New Associate Health Assessments

Associate Health Services provides health assessments and a post-offer physical exam for all new Scotland Health Care System associates. Please review the following information.

How do I prepare for my visit:

1. Complete the attached highlighted forms **prior to** your appointment.
2. Obtain copies of all Immunization records. Childhood (baby book) and adulthood immunization record should be brought in for proof of immunity. These can usually be obtained from your family doctor, local health department or a previous employer. We will be looking specifically for last TB skin test, adult MMR vaccine and if you have had the Hepatitis B vaccine. By bringing these records, you will save time and effort in getting your blood drawn.
3. Bring all completed forms to the Associate Health Department on the day of your appointment. Please arrive 10-15 minutes prior to your scheduled time.
4. Excessive use of colognes or perfumes must be avoided. Guests, patients, **and other employees** can be very sensitive to perfumes. Please do **not** wear any products with fragrance on the day of your appointment, to orientation, or to work. Remember that scented products include perfume, cologne, **and scented lotions or hand creams**.

What can I expect on the day of my visit:

All relevant health information will be assessed.

1. Rapid Drug screen collection will be performed on all applicants.
2. Titmus vision screen (eye exam) will be performed as part of all assessments.
3. The nurse will record measurements of height, weight, and vital signs.
4. Your **immunization records** will be reviewed for documentation of immunity to the following: measles, mumps, rubella, chickenpox and hepatitis B. If your records do not have the necessary documentation, blood will be drawn to make sure the employee is immune. ***Bring your records with you.***
5. If you are a staff member that will be required to enter airborne isolation rooms, you will be required to complete the attached ***"Respiratory Medical Questionnaire"***. A fit test will be conducted to determine brand, size and model of respirator you will need.
6. All employees, except those with a documented history of a past positive TB skin test, will have an ***initial skin test*** at the time of the new hire assessment. To comply with this policy the TB skin test will only be read in the ***Associate Health Department*** within 48-72 hours after placement.
    - After the reading of the initial TB skin test, the new hire will be instructed to return in one to three weeks for a ***second step TB skin test***. Any positive reading at the time of hire will be referred to their local health department for further follow-up.
    - Those with a ***past positive TB skin*** test will get a baseline chest x-ray during the new hire assessment and complete the TB Screening Questionnaire.

Thank you in advance for your assistance. If you have questions about any attached forms or policies, please do not hesitate to contact the Associate Health Department at the number listed below.

Tammy Holloway, RN, BSN, COHN-S
Assistant Director Associate Health
910-291-7676

Associate Health Assessment

Name: _____ Date: _____

Dept: _____ Exam Date: _____ Time In: _____

Reason for Exam: ☐ Pre-placement ☐ Annual ☐ Other

Social Security No: _____ Date of Birth: _____ Home Phone: ( ) _____

Mailing Address: _____ Cell Phone: ( ) _____

City/State: _____ Zip: _____ Family Doctor: _____

MEDICAL HEALTH HISTORY: *Have you ever had any of the following?* Check YES or NO on each

☐ Yes ☐ No Asthma	☐ Yes ☐ No Epilepsy/Seizures/Fits/Convulsions	☐ Yes ☐ No Peptic Ulcer
☐ Yes ☐ No Allergies	☐ Yes ☐ No Extensive Confinement from illness	☐ Yes ☐ No Pneumonia
☐ Yes ☐ No AIDS	☐ Yes ☐ No Fainting/Dizzy Spells	☐ Yes ☐ No Poliomyelitis
☐ Yes ☐ No Amputations	☐ Yes ☐ No Foot Problems	☐ Yes ☐ No Psychological Problems
☐ Yes ☐ No Anemia	☐ Yes ☐ No Headaches (Frequent)	☐ Yes ☐ No Pulmonary Disease
☐ Yes ☐ No Ankylosis of Joint	☐ Yes ☐ No Head Injury	☐ Yes ☐ No Rheumatic Fever
☐ Yes ☐ No Arteriosclerosis	☐ Yes ☐ No Heart Attack	☐ Yes ☐ No Ruptured Intervertebral Disc
☐ Yes ☐ No Back Problems/Injuries	☐ Yes ☐ No Heart Disease	☐ Yes ☐ No Scars
☐ Yes ☐ No Bone/Joint Problems	☐ Yes ☐ No Heavy Metal Poisoning	☐ Yes ☐ No Shortness of Breath
☐ Yes ☐ No Brain Damage	☐ Yes ☐ No Hemophilia	☐ Yes ☐ No Sickle Cell Anemia
☐ Yes ☐ No Breathing/Lung Problems	☐ Yes ☐ No Hepatitis	☐ Yes ☐ No Silicosis
☐ Yes ☐ No Bronchitis	☐ Yes ☐ No Hernia	☐ Yes ☐ No Sinus Problems
☐ Yes ☐ No Bursitis	☐ Yes ☐ No High Blood Pressure	☐ Yes ☐ No Skin Rash or Infections
☐ Yes ☐ No Cancer/Tumor	☐ Yes ☐ No Hodgkins Disease	☐ Yes ☐ No Sore Throat (Frequent)
☐ Yes ☐ No Carpel Tunnel Syndrome	☐ Yes ☐ No Hyperinsulinism	☐ Yes ☐ No Spinal Disc Disease
☐ Yes ☐ No Cerebral Palsy	☐ Yes ☐ No Ionizing Radiation Injury	☐ Yes ☐ No Stomach Problems
☐ Yes ☐ No Chest Pain	☐ Yes ☐ No Jaundice	☐ Yes ☐ No Stroke
☐ Yes ☐ No Chronic Cough	☐ Yes ☐ No Kidney Problems	☐ Yes ☐ No Swelling of Legs/Ankles
☐ Yes ☐ No Compressed Air Sequelae	☐ Yes ☐ No Loss of Sight	☐ Yes ☐ No Thrombophlebitis
☐ Yes ☐ No Colds (frequent)	☐ Yes ☐ No Mental Retardation	☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Deafness	☐ Yes ☐ No Motor Vehicle Crash	☐ Yes ☐ No Varicose Veins
☐ Yes ☐ No Diabetes	☐ Yes ☐ No Multiple Sclerosis	☐ Yes ☐ No Venereal Disease
☐ Yes ☐ No Ear Problems	☐ Yes ☐ No Osteomyelitis	☐ Yes ☐ No Vision Problems
☐ Yes ☐ No Emphysema	☐ Yes ☐ No Parkinson's Disease	

Please list any allergies:

☐ Medication Allergies: _____

☐ Food Allergies: _____

☐ Latex, powder, vinyl, nitrile, or dye allergies: _____

☐ Other allergies: _____

LIST ALL CURRENT MEDICATIONS:

NAME:	DOSE:	HOW OFTEN:	PHYSICIAN PRESCRIBED

SCOTLAND HEALTH CARE SYSTEM
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Associate Health Assessment **Name:** _____ **Date:** _____

HEALTH HISTORY: Answer **Yes** or **No** to the following:

1. Have you ever had a **positive** TB skin test? ☐ YES ☐ NO if yes, when & what medication taken and for how long: _____
2. Do you smoke? ☐ YES ☐ NO Have you ever smoked? ☐ YES ☐ NO If yes, what age did you quit _____ Total # of years smoked_____
3. Do you drink alcohol? ☐ YES ☐ NO If yes, how much and how often do you drink? _____
4. Based on your job description, do you currently have any physical or mental limitations and/or restrictions that would keep you from performing the essential functions of your new position? **(Examples would be: limited lifting, bending, climbing, pushing, pulling, squatting, sitting, standing, walking, etc.)** ☐ YES ☐ NO If yes, please describe or list the limitations:_____
5. Are you receiving any medical treatment at the present time? ☐ YES ☐ NO if yes, give reason _____
6. Do you wear a brace or use an appliance? ☐ YES ☐ NO
7. Have you had any recent exposures to infectious diseases? ☐ YES ☐ NO
8. Were you exposed to hazards during previous work assignments? This could include chemicals/cleaning compounds Radiations, dust or other respiratory hazards, excessive sun, infectious disease or bloodborne pathogen potential etc. If yes, please describe _____ ☐ YES ☐ NO
9. Do you currently use or have you used additive/habit forming drugs or medications that make you drowsy? ☐ YES ☐ NO
10. Have you ever had a blood clot? If **yes**, where? _____ _____when? _____ ☐ YES ☐ NO
11. Do you **currently** have an infection? _____ ☐ YES ☐ NO
12. Do you currently have an uncontrolled metabolic disease (diabetes, thyrotoxicosis, gout, myxedema, etc.) or serious disorder (mononucleosis, hepatitis, etc.)? Comments _____ ☐ YES ☐ NO
13. Has your doctor ever told you that you have a bone, joint, or musculoskeletal problem, such as arthritis or sciatica, that has been made worse by exercise or are you **currently** under medical care for any bone, joint or musculoskeletal problem? ☐ YES ☐ NO
14. Are you pregnant? ☐ YES ☐ NO
15. Do you require any accommodation or special consideration for any condition? ☐ YES ☐ NO
16. Do you have any condition (illness, infection, or medication), which affects your immune system, making you more Susceptible to infection? ☐ YES ☐ NO

PLEASE LIST ANY OPERATIONS/FRACTURES/SERIOUS ILLNESS OR INJURIES YOU HAVE HAD:

YEAR	PROBLEM:	PHYSICIAN	TYPE OF SURGERY:

WORKER'S COMPENSATION HISTORY: *Have you ever had?*

Have you ever been Injured on the job?	Date of Injury/Illness	Type of Injury/Illness	Workers Comp Benefits received?	Do you have any permanent restrictions?	Did you receive an impairment rating?
☐ Yes ☐ No			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

The Genetic Information Non-Discrimination 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.

I understand and acknowledge that Scotland Health Care System on the truth of the information that I have provided herein as a basis for my continued employment and that falsification of any of the information I have provided shall be grounds for my immediate dismissal. To that end, I certify that the information I have given herein is true and complete and I give permission for this medical examination. I also have been given an opportunity to ask any questions I might have about the information requested. I authorize release of medical information to this facility which may be necessary in determining my ability to meet the requirements of the job for which I am applying.

_____ _____

Signature of Applicant **Date**

Associate Health Assessment **Name:** _____ **Date:** _____

PHYSICAL EXAMINATION: ***TO BE COMPLETED BY MEDICAL STAFF/CHAPERONE***

Temp: _____ B/P: _____/_____ Pulse: _____ Resp: _____ Height: _____ Weight: _____ LMP: _____

		Yes	No
Skin	Skin color, mucosa pink	☐	☐
	Temperature warm	☐	☐
	Tugor normal	☐	☐
	Macules, papules, lesions, rash	☐	☐
Nails	Nail plate smooth and even	☐	☐
	Beds pink	☐	☐
	Capillary refill < 3 seconds	☐	☐
	Clubbing	☐	☐
Head	Shape symmetrical	☐	☐
Eyes	PERRLA	☐	☐
	Far (R)____/____ (L) ____/____ (B) ____/____ Color Pass	☐	☐
Ears	Tympanic membrane (shiny, translucent, pearl-gray color)	☐	☐
Nose	Septum aligned	☐	☐
	Mucosa pink	☐	☐
Neck	Veins nondistended	☐	☐
	ROM full	☐	☐
	Swallowing intact	☐	☐
	Cervical lymph nodes palpable, small, nontender	☐	☐
	Thyroid size normal	☐	☐
Lungs	Chest expansion symmetrical	☐	☐
	Respirations regular	☐	☐
	Breath sounds clear	☐	☐
	Cough (nonproductive, productive) (circle)	☐	☐
Heart	Rhythm regular	☐	☐
	Regular rate	☐	☐
	Murmur	☐	☐
Upper Extremity	Shoulder ROM full bilateral	☐	☐
	Elbow ROM full bilateral	☐	☐
	Wrist ROM full bilateral	☐	☐
	Radial pulses present	☐	☐
	Phalen's (right, left)	☐	☐
	Tinel's sign (right, left)	☐	☐
Back/Lower Extremity	Gait steady	☐	☐
	Full ROM (hip, knee, ankle)	☐	☐
	Leg raise	☐	☐
	Toe touch (inches from ground _____)	☐	☐
Abdomen	Bowel sounds present	☐	☐
	Rebound tenderness	☐	☐
	Masses	☐	☐

Referral to OH MD: ☐ **YES** ☐ **NO**

Comments: _____

In my opinion this employee is:

☐ Able to perform the essential functions of the job.

☐ Able to perform the essential functions of the job with the following restrictions/limitations: _____

☐ Performing this job would pose a direct threat to this employee or others in the work place. As per section 630.2(r) under the Americans with Disabilities Act, only assessments that directly impact the performance of essential job functions were considered in my opinion.

Signature of Examiner: _____ Date: _____ Time Out: _____

Signature of Medical Provider_____ Date: _____

Patients with Abnormal Findings: I have been notified of my evaluation results indicating the above findings. I have been advised by the Occupational Medical Provid er to follow-up with my family physician. Patient signature: _____ Date: _____

PATIENT SUMMARY LIST/MEDICATION RECONCILIATION FORM

Name: _____ DOB_____ MR # _____ Date _____

Allergies (if applicable-place allergy sticker with allergies listed on the outside of chart) ☐ **NKDA**

DRUG	REACTION

PRESENT MEDICATIONS (include OTC and Herbal medications)

DATE	NAME	DOSE	FREQ	Continue/ Discontinued	PCP	Pt. States No Provider	Summary Mailed, Faxed or Interoffice Mail	Date & Time	Initials
				Continue Discontinued					
				Continue Discontinued					
				Continue Discontinued					
				Continue Discontinued					
				Continue Discontinued					
				Continue Discontinued					
				Continue Discontinued					
				Continue Discontinued					

INJURIES

DATE	PROBLEM	PHYSICIAN	
			W/C Yes Closed Open No
			W/C Yes Closed Open No
			W/C Yes Closed Open No

SIGNIFICANT SURGICAL HISTORY

DATE	PROBLEM	PHYSICIAN	

SIGNIFICANT MEDICAL HISTORY

☐ **HTN** ☐ **Cancer** ☐ **Depression** ☐ **DM** ☐ **Stroke** ☐ **Hypercholesterol** ☐ **Cardiac/MI**
☐ **Ulcers** ☐ **Anemia**

SOCIAL HISTORY: Current Tobacco ☐ No ☐ Yes ☐ Ever Smoke # Pks/Day _____ # Yrs Smoked _____
Alcohol ☐ No ☐ Yes How Much? _____ Other Drug Use? ☐ No ☐ Yes If yes, what? _____
Literate ☐ No ☐ Yes Level of Education: ☐ Elementary ☐ High School ☐ College ☐ Other_____
Second Job ☐ No ☐ Yes If yes, what? _____
Hobbies: _____
Other: _____

SCOTLAND HEALTH CARE SYSTEM Reviewed /Reconciled By/Date: _____/_____ _____/_____

_____/_____ _____/_____

_____/_____ _____/_____

_____/_____ _____/_____

Tetanus/Diphtheria/Pertussis (Td/Tdap) Vaccine Administration Record

Employee Name: _____ Date of Birth: _____ ID#/ /SS# _____

Employer: _____ Department: _____ Job Title: _____

Vaccine:

Tetanus, diphtheria, and Pertussis are all caused by bacteria. Diphtheria and Pertussis are spread from person to person. Tetanus enters the body through cuts, scratches, or wounds. Immunization is one of the best ways to prevent disease from tetanus (lockjaw), diphtheria, and Pertussis (whooping cough

Contraindications: You should not take this vaccine without checking with your doctor if:

- You are sick right now with anything more serious than a cold;
- You have had a serious life-threatening reaction to Tetanus (DTP/DtaP/Td/Tdap) shots before;
- Persons who have had Guillain Barre Syndrome;
- You are taking a drug or undergoing a treatment that lowers the body's resistance to infection, such as: Cortisone, prednisone, certain anticancer drugs, or irradiation.
- You have had a serious life-threatening reaction to any component of the vaccine. Vaccine components can be found by going to www.cdc.gov/nip/publications/pink/appendices/b/excipient-table-2.pdf.
- Adacel (Sanofi Pasteur) is licensed only for persons ages 11-64 years.
- Have epilepsy or other nervous system problems.

Note: Use of Td or Tdap is not contraindicated in pregnancy. At the provider's discretion, either vaccine may be administered during the 2nd or 3rd trimester. Anyone who has a moderate or severe illness should wait until they recover before getting Td/Tdap.

Possible Adverse Events:

Many people have no reaction. Among patients that noticed any of these symptoms, most stated that they did not cause interference with normal activities: You may have none or some of these possible adverse events:

- Redness; swelling; or pain at or around the injection site,
- Mild fever of at least 100.4°F;
- Headache
- Tiredness
- Nausea, vomiting, diarrhea, stomach ache has occurred in 1 in 10 adults;
- Other mild problems reported include chills, body aches, sore joints, rash and swollen lymph glands

1. Are you sick, in any way today?	☐ Yes ☐ No
2. Are you pregnant or have you missed a period?	☐ Yes ☐ No
3. Do you have an acute respiratory infection or other active infection?	☐ Yes ☐ No
4. Have you ever been told you are allergic to Formalin preparations?	☐ Yes ☐ No ☐ Don't Know
5. Are you allergic to any medicine, eggs, or any vaccine or vaccine Component?	☐ Yes ☐ No
6. Have you received any radiation therapy?	☐ Yes ☐ No
7. Are you presently taking corticosteroids?	☐ Yes ☐ No
8. Do you, any person who lives with you, or any person you take care of have cancer, leukemia, AIDS, or any other immune system problem?	☐ Yes ☐ No

Consent or Declination

I have read the vaccine information statement on Td/Tdap vaccine provided by Scotland Healthcare System. I have had the opportunity to ask questions, which were answered to my satisfaction. I understand the benefits and risks of the Td/Tdap vaccine.

[ ] Yes, I want to take the Td/Tdap or Tetanus Toxoid Booster.

[ ] No, I do not wish to take the Td/Tdap or Tetanus Toxoid Booster.

Signature of person receiving or refusing vaccine _____ Date _____ Witness _____ Date _____

FOR CLINIC USE ONLY:

Temperature (less than 100°F) _____

Site of Injection:
☐ Lt. Deltoid ☐ Rt. Deltoid ☐ Other _____

Signature of Vaccine Administrator:
_____

Title of Vaccine Administration: ☐ RN ☐ LPN ☐ Other _____

_____ No adverse reaction noted (Initial)

Circle ONE: Tdap Td

Date Vaccine Administered: _____

Vaccine Manufacturer: _____

Vaccine Lot Number: _____ Exp Date: _____

Vaccine information statement given? ☒ Yes ☐ No
VIS Dated Td & Tdap (2/24/15)

_____ Monitored for 15 minutes following administration (Initial)

SCOTLAND MEMORIAL HOSPITAL

Tetanus Vaccine Administration Record
Clinic Address: Occupational Health Services
500 Lauchwood Drive Laurinburg, North Carolina ~ 28352
(910) 291-7676 ~ fax (910) 291-7564

RECORD OF TUBERCULOSIS SCREENING

Name: _____ **SS#** _____-_____-_____

Date of Birth: ___/___/___ **Department:** _____ **Title:** _____

Date of Last Chest X-Ray: _____

Have you ever had:

1. **Tuberculosis?** ☐ Yes ☐ No If yes, when and where were you treated? _____
2. **TB Skin Test?** ☐ Yes ☐ No ☐ Don't Know If yes, was it positive? ☐ Yes ☐ No If positive, how long ago, and where did you receive this test? _____
3. **Been inoculated with BCG?** ☐ Yes ☐ No If yes, how long ago and where did you receive this inoculation? _____

TB Risk Questionnaire: Please answer the following questions: Check Yes or No

1. Were you born outside the USA in one of the following parts of the World: Africa, Asia, Central America, South America, or Eastern Europe? If yes, explain __ _____ ☐ Yes ☐ No
2. Have you traveled outside the USA and lived for more than one month in one of the following parts of the world: Africa, Asia, Central America, South America, or Eastern Europe? If yes, explain _____ ☐ Yes ☐ No
3. Do you have a compromised immune system such as from any of the following conditions: HIV/AIDS, organ or bone marrow transplantation, diabetes, immunosuppressive medicines (e.g. prednisone, Remicade), leukemia, lymphomas, cancer of the head or neck, gastrectomy or jejeunal bypass, end-stage renal disease (on dialysis), or silicosis? If yes, explain _____ _____ ☐ Yes ☐ No
4. Have you ever done one of the following: used crack cocaine, injected illegal drugs, worked or resided in jail or prison, worked or resided at a homeless shelter? ☐ Yes ☐ No
5. Have you worked as a healthcare worker in direct contact with patients? ☐ Yes ☐ No

TB Symptom Questionnaire

Please answer the following questions. Do you currently have any of the following symptoms?

1. Unexplained cough lasting more than 3 weeks? ☐ Yes ☐ No
2. Unexplained weight loss? ☐ Yes ☐ No
3. Unexplained appetite loss? ☐ Yes ☐ No
4. Unexplained fever? ☐ Yes ☐ No
5. Night sweats ☐ Yes ☐ No
6. Shortness of breath? ☐ Yes ☐ No
7. Chest pain? ☐ Yes ☐ No
8. Unexplained fatigue? ☐ Yes ☐ No

The above health statement is accurate to the best of my knowledge. I will notify Employee Health and see my MD and/or local Health Department if my health status changes.

_____ _____

Signature **Date**

_____ _____

Witness **Date**

Skin Test:

☐ Standard Mantoux Test ☐ Other

Test Site: ☐ Left forearm ☐ Right forearm ☐ Other

Dosage: ☐ 0.1 ml of Tubersol injected intradermal

Mfg.: _____

Lot #: _____

Exp. Date: _____

Date Given: _____ Time given: _____ Signature: _____

Test Results: (Read 48-72 hours after injection)

Date results read _____/_____/_____ By: _____

TB Skin Test Results were: ☐ Negative ☐ Positive, size of induration ____mm.

Associate Health Department
500 Lauchwood Drive ~ Laurinburg, NC ~ 28352
(910) 291-7127 or (910) 291-7121 ~ Fax (910) 291-7564

SCOTLAND HEALTH CARE SYSTEM
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Drug Testing Procedure Fact Sheet For Non DOT

NOTICE TO ALL DRUG SCREEN DONORS

New Drug Screen Law Effective December 1, 2002

IT IS NOW A CRIMINAL OFFENSE TO ATTEMPT TO ALTER OR DEFRAUD DRUG OR ALCOHOL SCREENING TESTS.

The General Assembly of North Carolina enacts: Section 1. Article 52 of Chapter 14 of the General Statutes is amended by adding a new section to read S 14-401.20. Defrauding drug and alcohol screening tests; penalty.

1) **It is unlawful for a person to do any of the following**
   a) **Sell, give away, distribute, or market urine in this State or transport urine into this State with the intent that it be used to defraud a drug or alcohol screening test.**
   b) **Attempt to foil or defeat a drug or alcohol screening test by the substitution or spiking of a sample or the advertisement of a sample substitution or other spiking device or measure.**
2) **It is unlawful for a person to do any of the following:**
   a) **Adulterate urine or other bodily fluid sample with the intent to defraud a drug or alcohol screening test.**
   b) **Possess adulterants that are intended to be used to adulterate a urine or other bodily fluid sample for the purpose of defrauding a drug or alcohol screening test.**
   c) **Sell adulterants with the intent that they be used to adulterate a urine or other bodily fluid sample for the purpose of defrauding a drug or alcohol screening test.**
3) **A violation of this section is punishable as follows:**
   a) **For first offense under this section, the person is guilty of a Class 1 misdemeanor.**
   b) **For a second or subsequent offense under this section, the person is guilty of a Class 1 felony.**

If caught, offenders can be prosecuted by their company!

Non-Federal Drug Testing Custody and Control Form (For Non DOT only).

You have been selected for a urine drug test. The testing procedure to be followed is in accordance with the Scotland Memorial Hospital Occupational Health and Laboratory procedure manuals. It is designed to provide accuracy while protecting your rights to privacy. Failure to cooperate will deem you unqualified, and the test will not be performed. This fact sheet was developed to advise you of your responsibilities, your rights, and to help you understand the procedure.

1. You must register before beginning the drug screening process.
2. **A picture I.D. is required.**
3. Once you have been registered you must remain in the waiting room until your drug screen is completed.
4. Any friends, family, or the company representative, etc. must remain in the waiting room while you are being tested.
5. You will be asked to hang any loose outer garments/possessions on the coat rack in the specimen collection area.
6. You must **WASH (USE SOAP), RINSE** and **DRY** your hands before you collect the specimen.
7. A sealed specimen collection kit will be provided to you.
8. You will proceed to the bathroom and provide a 45cc urine specimen (approximately ½ cup) in a container. If you have a problem providing an adequate sample you need to drink fluids to induce urination. Only a 3 hours length of time will be allowed for the collection of the specimen. The Occupational Health Department will notify the industry requesting the test of any failure to provide an acceptable specimen.
9. Give the specimen container to the collector, making certain that it is kept within our view at all times, until it is officially sealed and labeled. Do not attempt to tamper with or substitute the specimen. It will be visually inspected. A temperature will be measured. If the staff suspects tampering or temperature out of range, your company will be notified and we will follow the company protocol.
10. Sign, initial and date where indicated (on the chain of custody form and container label).
11. Observe the sealing and labeling of specimen.
12. Be sure to keep up with any paperwork you are to return to the employer.
13. All results of drug screen applicants are reported directly to the designated company official that you are testing for. Scotland Memorial Hospital cannot release the results to anyone else.
14. YOU ARE TO DISPLAY APPROPRIATE BEHAVIOR DURING THE COLLECTION PROCESS. ANY ABUSIVE REMARKS OR ACTIONS WILL CANCEL THE SCREENING PROCESS AND THE COMPANY WILL BE NOTIFIED.

When you have finished reading this, sign and date this form to acknowledge your understanding of the drug test. Please have your photo I.D. ready and any chain of custody forms (drug testing form) provided by the company for which you are being tested. Take all of these documents to the registration desk with this fact sheet.

Signature: _____

Occupational Health Services
500 Lauchwood Drive ~ Laurinburg, North Carolina ~ 28352
(910) 291-7676 ~ Fax (910) 291-7564

NC CONTROLLED SUBSTANCE EXAMINATION REGULATION ACT

INITIAL NOTICE TO EMPLOYEES/APPLICANTS

In accordance with our company policy, you have been selected for a New Hire Controlled substance test (specify: Random, Post Incident, New Hire, Reasonable Suspicion). In accordance with 13 NCAC 20.0401, this notice explains your rights and responsibilities under the NC Controlled Substance Examination Regulation Act (CSERA) (Chapter 95, Article 20 of the NC of the NC General Statues) and the corresponding administrative rules (Title 13, Chapter 20 of the NC Administrative Code).

- You may refuse this test, however, your job or employment opportunity may be in jeopardy.
- Although applicants may be screened by means of a Quick Test, any positive result must be confirmed by an approved lab using gas chromatography with mass spectrometry (GM/MS), or equivalent accepted method before hiring decisions are made.
- Current employees cannot be screened by means of a Quick Test.
- An approved laboratory must perform testing samples.
- You can request a re-test of any positive sample. Re-test must be of the same sample and must be paid for by the employee.
- You can file a complaint with the NC Department of Labor-Wages and Hour Bureau at (919) 807-2796 or 1-800-2798 or 1-800-NC-LABOR if you believe procedural requirements of the CSR were violated. The Department has no jurisdiction regarding an employer's requirement for controlled substance testing or its decision regarding results of controlled substance testing.

Please sign:

_____ _____

Employee/Applicant Date

_____ _____

Employer Representative Date

Occupational Health Services
500 Lauchwood Drive ~ Laurinburg, North Carolina ~ 28352
(910) 291-7676 ~ Fax (910) 291-7564

LATEX ALLERGY QUESTIONNAIRE

Please answer the following: **Risk Factor Assessment:**

Exposure History:

A. Are you a health care worker? ☐ Yes ☐ No
   If you answer No, what is your occupation? _____
B. Do you wear latex gloves regularly or are you otherwise exposed to latex regularly? ☐ Yes ☐ No
C. Do you have a history of eczema or other rashes on your hands? ☐ Yes ☐ No
D. Do you have a medical history of frequent surgeries or invasive medical procedures? ☐ Yes ☐ No
   If yes, how many? _____
   Did these take place when you were an infant? ☐ Yes ☐ No
E. Do you have a history of "hay fever" or other common allergie? ☐ Yes ☐ No
F. Do your fellow workers wear latex gloves regularly? ☐ Yes ☐ No
G. Do you take beta-blocker medication (high blood pressure or migraine headaches, e.g.: Inderal)? ☐ Yes ☐ No
H. ***Circle*** any food below that cause hives, itching of the lips or throat, or more severe symptoms when you eat or handle them:

avocado, apple, pear, celery, carrot, hazelnut, kiwi, papaya, pineapple, peach, cherry, plum, apricot, banana, melon, chestnut, nectarine, grape, fig, passion fruit, tomatoes or potatoes

Contact Dermatitis Assessment: (for patients who wear latex gloves frequently)

A. Do you have rash, itching, cracking, chapping, scaling or weeping of the skin from latex glove use? ☐ Yes ☐ No
B. Have these symptoms recently changed or worsened? ☐ Yes ☐ No
C. Have you used a different brand of latex gloves? ☐ Yes ☐ No
   If so, have your symptoms persisted?
D. Have you used non-latex gloves? ☐ Yes ☐ No
E. If so, have you had the same or similar symptoms as non-latex gloves? ☐ Yes ☐ No
F. Do these symptoms persist when you stop wearing all gloves? ☐ Yes ☐ No

Contact Urticaria (Hives) Assessment: (for patients who wear latex gloves frequently)

A. When you wear or are around others wearing latex gloves do you get hives, red itchy swollen hands within 30 minutes, "water blisters" on your hands within a day? ☐ Yes ☐ No

Aerosol Reaction Assessment:

A. When you wear or are around others wearing latex gloves, have you noted:
   a. Itchy, red eyes, fits of sneezing, runny or stuffy nose, itching of the nose or palate? ☐ Yes ☐ No
   b. Shortness of breath, wheezing, chest tightness or or difficulty breathing? ☐ Yes ☐ No
   c. Other acute reactions, including generalized or severe swelling or shock? ☐ Yes ☐ No

History of Reactions Suggestive of Latex Allergy:

A. Do you have a history of shock or allergic reaction(s) during medical, surgical, or dental procedures or operations? ☐ Yes ☐ No
B. Have you had itching, swelling or other symptoms following dental, rectal, or pelvic exams? ☐ Yes ☐ No
C. Have you experienced swelling or difficulty breathing after blowing up a balloon? ☐ Yes ☐ No
D. Do rubber handles, rubber bands or elastic bands on clothing cause any discomfort? ☐ Yes ☐ No
E. Other symptoms that might be related or caused by latex Exposure? ☐ Yes ☐ No

FOR OFFICE USE ONLY:

Form reviewed by: _____ Date: _____

Place in Latex Allergy Sensitivity: ☐ YES ☐ NO Note: _____

Occupational Health Services
500 Lauchwood Drive ~ Laurinburg, North Carolina ~ 28352
(910) 291-7676 ~ Fax (910) 291-7564

Hepatitis B Vaccine Acceptance/Declination Form

Employee Name: _____ Date of Hire: _____

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. I have been given the opportunity to be vaccinated with the Hepatitis B vaccine at no charge to me.

I have decided to:

_____ Request that I receive the Hepatitis B Vaccine
_____ Decline vaccination due to:
_____ Titer evidences immunity
_____ Previous Hepatitis B vaccination
_____ Decline for other personal reasons
_____ Medical contraindication (contraindications include: pregnancy, active infection such as a cold or bronchitis, lactation, allergy to yeast or yeast products.)

Declination:

I understand that:

- *due to my occupational exposure to blood or other potential infectious materials I may be at increased risk of acquiring hepatitis B virus (HBV) infection;*
- *I have been given the opportunity to be vaccinated with the Hepatitis B vaccine, at no charge to myself. However, I still wish to decline the Hepatitis B vaccination at this time;*
- *declining this vaccine, I continue to be at increased risk of acquiring Hepatitis B, a serious decease;*
- *If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.*

_____ _____ _____
Employee Signature Date Social Security Number

_____ _____
Witness Date

Employment termination date: _____

Note: This record must be maintained throughout employment and for 30 years thereafter.

Documentation of Immunity to Chicken Pox

I, as the above documented employee, do hereby certify that the statement below is accurate to the best of my knowledge.

_____I HAVE had chickenpox or history of shingles.

_____ I do NOT have a history of chickenpox or history of shingles.

Employee Signature:_____

Date:_____

Occupational Health Services
500 Lauchwood Drive ~ Laurinburg, North Carolina ~ 28352
(910) 291-7676 ~ Fax (910) 291-7564

QUALITATIVE RESPIRATOR FIT TEST RECORD

Employee's Name			
Department			
Prescription Glasses Required?	☐ Yes ☐ No	Contact Lenses Required?	☐ Yes ☐ No
Presence of Facial Hair? (If yes, Specify below)	☐ Yes ☐ No	Presence of Dentures?	☐ Yes ☐ No
Beard ☐ Mustache ☐ Other ☐			

TEST RECORD			
Respirator Manufacturer	**Type**	**Model**	**Size**
Test Agent:	☐ Irritant Smoke ☐ Isoamyl Acetate ☐ Saccharin Mist ☐ Bitrex		

Number of puffs fro sensitivity test ☐ 10 ☐ 20 ☐ 30

1. Initial fit okay?
2. Positive Pressure Test
3. Negative Pressure Test (5 min. pause)
4. Exercise Regime Test (Instructions of test regime)
   a. Normal breathing (1minute)
   b. Deep breathing (1minute)
   c. Turning head side to side (1 minute)
   d. Moving head up and down (1 minute)
   e. Reading (rainbow passage)
   f. Bending Forward (1 minute)
   g. Normal breathing (1 minute)
   h. Fit Satisfactory: ☐ Yes ☐ No

Test 1		Test 2		Test 3	
P	**F**	**P**	**F**	**P**	**F**
P	**F**	**P**	**F**	**P**	**F**
P	**F**	**P**	**F**	**P**	**F**
P	**F**	**P**	**F**	**P**	**F**
P	**F**	**P**	**F**	**P**	**F**
P	**F**	**P**	**F**	**P**	**F**
P	**F**	**P**	**F**	**P**	**F**
P	**F**	**P**	**F**	**P**	**F**
P	**F**	**P**	**F**	**P**	**F**

_____ **Instructed on use of Air Supplied Hood and storage location. Employee demonstrated and verbalized understanding of the use of the Air Supplied Hood.**

Employee (Signature) **Date:**

Fit test instructor (Signature) **Date:**

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EMPLOYEE HEALTH SERVICES
500 Lauchwood Drive
Laurinburg, NC 28352
Telephone (910)291-7676
Fax (910) 291-7564

OSHA Respirator Medical Evaluation Questionnaire
Section 1910.134 Appendix C (Mandatory)

Date: _____ *Name:* _____ *Job Title:* _____

Height: ___*ft.* ___*in. Weight* _____ *lbs. Birth Date:* ___/___/___ *Employee I. D.* _____ *Age:* _____ *Sex: Male Female*

Phone number where you can be reached by the health care professional who reviews this questionnaire: (___) _____-_____

The best time to phone you at this number: _____

Has your employer told you how to contact the health care professional who will review this questionnaire? (circle one) Yes No

Have you worn a respirator? (circle one) Yes No If "yes" what type(s): _____

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. Claustrophobic (fear of closed-in places)
			e. Trouble smelling odors
		3.	Have your **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 injuries 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 walking 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 and feet (not caused by walking)
			f. Heart Arrhythmia (heart beating irregularly)
			g. High Blood Pressure
		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 medications 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 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
			b. Skin allergies or rashes
			c. Anxiety
			d. General weakness or fatigue
			e. Any other problem that interferes with your use of a respirator
		9.	Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?

Questions 10-15 below must be answered by every employee who has been selected to use either a full-facepiece (Histopathogy worker) respirator or self-contained breathing apparatus (SCBA)(Emergency responder). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

Yes	/No		
		10.	Have you ever lost vision in either eye (temporarily or permanently)?
		11.	Do you have any of the following vision problems?
			a. Wear contact lenses
			b. Wear glasses
			c. Color blind
			d. Any other type of eye or vision problems
		12.	Have you ever had an injury to your ears, including a broken eardrum?
		13.	Do you currently have any of the following hearing problems?
			a. Difficulty hearing
			b. Wear a hearing aid
			c. Any other hearing or ear problems

Yes	/No		
		14.	Have you ever had a back injury?
		15.	Do you currently have any of the following musculoskeletal problems?
			a. Weakness in any of your arms, hands, legs, or feet
			b. Back pain
			c. Difficulty fully moving your arms and legs
			d. Pain or stiffness when you lean forward or backward at the waist
			e. Difficulty fully moving your head up and down
			f. Difficulty fully moving your head from side to side
			g. Difficulty bending at your knees
			h. Difficulty squatting to the ground
			i. Climbing a flight of stairs or ladder carrying more than 25 lbs.
			j. Any other muscle or skeletal problems that interferes with using a respirator

I certify the above information is correct.

Employee Signature: _____ **Date:** _____

TO BE COMPLETED BY EMPLOYEE HEALTH SERVICES ONLY

Mask Fit Test

☐ **Approved** ☐ **Denied For:** N, R, P Disposable respirator (filter-mask, non-cartridge type only)

☐ **Approved** ☐ **Denied for:** Other type (i.e. half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

TO THE PROVIDER/ LISENCED HEALTH CARE PROFESSIONAL (PLHCP)

Check the ONE that applies

- ❑ I have reviewed this questionnaire with the employee and I do not recommend that a physical examination be performed.
- ❑ I have reviewed the questionnaire with the employee and I am recommending that a physical examination be performed.
- ❑ I have reviewed the questionnaire without the employee and I do not recommend that a physical examination be performed.
- ❑ I have reviewed the questionnaire without the employee and I do recommend that a physical examination be performed.

TO BE FILED IN EMPLOYEE'S MEDICAL FILE

Medical Approval to Wear Respirator

Name: _____ Date: _____

In my opinion, the over named employee:

☐ May continue to work full duty on: _____/_____/_____

☐ Employee is fit to wear the respirator as tested here today. Employee has no detected medical condition that precludes continued work exposure to asbestos, tremolite, anthophyllite or actinolite. I have found no medical findings that would limit the employee's use of personal protective equipment.

☐ May return to work with restrictions on ____/____/____

Restrictions to include:

- ☐ Employee must try another respirator
- ☐ Employee must remove facial hair
- ☐ Other interference with respirator includes _____
- ☐ Other _____

☐ Return/report to clinic. Date: ____/____/____ Time: ____:____

For follow-up with ☐ Occupational Physician ☐ Occupational Nurse_____

☐ Refer to specialist. Dr. _____

- ☐ Appointment will be made by Occupational Nurse

Date _____ Time _____:_____

- ☐ Return to Occ. Clinic to review findings:

Date _____ Time ____/____/____

☐ Extensive consultation with patient Date _____

Employee Signature _____ Date _____

PLHCP Signature _____ Date _____

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Respiratory Training

I, the above named have been instructed and trained in the use, maintenance, cleaning, care and warnings regarding limitations of

_____(type) respirator.

- ☒ Why the respirator is necessary and how improper fir, usage, or maintenance can compromise the protective effect of the respirator;
- ☒ What the limitations and capabilities of the respirator are;
- ☒ How to use the respirator effectively in emergency situations, including situations in which the respirator malfunctions;
- ☒ How to inspect, put on and remove, use, and check the seals of the respirator.
- ☒ What the procedures are for maintenance and storage of the respirator;
- ☒ How to recognize medical signs and symptoms that may limit or prevent the effective use of respirators.

N95 TB Mask Information

Facts You Must Know

1. Any Healthcare worker entering any room that displays an airborne precaution sign must wear an approved N-95 respirator as per OSHA/NIOSH requirements.
2. All healthcare workers likely to care for high-risk TB patients should have been fit-tested and educated in the use of an approved N-95 TB respirator. If you are likely to work with a TB patient and have never been fit tested, contact Employee Health immediately for a fit test at ext. 7676.
3. TB respirators are personal protective equipment and are worn for worker respiratory protection purposes.
4. Particulate TB respirators should be inspected prior to each use, and if any damage or deterioration is detected, they should be placed immediately.
5. Any damage or signs of deterioration indicates the respirator should be discarded and replaced.
6. Filtration efficiency of the respirator will remain effective until:
   a. The product becomes damaged or
   b. The filter material becomes difficult to breathe through due to plugging or the filter, which may affect the facial seal.
7. TB respirators should be replaced if they become difficult to breathe through or contaminated with blood or body fluids.
8. In general, particulate TB respirators should be replaced after one shift of usage or 8-10 hours use or if soiled or damaged.
9. It is important not to write on the TB respirator, as this constitutes damage and may impact the product's filtration efficiency. Each respirator should only be worn by one individual and should not be shared. It should also be used for one individual patient. If you have two patients on isolation please use two separate respirators.
10. It is not appropriate to fold the respirator and place it in your pocket; this may impair the respirator's function.
11. To obtain adequate fit when using a particulate respirator, the sealing area of the respirator must come in direct contact to the skin. Any condition, which interferes with direct contact to the skin, may compromise the fit of the respirator.
12. Conditions which compromise the respirator fit may include but are not limited to:
    a. Facial hair
    b. Missing or poorly fitting dentures, teeth or implants
    c. Facial features such as scars, deep creases in the skin or other facial configurations.
    d. Temple pieces on glasses, which prevent contact of the TB mask with the skin.
    e. Head coverings, which pass between the respirator sealing area and the face.
13. Fit Testing should be repeated when a worker develops any condition which may affect a change in the way their respirator fits the face such as:
    a. Ten percent (10%) or greater change in weight.
    b. Dental conditions
    c. Reconstructive or cosmetic facial surgery, or
    d. Facial scarring in respirator sealing area
    e. If worker notices difficulty in usage of the respirator.
14. Please perform a fit check each time you don the respirator. (This will be demonstrated during your fit testing procedure.)

The signature below confirms training on the information above on the use, maintenance, cleaning and care of the respirator:

Employee signature: _____ Date _____

Trainer's Signature: _____ Date:_____

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Explanation of Pulmonary Function Test- (if indicated)

FVC – Forced Vital Capacity. This is the maximum amount of air you forcefully blew out of your lungs following a maximum inhalation.

FEV1 – Forced Expired Volume 1 second. This is the amount of air you forcefully blew out of your lungs in one second.

FEV1/FVC – This is the percentage of air you blew out in the first second. You get this number by dividing the FEV1 by the FVC. Most people should be able to blow out 75% of the total amount of air in the first second.

FEF25-75 – This flowrate tells the doctor the status of the medium- sized to small- sized airways of your lungs.

PEFR – Peak Expiratory Flow Rate. Sometimes this parameter is abbreviated PEF, FEF, or FEFR. This number tells the doctor the speed at which you blew out your air and whether or not a valid effort was performed.

MEAS – This is the measured column which lists the values that you obtained on your test.

PRED – This is the predicted column which lists the values that a person with normal lungs who is the same age, sex, and height as you should be able to achieve.

% PRED – This is the percentage of predicted. You get this number by dividing your measured values by your predicted values. Generally speaking, most of these values should be 80% or greater to be considered normal.

The results of your pulmonary function test are:

☐ **Normal**, no follow-up required.

☐ **Slightly abnormal**, follow-up with your family doctor during your next visit.

☐ **Abnormal**, follow-up with your family doctor soon.

Comments:_____

_____

_____

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Safe Lifting Competency – Back Injury Prevention:

Please Print:

Printed Name: _____ **Date:** _____

Safe Lifting Competency (Basic Lift):

☐ **Employee has demonstrated competency and good lifting technique in the following areas:**

- Positions body close to the object.
- Stands with a wide stance; either one foot forward or feet shoulder width apart.
- Keeps back straight and uses legs and hips to lower self to the object.
- Moves the load close to the body before attempting to lift.
- Grasps the object firmly with both hands.
- Tests the load prior to lifting to assess the need for assistance.
- Bends Knees, extends the legs, keeps the back straight and lifts the load by holding object close to the body.

☐ **Employee has Physical Limitations/Restrictions that would prevent them from demonstrating a safe lifting technique. However, employee is able to verbalize competency of proper lifting techniques.**

The signatures below indicate that the Employee successfully demonstrated or verbalized **(verbalizes only if employee has physical limitations)** Safe Lifting Technique and any questions the Employee might have had during this sessions were answered.

Note: _____

Evaluator Signature: _____ Date: _____

Associate Signature: _____ Date: _____