MOUNT CARMEL

On behalf of **Employee Health**, welcome to Mount Carmel! Congratulations on your acceptance to be part of our team. As part of your onboarding process with Mount Carmel, you will be meeting with us for a drug and health screening. This is a process designed to ensure that all new hires meet health criteria to perform the job. Talent Acquisition set up your appointment for the drug and health screening. Please bring the following items with you:

- Completed Pre-Employment Health History Questionnaire (attached)
- **Photo ID**, preferably a State ID or Driver's License
- Immunization records (COVID, Influenza, MMR, Varicella, Tdap or Td)
- TB and/or health records from previous employers
- Glasses or corrective lenses
- Detailed documentation of any significant medical conditions that might affect your ability to perform your job/position

What to expect during drug and health screening :

- **Submit a urine sample for drug testing**
- **Blood draw for testing for TB screening and immunizations if applicable**
- **Request for additional medical documentation if applicable**
- **Vision screening**

In preparation, please refrain from over hydrating (drinking too much fluid) for your drug screen as this may cause it to be too dilute. If your urine sample tests as "too dilute", that sample will be rejected, and you will be asked to submit another. This could delay your start date

We are looking forward to meeting you and having you as part of our Mount Carmel team.

MOUNT CARMEL
EMPLOYEE HEALTH

PRE-EMPLOYMENT HEALTH HISTORY QUESTIONNAIRE

NAME:		**WORK SITE**	**DOB:**	**SEX:** M F
SS #:	**Cell phone number:**	**Email address**		
ADDRESS:		**CITY**	**STATE**	**ZIP**
DEPT:	**POSITION:**	**STATUS: (circle one)** FT PT	**SHIFT: (ex: 7a – 3p)**	
EMERGENCY CONTACT INFORMATION				
NAME: _____ **TEL.#:** _____				
PHYSICAN NAME: **TEL. #:**				

Bring immunization documentation for the following to your drug and health screening appointment:

- Varicella (chicken pox) – documentation of 2 doses of the vaccine or lab documented proof of immunity
- Influenza – proof of vaccination from current season
- COVID-19 – proof of vaccination or approved exemption
- Mumps, Measles & Rubella – documentation of 2 doses of the vaccine or lab documented proof of immunity
- Pertussis – Documentation of Tdap vaccine
- Hepatitis B (for jobs prone to exposure to blood) – documentation of vaccine series (3 shots) or lab documented proof of immunity
- Proof of previous TB skin or blood test within the last year

Have you ever had the BCG (TB) vaccine? Yes No If yes, when? _____

Have you ever had a positive TB skin test (TST)? Yes No If yes, when? _____

Have you ever had a Chest X-ray due to a positive TB test? Yes No If yes, when? _____

Have you ever taken medicine to treat or prevent TB? Yes No If yes, what year? _____

I understand that because I will be working in a health care environment, annual vaccination for the seasonal influenza is mandatory for my protection, the patients', and the community we serve. I understand that seasonal flu and COVID-19 vaccinations or approved exemptions are a condition of employment.

Signature: _____ **Date:** _____

PERSONAL HEALTH SCREENING

ALLERGIES	
If applicable, please list and describe any allergic reaction to the following:	
Medications	
Vaccines	
Latex	
Food	
Environment	
Other	

Do you smoke? Yes No If yes, # packs/ day:_____ How many years?: _____

Do you use any other tobacco products? Yes No If Yes, please describe:

_____

_____

Have you ever had surgery? Yes No

If "Yes", please explain:_____

_____

Have you ever had any Back, Neck or other "joint" injuries? Yes No

If "Yes", please explain:_____

_____

Do you have any conditions, limitations, or other unique needs that we might need to consider some form of accommodation for?

_____

_____

PERSONAL MEDICAL HISTORY			
Have you ever had any of the following:			
CONDITION	**NO**	**YES**	**If 'YES', give brief explanation**
Abdominal pain			
Chest pain			
Cardiac disease / Heart attack			
Autoimmune Disorders			
Blood Disorder/ unexplained bruises			
Cancer or tumor			
High or low blood pressure			
Heart failure/ murmur/ irregular beat			
Chronic pain / Fibromyalgia			
Diabetes			
Epilepsy / Seizures			
Ear / Hearing problems			
Eye/ Vision difficulties			
Fractures / Severe sprains			
Head Injuries			
Headaches, Severe or Chronic			
Stroke			
Hernia			
Stomach or digestive problems e.g. heartburn/ indigestion/ GERD			
Bowel/Bladder issues or changes			
Joint pain (arthritis, gout etc.)			
Kidney/ Bladder problems			
Liver Disease / Hepatitis			
Lung Disease / Emphysema/ Asbestosis/ COPD/ bronchitis			
Shortness of breath with activity e.g. walking level or incline or while bathing or dressing			
Asthma			
Swelling of feet or legs			
Thyroid problems			

To your knowledge are there any restrictions that may hinder your ability at work, such as:

Lifting restrictions: Yes No Explain _____

Standing restrictions: Yes No Explain _____

Bending/twisting restrictions: Yes No Explain _____

Hand/wrist restrictions: Yes No Explain _____

Have you ever had a WORKERS' COMPENSATION CLAIM? Yes No

If "Yes", please explain:_____

_____

_____

Disclaimer – Release of Information

I authorize Mount Carmel, its agents, and Employee Health to perform a health screening assessment and diagnostic tests necessary to determine my ability to perform the duties of this job.

I authorize my doctor's office and facilities, where I have received medical treatment in the past, to release medical information to Mount Carmel Employee Health. I understand Employee Health may disclose any and all information regarding any work-related injury, for the purpose of OSHA, Infection Control, and Employee Health reporting/ Worker's Compensation insurance claims. Disclosure method could be verbal, hard copy, or facsimile.

I hereby certify that the above answers are complete and true. I understand this assessment does not take the place of a complete physical and that I am advised to see my personal physician for my health needs. I agree to notify Mount Carmel Employee Health of any changes in the condition of my health that would affect my abilities to perform my job.

I give consent for pre-employment urine drug screen testing and understand that a positive urine drug screen can result in automatic retraction of any job offer.

_____ _____

Signature **Date**

_____ _____

Reviewing RN Signature **Date**

MOUNT CARMEL EMPLOYEE HEALTH SERVICES
Medication Declaration Form

This form is a CONFIDENTAIL part of the Employee Health record. This information may be released to third parties that are contracted to assist Mount Carmel with medical clearance, such as a Medical Review Officer. Please list any prescription, over-the-counter, vitamin and/or herbal supplement you have taken **within the past 30 days**.

Medication	Prescribed by	Reason for taking

Printed name:_____ DOB: _____

Best contact number: _____ Alt. contact number: _____

Date completed:_____

HEPATITIS B IMMUNIZATION STATUS (WAIVER)

I understand that Hepatitis B infection is one of the leading occupational hazards of health care workers from significant exposure to blood and bloody body fluids.

I understand that the vaccine consists of three (3) intramuscular injections of vaccine given in the deltoid muscle (upper arm). Doses are given based on CDC guidelines for administration.

I understand that over 90% of persons who have taken three doses of the vaccine, will become immune to the disease and will be protected against Hepatitis B infection should significant exposure such as a needle stick or mucous membrane exposure occur. The vaccine is generally not protective until after all three doses have been taken; however, the vaccine is an integral part of post-exposure follow up in non-immune health care workers.

I have had the opportunity to read information about Hepatitis B Vaccine and to ask questions about the risks and benefits of the vaccine.

I understand that Mount Carmel provides Hepatitis B Vaccine to eligible Employees through the Employee Health Service at no cost to the Employee.

I understand that if I decline the opportunity to take the vaccine at this time I may request the vaccine series at a later date.

Please initial one of the following statements:

I am **declining** the vaccine at this time because:

____I have already completed the Hepatitis B vaccine series.

____I have been advised not to take due to:_____

____I do not want the Hepatitis B vaccine.

OR

____I would like to obtain the vaccine and intend to make a follow-up appointment with Employee Health.

____I have started, but not completed the series, and intend to complete the series as scheduled.

Printed Name: _____

Signature: _____ **Date:**_____

TUBERCULOSIS SCREENING

Name:_____ DOB:_____

Please check if you have experienced the following:

Yes	No		IF Yes, Date
		Had a positive reaction to a tuberculosis skin test	
		Had a positive reaction to a tuberculosis blood test	
		Had a history of active tuberculosis disease	
		Completed a treatment program for latent (inactive) TB infection	
		Completed a treatment program for active TB disease	
		Chest X-Ray	
		Received the BCG Vaccine	

Please answer all questions on the questionnaire:

During the past year, have you experienced any of the following:	No	Yes Resolved	Yes Pending	If yes, details including treatment or medication
Abdominal or gastrointestinal problems such asfrequent diarrhea, nausea or vomiting				
Persistent fever, unexplained weight loss or excessivefatigue				
Frequent upper respiratory symptoms such as colds,sore throat(s), productive cough, pneumonia				
Traveled outside the country				
Skin problems such as cold sores, boils, abscessesor other lesions on the face or hands				
Communicable diseases such as hepatitis, active TB, etc.				
Compromised immune system or other serious illness. Taking immunosuppressive drugs				
Close contact with someone with TB				

Reviewing RN signature:_____ Date:_____