Welcome!

We're excited to have you join our St. Joseph Health System family and we look forward to meeting you!

Please complete the attached paperwork, following the directions below, then bring to your new hire employee health appointment. Forms can be completed electronically then printed or printed then filled out. Please print single-sided. If you do not have access to a printer, they can be provided to you at your appointment.

1. Complete the following areas of the employee health forms, attached.

   New Hire Assessment-Section 1 as well as allergies and associated reaction at the top
   Tuberculosis Risk Assessment-all
   Health Questionnaire- all
   Opinion for Hepatitis B Vaccine-Top demographics and employee signature
   Ishihara's Tests for Colour-Deficiency -top demographics
   OSHA Respirator Medical Evaluation-all, through your signature (only for those who will enter patient rooms or directly care for patients)

2. Bring the following immunization records with you to your appointment. If you do not have your immunization records, you can check with your family physician, school system or health department. Most residents have vaccine records stored in the IN vaccine registry. Go to myvaxindiana.in.gov to learn how to access your immunization records or click here: MyVaxIndiana
   Required Vaccinations:
   *MMR (Measles, Mumps, Rubella)- 2 doses
   *Varicella or chickenpox– 2 doses
   *If you do not have record of these vaccines, we will check labs to verify immunity.

   Vaccinations that are strongly recommended:
   Current season Influenza (when in flu season)
   COVID-19 vaccines
   Hepatitis B- series of 2 or 3
   Tdap (Tetanus, Diphtheria and Pertussis or whooping cough)- every 10 years

   We offer MMR, Varicella, Flu (during flu season), Hepatitis B, and Tdap vaccines to colleagues at no cost.

Your Appointment

Bring your valid government issued photo ID, immunization records and completed employee health forms. A urine drug screen is part of this appointment please be sure you're drinking fluids prior in order to provide a sample. Your appointment will take approximately 1.5-2 hours.

Please arrive 15 minutes early. If you're at the Mishawaka location, take the elevator to the ground floor then sit on the bench outside the elevator and call employee health (574-335-1030) to notify them of your arrival. If you're in Plymouth, notify the front desk. If you are not able to make your appointment, call your recruiter to reschedule. Please also call employee health if you're canceling the same day as your appointment.

Employee Health Services
Saint Joseph Health System
p: 574.335.1030 (Mishawaka) 574-948-4011 (Plymouth)

NEW HIRE HEALTH ASSESSMENT

☐ Mish ☐ Ply ☐ VNA

Today's Date	Employee #:
	NAO Start Date:
Allergies and Reaction	

SECTION 1. TO BE COMPLETED BY NEW HIRE APPLICANT

LAST NAME: FIRST NAME: MIDDLE INITIAL:

BIRTH DATE: SS #: PHONE NUMBER:

MAILING ADDRESS: CITY: STATE: ZIP:

DEPARTMENT: POSITION:

SECTION 2. TO BE COMPLETED BY EMPLOYEE HEALTH STAFF

IMMUNE STATUS

DISEASE	Date of Vaccine #1	Date of Vaccine #2	Date of Vaccine #3	Date of Titer	Results	Vaccine Declination
HEPATITIS B SERIES 1						
HEPATITIS B Booster series						
MMR						
RUBELLA						
RUBEOLA						
Mumps						
Td/Tdap						
VARICELLA						
Flu						
COVID						
CAPR						
Fit Test	Manufacturer	Model	Size	Referred for Medical clearance	Referred for P100	
OTHER						

TUBERCULOSIS SCREENING INFORMATION

Q Gold__________ (Date) **Results**__________ **TBQ**__________ (Date) **Results**__________

Chest Xray__________ (Date) **Results**__________ ☐ **Latent TB info given** __________ (Date/Initials)

Specimen ID#	Date Collected	Date Completed/results	Cleared Date/Initials
Specimen ID#	Date Re-collected	Date Completed/results	Entered into WD Date/Initials

Color Screen____/14 Temperature______ Pulse______ Respirations______ Blood Pressure______

SECTION 3. OTHER CHECKLIST ITEMS

(Check if completed. Use "NI" if Not Indicated)

1. ☐ Ask if any reasonable workplace accommodations are required in order to perform the normal duties of the job being offered. ☐ Yes ☐ No
   If yes, please describe: ____________________
2. ☐ Ask about latex sensitivity and give out booklet if indicated sensitivity or allergy, ☐ Yes ☐ No
3. ☐ Explain worker's compensation procedures, show THEIR policy form, and give out brochure.
4. ☐ Entrance screening and masking requirements reviewed.

Job Specific...

1. ☐ Complete *Health Care Professionals Written Opinion* form.
2. ☐ Safe lifting and movement of patients
   - Review the policies: Safe Lifting and Movement of Patients and Safe Lifting and Handling Techniques.
   - If the policies are not adhered too and injuries occur, appropriate re-training will occur including reviewing the use of lifting equipment and/or reassignment of the Healthstream modules on safe lifting.
3. ☐ Pre-employment *Evaluation of Dietary Workers* form.
4. ☐ Does the employee need further evaluation by MD, PA or NP? ☐ Yes ☐ No

   If yes, why? ____________________

____
Signature of EHS Staff Completing Form Date

Section 4. LIST ANY FURTHER FOLLOW UP ITEMS HERE

SAINT JOSEPH HEALTH SYSTEM

☐ Mishawaka ☐ Plymouth ☐ Medical Group
☐ Volunteer ☐ Other____________________

Tuberculosis Risk Assessment

Name____ Employee ID______________________

Department__________________________________ Phone #___________________________

History	Additional questions
If you answer yes to any of these questions, complete the additional questions to the right. Have you ever had a positive TB skin test or TB blood test? Y N Have you been told you have latent TB? Y N Have you been told you have active TB disease? Y N	1-Date of positive test __________ Type_______ 2-Was a chest x-ray done at that time? Y N 3-If yes, was it normal? Y N 4-Did you take any anti TB medication? Y N 5-If yes, did you complete entire treatment? Y N 6-Have you received the BCG vaccine? Y N

Please answer the following questions re: baseline risk and symptoms ***while thinking of the past year.***

Baseline Individual TB Risk	No	Yes, please provide details
Have you been exposed to someone with known active TB disease? (without a respirator)		
Have you traveled to a country with high rate of TB for more than 1 month? (any country other than the US, Canada, Australia, New Zealand, and those in Northern or Western Europe)		
Do you currently have a condition or are you on a medication that weakens your immune system? Including: HIV, organ transplant recipient, treatment with TNF-alpha (e.g. infliximab, etanercept or other), chronic steroids (equivalent of prednisone ≥ 15 mg/day for 1 month or more)		

Symptom Evaluation	No	Yes, please describe
Cough for 3 or more weeks		
Bloody sputum (phlegm from deep inside lungs)		
Unexplained weakness or fatigue		
Unexplained weight loss		
Unexplained fever or chills		
Unexplained night sweats		

I understand that I need to inform Employee Health Services should I develop any symptoms of TB. More information about TB can be found at https://www.cdc.gov/tb or in Policy Tech-Tuberculosis Screening of Colleagues.

Colleague Signature____ Date______________________

Employee Health Use Only

- This individual does not have history of a positive test/disease and does not have symptoms of active TB disease or risk factors of being exposed to TB. Will proceed with TB testing.
- This individual has a history of a positive TB test or latent TB without symptoms of active TB disease. Education provided re: latent TB, referred to medical provider re: counseling for treatment. Annual follow up needed.
- Other:

EHS staff signature____ Date______________________

HEALTH QUESTIONNAIRE

NAME: (PRINT) ____

1. To your knowledge, do you currently have any infections diseases, which may be communicable to our patients, employees, or visitors?

   ☐ Yes ☐ No

   Please explain YES responses:

   ____

   ____

   ____

2. Do you currently have an ongoing illness, which would put you at significant risk in working in the position for which you have been hired? (Examples: uncontrollable seizures, immuno-suppressed individual working in an area which treats many infectious/communicable disease.)

   ☐ Yes ☐ No

   Please explain YES responses:

   ____

   ____

   ____

______________________________ ______________________
Signature *Date*

SAINT JOSEPH
HEALTH SYSTEM

HEALTH CARE PROFESSIONAL'S WRITTEN OPINION FOR HEPATITIS B VACCINE

NAME:______________________________ **DATE:** ____________________

JOB TITLE: _________________________ **DEPT:** ____________________

This job has the potential to occupationally expose the employee to blood and body fluid of patients.

As described in the OSHA rules and regulations on Occupational Exposure to Bloodborne Pathogens (29 CFR Part 1910.1030), the hepatitis B vaccine shall be made available, at no cost, within ten (10) working days of the initial assignment to all employees who may have occupational exposure to pathogenic (disease producing) micro-organisms that are present in human blood and other body fluids. You are entitled to a copy of this regulation. Make your request known to Employee Health Services. These pathogens include, but are not limited to, hepatitis B virus (HBV) and human immuno-deficiency virus (HIV).

The hepatitis B vaccine may not be indicated if:

1. The employee has previously received the complete hepatitis B vaccine series.
2. Antibody testing has revealed that the employee is immune.
3. The vaccine is contraindicated for medical reasons.
4. The employee is not expected to be exposed to blood and body fluids of patients.
5. The evaluating health care professional deems any other reason significant.
   All pending diagnoses will remain confidential and will not be included in this report.

HEALTH CARE PROFESSIONAL'S WRITTEN OPINION: *

☐ YES ☐ NO The above-mentioned employee has already received the Complete hepatitis B vaccine series.

☐ YES ☐ NO The hepatitis B vaccine is indicated for the above-mentioned employee.

______________________________ ____________________
HEALTH CARE PROFESSIONAL SIGNATURE DATE

I understand if I would like a copy of this form I can request one.

______________________________ ____________________
EMPLOYEE SIGNATURE DATE

Comments:____

____

**Consistent with standing orders*

SAINT JOSEPH
Regional Medical Center

EMPLOYEE HEALTH SERVICES
Ishihara's Tests for Colour-Deficiency

ID#: ________________ Name (print): ______________________________________

Department: ______________________________________ Date: ________________

Supervisor: ______________________________________ Phone #: ______________

Number of Plate	Normal Person	Patient Response	Person with Color Blindness	Person with Red/Green Deficiencies
1	12			
2	8			
3	5			
4	29			
5	74			
6	7			
7	45			
8	2			
9	X			
10	16			
11	Traceable			
12	35			
13	96			
14	Can trace two lines			

An assessment of the reading plates 1 to 11 determines the normality of defectiveness of color vision. If 10 or more plates are read normally, the color vision is regarded as normal. If only 7, or less, plates are read normal, the color vision is regarded as deficient. However in reference to plate 9, only those who read the numerals 2 and read to easier than those on plate 8 are recorded as abnormal.

It is rare to find a person whose recording of normal answers is 9 or 8 plates. An assessment of such case requires the use of other color vision tests, including anomaloscope.

Total # Correct ________________

Total # Wrong ________________

Test Performed By: ______________________________________

SAINT JOSEPH
Regional Medical Center

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

To the Employee: Can you read (circle one)?: Yes No

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers. Completed forms can be sent to Employee Health Services via interoffice mail or faxed to 574-335-1029 for review.

Part A - 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. Today's date: ______________________________ ID# ________________________
2. Your name:____
3. Your age (to nearest year):_______ 4. Sex: Male Female
5. Your height: _____ ft. ____ in. 6. Your weight: ___________ lbs.
7. Your job title:_________________________________ Department: _____________________
8. A phone number where you can be reached by the healthcare professional who reviews this questionnaire (include the area code): ____________________________________.
9. The best time to phone you at this number: ________________AM PM
10. Has your employer told you how to contact the healthcare professional who will review this questionnaire? (circle one): **[The healthcare professional who will review this questionnaire is the Employee Health nurse and can be reached at 335-1030 or 335-2399. Yes, See above.** No
11. Check the type of 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-facepiece type, CAPR, supplied air, self-contained breathing apparatus).
12. Have you worn a respirator? (circle one): Yes No

    If yes, what type(s): ____

Part A - Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator. Circle yes or no.

1. Do you currently smoke tobacco or have you smoked tobacco in the last month? Yes No
2. Have you ever had any of the following conditions?

    a. Seizures (fits)? Yes No
    b. Diabetes (sugar disease)? Yes No
    c. Allergic reactions that interfere with your breathing? Yes No
    d. Claustrophobia (fear of closed-in places)? Yes No
    e. Trouble smelling odors? Yes No

3. Have you ever had any of the following pulmonary or lung problems?

a.	Asbestosis	Yes	No
b.	Asthma	Yes	No
c.	Chronic Bronchitis	Yes	No
d.	Emphysema	Yes	No
e.	Pneumonia	Yes	No
f.	Tuberculosis	Yes	No
g.	Silicosis	Yes	No
h.	Pneumothorax (collapsed lung)	Yes	No
i.	Lung Cancer	Yes	No
j.	Broken Ribs	Yes	No
k.	Any chest injuries or surgeries	Yes	No
l.	Any other lung problem that you've been told about	Yes	No

4. Do you currently have any of the following symptoms of pulmonary or lung illness?

a.	Shortness of breath	Yes	No
b.	Shortness of breath when walking fast on level ground or walking up a slight hill or incline	Yes	No
c.	Shortness of breath when walking with other people at an ordinary pace on level ground	Yes	No
d.	Have to stop for breath when walking at your own pace on level ground	Yes	No
e.	Shortness of breath when washing/dressing yourself	Yes	No
f.	Shortness of breath that interferes with your job	Yes	No
g.	Coughing that produces phlegm (thick sputum)	Yes	No
h.	Coughing that wakes you early in the morning	Yes	No
i.	Coughing that occurs mostly when you are lying down	Yes	No
j.	Coughing up blood in the last month	Yes	No
k.	Wheezing	Yes	No
l.	Wheezing that interferes with your job	Yes	No
m.	Chest pain when you breathe deeply	Yes	No
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	Yes	No
b.	Stroke	Yes	No
c.	Angina	Yes	No
d.	Heart failure	Yes	No
e.	Swelling in your legs or feet (not caused by walking)	Yes	No
f.	Heart arrhythmia (heart beating irregularly)	Yes	No
g.	High blood pressure	Yes	No
h.	Any other heart problem that you've been told about	Yes	No

6. Have you ever had any of the following cardiovascular or heart symptoms?

a.	Frequent pain or tightness in your chest	Yes	No
b.	Pain or tightness in your chest during physical activity	Yes	No
c.	Pain or tightness in your chest that interferes with your job	Yes	No
d.	In the past two years, have you noticed your heart skipping or missing a beat	Yes	No
e.	Heartburn or indigestion that is not related to eating	Yes	No
f.	Any other symptom you think may be related to heart or circulation problems	Yes	No

7. Do you currently take medication for any of the following problems?

a. Breathing or lung problems	Yes	No
b. Heart trouble	Yes	No
c. Blood pressure	Yes	No
d. Seizures (fits)	Yes	No

8. If you've used a respirator, have you ever had any of the following problems? (If you've never used a respirator, check here _____ and go on to question 9.)

a. Eye irritation	Yes	No
b. Skin allergies or rashes	Yes	No
c. Anxiety	Yes	No
d. General weakness or fatigue	Yes	No
e. Any other problem that interferes with your use of a respirator	Yes	No

9. Would you like to talk to the healthcare professional who will review this questionnaire? **(If yes, call Employee Health at 51030 or 52399.)** Yes No

10. If you have questions about the **CAPR** use or fit-testing, contact Employee Health at 51030 or 52399.

Are you allergic to saccharin? Yes No

Signature ___________________________ Date ______________________________

FOR EMPLOYEE HEALTH PROVIDER USE ONLY

___ Medically cleared to use the PAPR or N95 respirator (filter mask).

___ Medically cleared with restrictions as shown: ______________________________

____

___ Further evaluation needed.

___ Medically not cleared.

____

(Printed Name/Signature) Date
Employee Health Provider

If fit tested for N95-

Date fit tested:______________Model ____________________ size_____________

Signature of fit tester:____