first day at work. Applicants who do not complete health screening requirements, who are confirmed positive for illegal drugs or unauthorized use of controlled substances, or who have refused a drug test will not be allowed to begin work and will be separated from employment and the Graduate Medical Education Program. To ensure compliance and to expedite completion of physical and drug testing requirements, please do the following:

1. Email or Fax the completed **OHS Health Forms (a thru d) with immunization records or titers** to Occupational Health Services (OHS) as soon as possible.
   - *a) Registration and Consent Form (your signature required)*
   - *b) OHS Pre-Placement Health Screen Form*
   - *c) OHS Medical and Occupational History Statement Form (your signature required)*
   - *d) Respirator Medical Questionnaire Form*
   - e) *Immunization records and/ or titers*
2. View the table below for the first and last available appointment dates to schedule your OHS appointment.
3. Call **786-466-8381** to *schedule an appointment*.

Note: OHS Health forms must be submitted prior to scheduling appointment date.

DEADLINES FOR COMPLETING HEALTH SCREEING REQUIREMENTS

New Residents & Fellows	Start Date at JHS	**First Available** Appointment for Drug Screening	**Last Available** Appointment for Drug Screening
PGY 1	6/24/14	5/12/14	7/24/14
PGY 2 - 7	7/1/14	6/2/14	8/1/14

4. Bring government- issued photo identification (Examples: Driver's License, Passport, State ID)
5. Plan to arrive at least 30 minutes early to allow for any delays.
6. Plan to spend at least two hours. There is a parking charge; you will be responsible for this fee.
7. Due to safety guidelines and limited space, we ask that you leave children at home.
8. **Questions or concerns** – Call the Pre-placement Coordinator at 786-466-8381 or email HealthOffice@jhsmiami.org.

OCCUPATIONAL HEALTH SERVICES

Phone: (786)466-8381 **Fax:** (305)355-5394

Email: HealthOffice@jhsmiami.org

The following are required by Jackson Health System and regulatory agencies for Health Care Workers:

- **Medical and Occupational History** including prior injuries, exposures drug abuse history and any current work restrictions
- Proof of (2) **Measles, Mumps and Rubella** vaccine **(MMR)** or proof of positive **Measles, Mumps** and **Rubella** titers. (All Three)
- Proof of **Varicella (Chickenpox)** titer or proof of (2) varivax vaccinations
- History of **Hepatitis B Vaccination** or sign a declination form
- **Respirator Fit Test**
- **TB Screening Tests:**
  - If you have a negative TB skin test (TST) or Interferon- Gamma Release Assay (IGRA) **QuantiFERON** or **T-SPOT testing** within 12 months you will receive a screening test.
  - If you have not received a TST or IGRA test in the last 12 months, you will need a two-step skin testing at least one week apart.
  - Be prepared to return in 48-72 hours to have the TST read.
- **Chest X-Ray** taken within the past 6 months if you have a history of a positive TST or positive IGRA test.

DRUG TEST PREPARATION

Alcohol and Urine Drug Screening is performed according to Miami-Dade County Scientific and Administrative Protocol

- You can have a regular breakfast but do not consume over 8oz of fluids within two (2) hours prior to your appointment.
- Bring medication bottles or prescription description from a pharmacy for any controlled substances taken in the two weeks prior to the drug test date, such as sleeping pills, or pills for anxiety or depression.

Reasons and Consequences of Failed drug test includes ANY of the following without exception:

- Positive test for an illegal substance
- Positive test for a controlled substance without a valid medical prescription
- Cancel or attempt to reschedule a drug test appointment after the "last date to schedule"
- Breath analysis is positive for alcohol
- An applicant will be reported to have *"refused to provide a drug test"* when the applicant:
  - Cancels or attempts to reschedule a drug test appointment after the "last date to schedule".
  - Attempts to delay testing, adulterate or modify the sample or test outcome

Licensed professionals who fail the drug test will be reported to the Florida Agency for Health Care Administration Licensing Board and/or to the Professional Resource Network (PRN). All expenses for further medical evaluation or treatment as a result of positive drug test or appeal will be the responsibility of the applicant.

RESPIRATOR FIT TESTING PREPARATION

- No sweets two hours before the test including gum, soft drinks, sweet coffee, mints, hard candy, etc.
- No facial hair where the edges of the respirator will be in contact with the face.

Occupational Health Services
Registration and Consent

INSTRUCTIONS: **PLEASE PRINT LEGIBLY AND COMPLETE ALL BLANKS.**
IF THE QUESTIONS ARE NOT APPLICABLE, PLEASE WRITE (N/A)

PRINT YOUR NAME AS IT APPEARS ON YOUR PROFESSIONAL LICENSE OR SOC. SEC. CARD

NAME:			**SOCIAL SECURITY #**	
PHONE (home):	**CELL**		**EMAIL**:	
ADDRESS:		**APT#**	**PAGER**	
CITY:	**STATE**:		**ZIP CODE**:	
DATE OF BIRTH: **AGE**:	**SEX**: F M	**RACE**: W B H Other	**Marital Status**: S M D	
FEMALES ONLY: MAIDEN NAME:	OTHER LAST NAMES USED			
Have you ever been a patient, employee, or student at Jackson memorial Hospital before? **Yes** **No**				
If yes, under what name(s) were you admitted? _____ Year(s)_____				

Acknowledgement of Pre-Placement Drug Testing and Health Requirements

My signature below means that I understand that all JHS employees must participate in a **physical exam, complete all immunizations,** and be tested for alcohol and **drugs of abuse within 45 days of the first day at work**. I understand that if I do not complete health screening as requested by Occupational Health Services, I am confirmed positive for illegal drugs or unauthorized use of a controlled substance, or I am considered to have refused a drug test, I will not be allowed to work for Jackson Health System and will be separated from employment, Graduate Medical Education Program or any other Jackson Health System program for which I am required to have pre-placement health screening. If I am required to provide a urine specimen for drugs of abuse, I understand that my urine will be tested for narcotics, depressants, hallucinogens, stimulants, marijuana, or other controlled substances. Testing is performed according to the Drug Free Workplace Act and the Miami-Dade County Scientific and Administrative Protocol. I will be considered to have a **positive drug screen** if my urine is **positive for an illegal substance, positive** for a **controlled substance** without a valid medical prescription, my **breath analysis** is **positive for alcohol,** or I **refuse to provide a drug test** or I take any action that may delay or adulterate testing**.**

I also understand that **licensed professionals who have a confirmed positive drug test will be reported to the Florida Agency for Health Care Administration Licensing Board and/or to the Impaired Nurse Program or Professional Resource Network** if eligible to participate, and that all expenses for further medical evaluations as a result of a positive drug test or appeal will be my responsibility. I have read Occupational Health Services Instructions for Pre-Placement Health Screening and understand and agree to complete the health screening, immunizations, blood tests required, and deadlines for submitting required forms and for scheduling alcohol and urine drug screen appointments, and instructions for preparing for the drug test, respirator fit test and any other examinations required before or after arrival at Jackson Health System.

Authorization for Release of Information (Under 18 Requires Legal Guardian)

I agree to allow Jackson Health Systems Occupational Health Services to contact my Health Care Provider and obtain information from my medical records for the purposes of determining my fitness to work and to verify immunizations, lab tests, x-rays and other required communicable disease information required by Jackson Health System. I consent to use a faxed copy of this authorization as an original.

Signature: _____ **Date:** _____

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Occupational Health Services
Pre-Placement Health Screen

Phone: 786-466-8381 Email: HealthOffice@jhsmiami.org Fax: 305-355-5394

Pre-Placement Health Screen Form: Must be completed by your **Primary Care Physician/ Health Care Provider**

To Be Completed by Applicant for Employment or House staff Placement			
Name(Last, First, MI)PRINT:			Last 4 digits SS# :
Birth Place:	Birth Date	Service/Work Unit:	Contact Preference: ☐ Email ☐ Mobile ☐ Phone
Phone #	Mobile #	Email	Date to Start at JHS

HEALTH CARE PROVIDER HEALTH SCREENING VERIFICATION

Please verify that this applicant has completed the health screening requirements listed below. Falsification of health information will result in termination from employment or school. Records are subject to random audits. **Illegible** forms will not be accepted.

Tuberculosis Screening (Mandatory)

Negative Tuberculosis Skin Testing (TST): Record the last two negative TST. The last TST must be completed no earlier than 3 months from the date the applicant will start at JHS. If no TST has been performed in the previous 12 months, perform two-step TST on separate arms no less than 72 hours apart. If BCG was received equal to or greater than 7 years, complete the two-step TST. **Last BCG** ☐ NA Date: _____

TST # 1 Date_____ Location R or L Result in MM _____ Date_____

TST # 2 Date _____ Location R or L Result in MM _____ Date_____

Interferon-Gamma Release Assay (IGRA) QuantiFERON or T-SPOT Result ☐ NA Date ____Result ☐ Positive ☐ Negative

Positive Tuberculosis TB Skin Tests or Positive IGRA: Date _____ **TB symptoms** ☐ No ☐ Yes

Chest X-ray PA (Must be within the past 6 months) Date _____ Results ☐ Neg. ☐ Pos. ☐ No TB? ☐Active TB?

Took INH or other TB meds?: ☐ NA ☐ No ☐ Yes Date: _____Number of Months _____

Communicable Disease Immunizations and Immunity Screening

MMR (Mandatory): Primary MMR and one MMR Booster or Must have positive titer for all 3

☐ **MMR #1 Date** _____ ☐ **MMR #2 Date** _____ If no proof give ☐ **MMR Booster** ☐ Date: _____ OR

☐ Pos. Measles(Rubeola)Titer Date _____ ☐ Pos. Mumps Titer Date _____ ☐ Pos. Rubella Titer Date _____

Varicella Titer: (Mandatory): Date _____ ☐ Negative ☐ Positive

Varicella Vaccine: ☐ Vaccination Declined Date: _____ Vaccination Date # 1_____ Date # 2 _____

Tetanus/Diphtheria (Mandatory) Must be within last 10 years ☐ **Td or** ☐ **T Dap** Date_____

Hepatitis B Vaccine (Mandatory) Declined Vaccine or Vaccination Record ☐ Declined vaccine Date: _____

Series 1 Dates: #1_____, #2_____, #3_____, HBsAbTiter: Date _____ ☐ Positive ☐ Negative. **If neg**

Series 2 Dates: #1_____, #2_____, #3_____, HBsAbTiter: Date _____ ☐ Negative ☐ Positive

If negative after 2nd series Hepatitis B Surface Antigen Titer: Date _____ ☐ Negative ☐ Positive ☐ Non-Responder

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Pre-Placement Health Screen

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Fitness for Duty / Free of Communicable Disease Statement
*** MUST BE COMPLETED BY YOUR HEALTHCARE PROVIDER***

This applicant has been examined by me and found to be free of communicable disease and fit to work in the occupation listed on this form. I certify that the above information is correct and proof is on medical file.

Printed Name of Healthcare Provider: _____

Signature_____ **Date**_____

Name of Medical Facility Completing This Form	**Phone**
Address (Street, City, State, Zip)	**Fax or Email**

OTHER REQUIRED SCREENING

Vision Screening (Mandatory)
May be completed by Primary Care Physician, Optometrist or Employee Health Service

Visual Acuity (Mandatory): Date _____ Right _____/_____ Left _____ /_____

Corrected: ☐ Contact Lenses ☐ Eye Glasses ☐ NA **Color (Mandatory)**: Date_____ ☐ Normal ☐ Abnormal

If color tests are abnormal, describe. _____

Can vision be corrected? ☐ No ☐ Yes If Yes Explain: _____

Completed by: _____**Company** _____**Phone:**_____

Respirator Fit Testing (Mandatory for Direct Care Givers)
To be completed by Employee Health Services at current facility, if the facility uses one of the respirators listed below.
If fit testing has not been completed on one of these respirators, you will be fit tested when you arrive for drug testing.

Indicate (P) Pass or (F) Fail or NA (Not Fit Tested) below. Fit Test is required every 12 months

☐ 3M 1860R ☐ 3M 1860S ☐ KC (Duckbill) Regular PFR95270 ☐ KC (Duckbill) Small PFR95274

Last Date: ___/___/___ Other Respirator Manufacturer and Model Used: _____

Completed by: _____**Company** _____**Phone:**_____

Occupational Health Services

Medical & Occupational History Statement

Name;_____ **DOB**: _____ **Age**:_____

Department:_____ **Job Title**:_____ **SS#**_____

A. HAVE YOU EVER BEEN DIAGNOSED AND TREATED FOR THE FOLLOWING?

Yes	No		Yes	No	
___	___	High cholesterol/triglyceride	___	___	Thyroid disease
___	___	Heart attack	___	___	Ulcer/Stomach problems
___	___	High blood pressure	___	___	Anemia
___	___	Diabetes	___	___	Arthritis
___	___	Cancer/tumors	___	___	Back injury/pain
___	___	Asthma/wheezing	___	___	Varicose veins
___	___	Epilepsy	___	___	Kidney disease
___	___	Skin problems	___	___	Hernia
___	___	Rheumatic fever	___	___	Hay fever/allergies
___	___	Serious injury/auto accident	___	___	Painful periods
___	___	Other_____			

B. HAVE YOU RECEIVED MEDICAL CARE FOR OR HAD ANY OF THE FOLLOWING SYMPTOMS IN THE PAST 5 YEARS?

Yes	No		Yes	No	
___	___	Fainting/dizziness	___	___	Chronic fever
___	___	Severe headaches	___	___	Blood in urine
___	___	Convulsions or fits	___	___	Painful urination
___	___	Loss of memory	___	___	Frequent urination
___	___	Deafness	___	___	Jaundice
___	___	Hearing loss	___	___	Vomiting blood
___	___	Nosebleeds	___	___	Recent weight loss
___	___	Frequent hoarseness	___	___	Coughing up blood
___	___	Shortness of breath	___	___	Frequent chronic cough
___	___	Chest pain	___	___	Frequent vomiting
___	___	Palpitations	___	___	Night sweats
___	___	Swollen ankles	___	___	Black/bloody Stools
___	___	Painful joints	___	___	Frequent diarrhea
___	___	Anxiety/depression/psychosis	___	___	Constipation

C **ALLERGIES**

Yes	No	
___	___	Environmental (Dust, Pollen)
___	___	Food
___	___	Drugs
___	___	Latex gloves
___	___	Other:_____

D. **SUBSTANCE USE**

Yes	No	
___	___	Tobacco/packs per day: _____
___	___	Alcohol intake drinks per Wk _____
___	___	Caffeine /cups per day: _____
___	___	Other: _____

E. OPERATIONS/HOSPITALIZATIONS

List reasons and dates: _____

F. LAST CHEXT X-RAY DATE _____ RESULTS:_____

Occupational Health Services

Medical & Occupational History Statement

Name: _____

G. LAST EKG DATE _____ RESULTS: _____

H. FEMALES ONLY
Last menstrual period: _____
Last pap smear: _____
Last breast exam: _____
# of pregnancies: _____ # Live births: _____

I. MEN ONLY
History of prostate problems: _____
Swelling or pain in scrotum: _____

J. WORK HISTORY

	Yes	No
Have you ever worn a respirator ?	___	___
Have you ever been unable to hold a job or perform certain tasks in a job because of?	___	___
Inability to perform certain motions	___	___
Inability to assume certain positions	___	___
Sensitivity to any chemicals, dust, latex, gloves, etc.	___	___
Other medical and/or mental reasons	___	___

Have you ever been?	Yes	No
Refused employment because of health	___	___
Refused insurance because of health	___	___
A patient in mental hospital or a drug rehab program?	___	___
Used a self-help rehabilitation program for drug/alcohol abuse	___	___
Required to participate in a drugs of abuse program e.g. IPN, PRN?	___	___
Rejected or discharged from military service because of physical/mental reasons	___	___

Have you ever applied for, received or intend to apply for workers' compensation or other injury compensation program? Yes No
If yes, describe _____

Do you have any physical or mental impairment that would prevent you from performing specific kinds of work? Yes No

Comments: _____

_____

Certification / authorization

I hereby certify that all statements made on this form are true to the best of my knowledge. I fully realize that should an investigation disclose any misrepresentation, I will be subject to immediate dismissal.

_____ _____
SIGNATURE DATE

Respirator Medical Evaluation Questionnaire

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. Name: _____ Job Title: _____ Today's Date: _____
2. Age (to nearest year): _____ Gender: ☐Male ☐Female Height: _____ft. _____in. Weight: _____lbs.
3. A phone number where you can be reached by health care professional: _____ The best time to phone at this number: _____
4. Has your employer told you how to contact the health care professional who will review this questionnaire? ☐Yes ☐No
5. Check the type of face mask (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).
6. Have you worn a (respirator)? ☐Yes (Include brand and model numbers) _____ ☐No

Section 2. **(Mandatory)** Questions 1 through 9 below must be answered (please check "yes" or "no").

	Yes	No
1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?	☐	☐
2. Have you ***ever had*** any of the following conditions?		
a. Seizures (fits)	☐	☐
b. Diabetes (sugar disease)	☐	☐
c. Allergic reactions that interfere with your breathing	☐	☐
d. Claustrophobia (fear of closed-in places)	☐	☐
e. Trouble smelling odors	☐	☐
3. Have you ***ever had*** any of the following pulmonary or lung problems?		
a. Asbestosis	☐	☐
b. Asthma	☐	☐
c. Chronic bronchitis	☐	☐
d. Emphysema	☐	☐
e. Pneumonia	☐	☐
f. Tuberculosis	☐	☐
g. Silicosis	☐	☐
h. Pneumothorax (collapsed lung)	☐	☐
i. Lung cancer	☐	☐
j. Broken ribs	☐	☐
k. Any chest injury or surgeries	☐	☐
l. Any other lung problem that you've been told about?	☐	☐
4. Do you ***currently*** have any of the following symptoms of pulmonary or lung illness?		
a. Shortness of breath	☐	☐
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline	☐	☐
c. Shortness of breath when walking with other people at an ordinary pace on level ground	☐	☐
d. Have to stop for breath when waling at your own pace on level ground	☐	☐
e. Shortness of breath when washing or dressing yourself	☐	☐
f. Shortness of breath that interferes with your job	☐	☐
g. Coughing that produces phlegm (thick sputum)	☐	☐
h. Coughing that wakes you early in the morning	☐	☐
i. Coughing that occurs mostly when you are lying down	☐	☐
j. Coughing up blood in the last month	☐	☐
k. Wheezing	☐	☐
l. Wheezing that interferes with your job	☐	☐
m. Chest pain when you breathe deeply	☐	☐
n. Any other symptoms that you think may be related to lung problems	☐	☐

	Yes	No
5. Have you ***ever had*** any of the following cardiovascular or heart problems?		
a. Heart attack	☐	☐
b. Stroke	☐	☐
c. Angina	☐	☐
d. Heart failure	☐	☐
e. Swelling in your legs or feet (not caused by walking)	☐	☐
f. Heart arrhythmia (heart beating irregularly)	☐	☐
g. High blood pressure	☐	☐
h. Any other heart problem that you've been told about?	☐	☐
6. Have you ***ever had*** any of the following cardiovascular or heart symptoms?		
a. Frequent pain or tightness in your chest	☐	☐
b. Pain or tightness in your chest during physical activity	☐	☐
c. Pain or tightness in your chest that interferes with your job	☐	☐
d. In the past two years, have you noticed your heart skipping or missing a beat	☐	☐
e. Heartburn or indigestion that is not related to eating	☐	☐
f. Any other symptoms that you think may be related to heart or circulation problems	☐	☐
7. Do you ***currently*** take medication for any of the following problems?		
a. Breathing or lung problems	☐	☐
b. Heart trouble	☐	☐
c. Blood pressure	☐	☐
d. Seizures (fits)	☐	☐
8. If you've used a face mask (respirator), have you ***ever had*** any of the following problems? (If you've never used a face mask (respirator), check the following space and go to question	☐	☐
a. Eye irritation	☐	☐
b. Skin allergies or rashes	☐	☐
c. Anxiety	☐	☐
d. General weakness or fatigue	☐	☐
e. Any other problem that interferes with your use of a face mask (respirator)? Describe_____	☐	☐

Health Care Provider Opinion

Approved to use face mask (respirator)? ☐Yes ☐No (If no give reason) _____

Provider Signature: Date: