ASSOCIATE HEALTH PRE-PLACEMENT, POST OFFER MEDICAL SCREENING

Hello and welcome to Holy Cross Hospital! We are happy that you have chosen to work here. Our Associates (employees) are the heart of Holy Cross Hospital and we are committed to providing a safe environment in which to work. A conditional offer of employment has been made to you. This offer is contingent upon successful completion of a drug screen, physical examination and/or inquiry about health related issues. ***NOTE:*** This information will be kept in confidence and will not be used to discriminate against qualified individuals with a disability in any phase of employment.

Name: ________________________________ Date of Birth: _______________ Previous Names Used: ________________

Address: ________________________________ City: ______________________ State: ____________ Zip: __________

Home Phone: ______________ Cell: ________________________ Social Security Number: _________________________

Position Applied for: ____ Department: ______________________________

In Case of Emergency Notify: ______________________________ Relationship: _________________________________

Phone: ________________ Address: _____________________________ City: ____________________ State: __________

Have you ever worked at Holy Cross Hospital before? ❑ YES ❑ NO If YES, when:________________________________

1. Has a physician ever assigned a permanent disability or permanent limitations or restrictions to you?..... ❑ YES ❑ NO

2. Have you ever had contact with any substance or items that caused a reaction
(Examples: latex gloves, medical devices, personal items – balloons, condoms,
band-aids, adhesive tapes, clothing with elastic or stretch fabrics? .... ❑ YES ❑ NO

3. Have you ever been discharged or rejected from the Armed Forces for a medical reason? .... ❑ YES ❑ NO

4. Have you ever been involved in a motor vehicle accident? .... ❑ YES ❑ NO Date: ________________________

5. Have you ever experienced a neck or back injury? .... ❑ YES ❑ NO Date: ________________________

6. Have you ever been told or suspect you have a herniated disc?... ❑ YES ❑ NO

7. Have you ever been exposed to any hazardous environments in the past
(Examples: Asbestos, Toxic Chemicals, etc.)? .... ❑ YES ❑ NO

8. Is there a possibility you could be pregnant?... ❑ YES ❑ NO

9. Having reviewed your job description, are you able to satisfactorily perform
the essential functions of the job?... ❑ YES ❑ NO

If NO, please explain: ____

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Please explain any items answered YES: ____

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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 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.

ALLERGIES:

Medication ..... ❑ Yes ❑ No Name: ____________________ Type of Reaction: ________________________________

Food........... ❑ Yes ❑ No Name: ____________________ Type of Reaction: ________________________________

Latex .... ❑ Yes ❑ No Name: ____________________ Type of Reaction: ________________________________

Other .... ❑ Yes ❑ No Name: ____________________ Type of Reaction: ________________________________

Illness / Virus	Immunization	Have You Had the Illness/Virus?	Illness / Virus	Immunization	Have You Had the Illness/Virus?
Mumps	❑ YES ❑ NO	❑ YES ❑ NO	Hepatitis C	No Vaccine Available	❑ YES ❑ NO
Measles	❑ YES ❑ NO	❑ YES ❑ NO	Polio	❑ YES ❑ NO	❑ YES ❑ NO
Rubella	❑ YES ❑ NO	❑ YES ❑ NO	Tetanus	❑ YES ❑ NO	❑ YES ❑ NO
Varicella	❑ YES ❑ NO	❑ YES ❑ NO	BCG	❑ YES ❑ NO	N / A
Hepatitis A	❑ YES ❑ NO	❑ YES ❑ NO	DPT	❑ YES ❑ NO	❑ YES ❑ NO
Hepatitis B	❑ YES ❑ NO	❑ YES ❑ NO	Meningitis	❑ YES ❑ NO	❑ YES ❑ NO

List any Surgical, Medical or Psychiatric Hospitalizations. Please include Date and Reason of Hospitalization: ________________

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MEDICAL HISTORY (Please check all that apply)

❑ Ear Infections
❑ Lupus
❑ Hernia
❑ Constipation
❑ Hearing Loss
❑ TMJ
❑ Gout
❑ Cancer
❑ Arthritis
❑ Phlebitis
❑ Migraines
❑ Depression
❑ Vomiting
❑ Diabetes
❑ Chest Pain
❑ Stroke
❑ Diarrhea
❑ Nose Bleeds
❑ Hemorrhoids
❑ Heart Murmur
❑ Sore Throat
❑ Jaundice / Hepatitis
❑ Color Blindness
❑ Knee Problems
❑ Swollen Ankles
❑ High Cholesterol
❑ Nervousness
❑ Chronic Fatigue
❑ Failing Vision
❑ Leg Pain / Walking
❑ Wrist Problems
❑ Psoriasis / Eczema
❑ Venereal Disease
❑ Sinus Trouble
❑ Loss of Appetite
❑ Varicose Veins
❑ Eye Infections
❑ Blood in Urine
❑ Peptic Ulcers
❑ Thyroid Disease
❑ Kidney Stones
❑ Crohn's / Colitis
❑ Irregular Heart Beat
❑ Carpal Tunnel Syndrome
❑ Bronchitis / Chronic Cough
❑ Shoulder Problems
❑ Glasses / Contact Lenses
❑ Drug / Alcohol Abuse
❑ Coronary Artery Disease
❑ Difficulty Swallowing
❑ Abdominal Pain / Chronic
❑ Tremors / Hands Shaking
❑ Irritable Bowel Syndrome
❑ Myofascial Pain Syndrome
❑ Loss of Bladder Control
❑ Indigestion or Heartburn
❑ Frequent / Painful Urination
❑ Numbness / Tingling Sensation
❑ High Blood Pressure
❑ Weight Loss / Recent
❑ Gallbladder Trouble
❑ Dizziness / Fainting
❑ Fibromyalgia
❑ Convulsions / Seizures
❑ Headaches / Frequent
❑ Foot / Ankle Problems
❑ Muscle Disease
❑ Elbow Problems
❑ Ringing in Ears
❑ Change in Bowel Habits
❑ Bloody or Black Stools
❑ Anemia / Bruise Easily
❑ Difficulty Urinating / Dribbling
❑ Back Pain / Chronic / Recurrent
❑ Neck Pain / Chronic / Recurrent
❑ Osteoporosis (Brittle Bones)
❑ Urinary Infections / Frequent
❑ Diverticulitis
❑ Pneumonia
❑ Rashes / Hives
❑ Persistent Nausea
❑ Hay Fever / Allergies
❑ Asthma / Wheezing
❑ Surgically / Accidentally Implanted Metal Objects / Devices

Please explain any above **checked** items: ____

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Do you participate or have you ever participated in yearly screenings with your employer?
(Example: Hearing, Chemical or Radiation Exposure, Tuberculosis, etc.) .... ❑ Yes ❑ No

TUBERCULOSIS SCREENING

Have you ever had a positive (raised or hardened) TB Skin Test? .... ❑ Yes ❑ No

If YES, date of last positive TB Test – Month: ____________ Date: ____________ Year: ____________

Have you received a Measles, Mumps, Rubella or Varicella vaccine in the past 6 weeks? .... ❑ Yes ❑ No

Have you had a viral infection (Influenza, Mumps, Measles) in the past 6 weeks?.......... ❑ Yes ❑ No

Are you taking any medication that would affect this reading? (Steroids, Anti-Viral, Immunosuppresant)...... ❑ Yes ❑ No

Do you have any signs or symptoms of the following:

Cough / Hoarseness lasting longer than (3) weeks?.......... ❑ Yes ❑ No

Coughing up Blood?.......... ❑ Yes ❑ No

Fever lasting longer than (3) weeks?.......... ❑ Yes ❑ No

Night sweats?.......... ❑ Yes ❑ No

Unintentional Weight Loss? .... ❑ Yes ❑ No

Loss of Appetite?.......... ❑ Yes ❑ No

****A History of BCG Vaccination is not a Contraindication for Tuberculin Skin Testing****
****Pregnancy is not a Contraindication to Tuberculin Skin Testing****

This information will be used in establishing various Employee Wellness Programs:

My Height is: ______ Feet _______ Inches My Weight is: __________ Pounds

Do you Smoke (Cigarette, Cigar, Pipe)?.......... ❑ Yes ❑ No

If YES, verbalized understanding of the Holy Cross Hospital Smoke Free Policy .... ❑ Yes ❑ No

Alcohol Usage: ______________________________ Daily Exercise: ______________________________

Weight Control (Any Special Diet): ____

I have read the foregoing or, it has been read to me and I hereby affirm that the information set forth therein is true to the best of my knowledge and belief and I understand this will become a part of my permanent Medical Record.

Should I experience any of the above TB symptoms, I must immediately notify Employee Health or Infection Control. I understand that I may receive a copy of this form with the results for my records. I authorize Holy Cross Hospital to administer the Mantoux Tuberculin Skin Test to me. I understand that symptoms may include redness, swelling and/or itching at or near the injection site. If I react positively to the test, I may develop small blisters or a blackened area at or around the injection site.

I agreed that any false statement or misrepresentation, including an omission of any material facts on the above questionnaire would be cause for termination.

Signature: ____ **Date:** ______________________

Holy Cross Hospital

HEPATITIS B VACCINATION DECLINATION / INFORMATION FORM

SECTION A: Please complete if you have never had the Hepatitis B Vaccine

SECTION B: Please complete if you have already have already received the Hepatitis B Vaccine

SECTION A:

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 Hepatitis B Vaccine at no charge to myself. 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 with Hepatitis B Vaccine, I can receive the vaccination series at no charge to me.

Signature of Person Declining the Vaccine: ________________________________ **Date:** ______________

Reason for Declining:

❑ No Exposure Potential in my Job ❑ Allergic ❑ I Will Receive the Vaccine at a Future Date

SECTION B:

I Have Already Received the Vaccine .... ❑ Yes ❑ No

Have you ever had a Hepatitis B Titer Done? .... ❑ Yes ❑ No

The Titer was: ❑ Positive ❑ Negative

Positive: Indicates the Presence of Antibodies

Negative: Indicates that No Antibodies are Present

Signature: ____ **Date:** __________________________

This form is designed for you to record any information you consider relevant to the drug test which you will be taking. The information recorded below may include identification of currently or recently used prescription or non-prescription medication or other relevant medical information. To assist you in completing this form, a list of common medications which may alter or affect a drug test is on the bottom of this form.

I understand and agree to abide by the policies and procedures of Holy Cross Hospital regarding use, possession or sale of narcotic, hallucinogens, depressants, stimulants, marijuana or other controlled substances. I understand that evidence of illegal drug usage or abuse of prescribed drugs could affect my eligibility for employment with Holy Cross Hospital and I agree to abide by any decision made by the Hospital in this regard.

Please list ALL over-the-counter drugs (cough medicine, anti-histamines, anti-diarrhea) and prescription medications (including injections) you have taken (received) in the last four weeks.

MEDICATION DRUG AND STRENGTH	REASON FOR MEDICATION	DATE AND TIME OF LAST DOSE	NAME OF DOCTOR

I certify that the specimen given is my urine, that it was voluntarily given for purpose of drug usage urinalysis and that the above information given is correct. Further, I hereby release and agree to hold harmless Holy Cross Hospital, its employees and its agents from any liability to me based on the results of said drug usage urinalysis. I also understand and agree that positive test results may be reported to state licensure agencies.

This list is in accordance with the Department of Health and Rehabilitation Services, Chapter 10E-18 Florida Administrative Code of Drug-Free Workplace Standards. Due to the large number of obscure brand names and constant marketing of new products, the list as follows, cannot and is not intended to be all inclusive.

- Amphetamines (Binhetamine, Desoxyn, Dexedrine)
- Methaqualone (Quaalude, Parest, Sopor)
- Benzodiazophines (Ativan, Azene, Clonopin, Dalmane, Diazepam, Halcion, Librium, Poxipam, Restoril, Serax, Tranxene, Valium, Verton, Xanax)
- Propoxyphene (Darvocet, Darvon N, Dolene)
- Alcohol
- Cocaine
- Barbiturates (Phenobarbital, Tuinal, Amytal)
- Opiates
- Methadone (Dolophine, Methadose)
- Cannabinoids (Marijuana, Hashish)
- Phencyclidine (PCP)

Name: ______________________ **Social Security Number:** ______________________

Signature: ______________________ **Witness:** ______________________

ASSOCIATE HEALTH PRE-PLACEMENT, POST-OFFER MEDICAL SCREENING CERTIFICATION

I certify that this form was completed by me. I certify that the information on the Associate Health Pre-Placement, Post-Offer Medical Screening form is true, complete and correct. I understand that falsification or omission whenever or however discovered, may jeopardize my opportunities for employment or, if hired, may be reason for termination of employment. While this form will be given every consideration, its receipt does not imply or guarantee that I will be employed.

By signing this form, I authorize Holy Cross Hospital, Inc. and its subsidiaries and their agents to investigate information I have given in this application, resume or during the interview process and to conduct a background investigation.

This form when signed becomes the property of Holy Cross Hospital, Inc. or its subsidiaries.

Signature: ____________________________________ **Date:** ______________________________

Printed Name: ________________________________

Holy Cross Hospital

DO NOT WRITE BELOW – FOR OFFICE USE ONLY

Name: ________________________________

Pulse: ❑ Regular ❑ Irregular **Respirations:** ______________ **B/P:** ______________ **Re-Check B/P:** ______________

ASSESSMENT	DESCRIPTION OF FINDINGS
Color Acuity: ❑ Pass ❑ Fail	❑ Denies Visual Disturbances Other: ______________
Lungs: ❑ Pass ❑ Fail	❑ Denies SOB, Able to Speak in Clear Sentences, Respirations Even and Unlabored Other: ______________
Extremities: ❑ Pass ❑ Fail	❑ MOE, Grips and Pushes Equal and Strong Other: ______________
Gait: ❑ Pass ❑ Fail	❑ Independent and Steady Other: ______________
Flexibility/Spinal Column: ❑ Pass ❑ Fail	❑ Denies Back Pain at this Time Other: ______________

Physician Physical Examination Required: ❑ Yes ❑ No **If YES, see attached sheet. Documentation Received:** ❑ Yes ❑ No

Urine Drug Test Collected: ❑ Yes ❑ No **Results:** ❑ Positive ❑ Negative

Respirator Fit Testing Completed: ❑ Yes ❑ No ❑ See Attached Documentation ❑ To be done at Nursing Orientation

Labs Received: ❑ Yes ❑ No **Check Negative Results:** ❑ Measles ❑ Mumps ❑ Rubella ❑ Varicella ❑ Hep B ❑ Hep A

Nurse's Notes: ________________________________

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CXR: ❑ Yes ❑ No **If YES, Results:** ❑ Positive ❑ Negative

TB Referral for Positive TST: ❑ Yes ❑ No **If YES, Follow-Up for Positive TST:** ______________

1st Step Dose: 5TU TST Lot #: ______ EXP Date: ______ Date: ____________ Site: LFA Given by: ______________

Read Date: ____________ Results: ____________ mm Read by: ______________

2nd Step Dose: 5TU TST Lot #: ______ EXP Date: ______ Date: ____________ Site: LFA Given by: ______________

Read Date: ____________ Results: ____________ mm Read by: ______________

Medically Qualified ❑ Yes ❑ No **Medically Disqualified** ❑ Yes ❑ No **Human Resources Notified:** ❑ Yes ❑ No

Employee Health Nurse Signature/RN Signature: ______________________________ **Date:** ______________