UCLA Health

PRE-EMPLOYMENT PHYSICAL

OCCUPATIONAL HEALTH QUESTIONNAIRE

Print Form, Complete All Questions

Last Name: _____ **First Name:** _____ **MI:** ___

Date of Birth: _____ **SSN (last 4 only):** _____ ☐ **Male** ☐ **Female**

Address: _____

Street **City** **State** **Zip**

Email Address: _____ **Phone Number:** _____

Position Applied For: _____ **Hiring Department:** _____

I have reviewed the description of the job for which I am applying.

_____ _____

X Signature **Date**

Do you have any condition, illness, injury, or are taking any medication that affects any of the following job related abilities for your position as identified in your job description? (*Please answer ONLY the specific questions below that relate to the essential functions of the job for which you are applying, as outlined in your job description.)*

VISION

Do you have any impairment of vision, which is not correctable?

☐ Yes ☐ No Please explain _____

HEARING

Do you have any impairment of hearing, which is not correctable?

☐ Yes ☐ No Please explain _____

SPEECH

Do you have any impairment which interferes with your ability to communicate with others?

☐ Yes ☐ No Please explain _____

MOVEMENT & STRENGTH

Do you have any impairment of the following body parts:

SHOULDER or ELBOW

☐ Yes ☐ No Please explain _____

HAND or WRIST

☐ Yes ☐ No Please explain _____

FOOT or LEG

☐ Yes ☐ No Please explain _____

NECK

☐ Yes ☐ No Please explain _____

BACK

☐ Yes ☐ No Please explain _____

Continue on next page

UCLA Health

HEALTH QUESTIONNAIRE
(Continued)

BREATHING
Do you have any problems with your breathing?

☐ Yes ☐ No Please explain _____

CARDIAC
Do you have any condition or medication which would limit you?

☐ Yes ☐ No Please explain _____

BALANCE AND/OR CONSCIOUSNESS
Do you have any condition or medication which can effect your balance and/or consciousness?

☐ Yes ☐ No Please explain _____

PSYCHOLOGICAL AND/OR EMOTIONAL DISORDERS

☐ Yes ☐ No Please explain _____

ALLERGIES (example Latex, Peanuts, Penicillin, etc)

Please list _____

_____

ANY OTHER CONDITION that would limit your ability to do any of the essential job functions as described in the job description?

☐ Yes ☐ No If yes, please explain _____

_____

_____

I attest that the above is true to the best of my knowledge.

Signature: X_____ **Date:** _____

UCLA Health
Occupational Health Services
10833 Le Conte Ave, CHS 67-120
Los Angeles, CA 90095
Tel: (310) 825-6771 Fax: (310) 206-4585

Occupational Health Only
TB Screen Result
☐ **CLEARED**
☐ **NOT CLEARED**

Reviewer Signature

Reviewer Name

Date

PRE-PLACEMENT
TUBERCULOSIS SCREENING

Name: _____ **Date of Birth:** _____

Staff ID# (if any): _____ **Department:** _____

Email Address: _____ **Contact Tel:** _____

PLEASE ANSWER ALL QUESTIONS

1) **I have a history of a positive TB Skin Test, T-SPOT or Quantiferon Blood Test:**

☐ **Yes** (check appropriate box) ☐ **No**

2) **I have taken INH or other medication in the past for TB infection or disease:**

☐ **Yes (complete information below)** ☐ **No**

Dates: _____ **Number of Months:** _____ **Medication:** _____

3) **Do you have:**

Recent contact of a person with active Tuberculosis	☐ **Yes**	☐ **No**
Any condition that decreases your immune system	☐ **Yes**	☐ **No**
An Organ Transplant	☐ **Yes**	☐ **No**

4) **Have you had any of the following active TB symptoms for more than 3 weeks?**

Coughing up blood	☐ **Yes**	☐ **No**
Persistent coughing	☐ **Yes**	☐ **No**
Excessive Fatigue	☐ **Yes**	☐ **No**
Excessive sweating at night	☐ **Yes**	☐ **No**
Persistent Fever	☐ **Yes**	☐ **No**
Hoarseness	☐ **Yes**	☐ **No**
Unexplained weight loss	☐ **Yes**	☐ **No**

Signature: X_____ **Date:** _____

Occupational Health Only

Quantiferon Blood Draw: Date: _____ **Result:** ☐ **Negative** ☐ **Positive** ☐ **Indeterminate**

Chest X-Ray: Date: _____ **Date Read:** _____ **Result:** _____

Action: _____

Reviewed By: _____ **Date:** _____

Appendix A

CONSENT TO SUBSTANCE ABUSE SCREENING

I. I, _____, consent to submit a specimen of urine or breath (alcohol suspicion based only) under the direction of medical personnel of UCLA Health. I understand that this specimen or sample will be used for the purpose of conducting a chemical analysis to determine if I have engaged in use of alcohol or illegal drugs. I further give my permission to UCLA Health to release my screening results to any authorized Medical Review Officer and to medical personnel in the UCLA Occupational Health Facility, but to no other person without my further written consent. I understand that this examination is being conducted pursuant to UCLA Policy. I will cooperate fully with UCLA Health and its designated testing personnel in the administering of the drug and alcohol screening.

II. I have ☐ I have not ☐ taken ANY medication and/or drugs of any kind
III. in the past thirty (check appropriate box) (30) days including:

☐ Over-the-counter medications ☐ Prescription or other drugs

IV. Drugs that I have taken within the past (30) days include (continue on separate sheet if necessary):

Brand Name of Drug	Dosage/Strength Per Day	Date and Time of Dosage	How Many Days Was it Used

Comments /Explanations _____

I certify that any urine and/or breath specimen or sample given by me belongs to me and is given solely for the purposes of substance abuse screening. I further certify that the above information is correct to the best of my knowledge. I understand that UCLA Health may require me to produce documentation to verify the above information and that my refusal to do so may result in disciplinary action up to and including dismissal from employment.

In consideration of my continued employment, I hereby release and agree to hold UCLA Health and its representatives harmless against any and all claims, charges or causes of action whatsoever I now have or may have in the future, which may arise from this test. I understand that UCLA Health or any other laboratory selected by UCLA has the exclusive control over the method of conducting this test. I CERTIFY THAT I HAVE READ AND AGREE TO THE ABOVE PROVISIONS.

_____ _____
Employee Signature Date

_____ _____
Witness Signature Date

UCLA Health

Occupational Health Immunization/Titer/TB Requirements

UCLA Health System screens new hires for Tuberculosis, Measles, Mumps, Rubella and Varicella, as recommended by the Center for Disease Control and Prevention. Please bring your immunization records with documentation of the following to your health screening appointment.

You are encouraged to bring records if available. If you are unable provide documentation of these requirements, these services will be provided during your health screening, however, a follow up appointment may be required for clearance.

Measles, Mumps and Rubella Immunity
Please provide one of the following:

- Medical documentation of 2 MMR vaccinations at least 28 days apart OR
- Laboratory blood titers **indicating immunity to Measles, Mumps and Rubella**

Note that a person with protective measles and mumps titers but not a protective rubella titer and who has only one MMR is considered protected from rubella

Varicella Immunity
Please provide one of the following:

- Medical documentation of 2 Varicella vaccinations at least 28 days apart
- Laboratory blood titers **indicating immunity to Varicella**

Tuberculosis Screening
If history of a positive TB screening test, please provide one of the following:

- Documented proof of a positive PPD or QuantiFERON Gold blood test
- Medical documentation of INH treatment including dates, if applicable.
- Chest radiograph medical report dated within the past 3 months, performed to document no active tuberculosis.

If history of a negative TB screening test please provide one of the following:

- Documentation of a QuantiFERON Gold blood test completed within the last 3 months
- Documentation of a 2-step TB skin test. Step 1 must be completed within the last 12 months. Step 2 must be completed within the last 3 months.

BCG vaccination does not exempt you from the above requirements.

Hepatitis B Screening
Please provide any one of the following:

- Proof of 3 Hepatitis B vaccinations.
- Proof of positive Hepatitis B surface Antibody blood titer demonstrating immunity.

Note that only completion of the 3 shot vaccine series plus a protective hepatitis surface antibody titer collected not earlier than 1-2 months after the 3 shot series is completed is considered evidence of protection against hepatitis B, so for the protection of healthcare personnel both are recommended

Tetanus, Diphtheria, Pertussis Vaccine (Tdap)
Please provide documentation if available. Healthcare personnel should have documentation of one TdaP on file.

Flu Vaccination
Please provide

- Documentation of seasonal flu vaccine. Flu vaccination will be available during pre-employment screening generally late Sept - April. UCLA requires employees working in a clinical area to wear a mask if declining immunization, in patient rooms or patient areas within 6 feet of patients during the flu season: Nov.1 – March 31.

Occupational Health Services
10833 Le Conte Avenue
CHS Bldg. Suite 67-120
Los Angeles CA 90095
Tel: (310) 825-6771
Fax: (310) 206-4585

Hepatitis B Vaccine

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring hepatitis B virus (HBV) infection.

(Please check appropriate box)

☐ **I would like to receive the Hepatitis B Vaccine.**

Hepatitis B Vaccine Declination (mandatory)

☐ I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to me; however, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. **If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated, I can receive the vaccination series.**

I decline the Hepatitis B Vaccination Series due to the following reason(s):

(Please mark at least one choice)

☐ I am declining because I choose not to have the hepatitis B vaccination series. I am aware that I may change my mind at a later date.

☐ I have completed the entire series of hepatitis B vaccinations. I have a record or know the date and location of those vaccinations.

☐ I have already completed the entire hepatitis B vaccination series. I do not have a record or cannot recall when I received the vaccination.

☐ I have a positive hepatitis B surface antibody titer.

☐ Other _____

_____ _____
Signature Date Date of Birth

_____ _____
Print Name Job Title/Department

_____
UCLA ID number

Revision Date: 1/15/16

Occupational Health Services
10833 Le Conte Avenue
CHS Bldg. Suite 67-120
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Tdap Vaccine

I understand that due to my occupational exposure to aerosol transmissible diseases, I may be at risk of acquiring infection with Pertussis.

(Please check appropriate box)

☐ **I would like to receive the Tdap vaccine.**

Tdap Vaccine Declination (mandatory)

☐ I have been given the opportunity to be vaccinated against this disease or pathogen at no charge to me. However, I decline this vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Pertussis, a serious disease. **If in the future I continue to have occupational exposure to aerosol transmissible diseases and want to be vaccinated, I can receive the vaccination.**

- ☐ I am declining because I choose not to have the Tdap vaccination. I am aware that I may change my mind at a later date.
- ☐ I have already received a Tdap vaccination. I have a record or know the date and location of that vaccination.
- ☐ I have already received a Tdap vaccination. I do not have a record or cannot recall when I received the vaccination.
- ☐ Other _____

_____ _____
Signature Date Date of Birth

_____ _____
Print Name Job Title/Department

_____
UCLA ID number

Revision date: 03/4/16

UCLA Health

Display face up on driver's side of dashboard

3 HOURS ALLOWED PARKING
Valid only in 1 of 3 spaces marked

'OHF Parking only'

Visitor Parking Lot 18

Visitor Parking Lot 18
10833 Le Conte Avenue, Los Angeles 90095
(Cross Street Tiverton)

Directions
Travelling north on Westwood Blvd turn right onto Le Conte Avenue
At Tiverton Avenue turn left, toward David Geffen SOM and Geffen Hall
Drive straight ahead into tunnel toward **'Visitor Parking 18'**
At Stop sign turn left, then pull forward and turn right into parking area

Turn left up 2nd isle, look right to see 3 parking spaces with wall sign 'OHF Parking Only'
(do not park in first space opposite yellow posts)

Parking permission paperwork must be placed on your dashboard

PLEASE NOTE

If Occupational Health designated parking spaces are full, you will need to purchase pay by space parking at the machine, you will be asked to input your license plate number and pay by credit card or cash $1, $5 notes accepted. Purchase 3 hours = $9. We apologize but we do not validate.

NOTE : Parking Officers are active - violators will be ticketed 12/21/16