

## **RESIDENTS/ FELLOWS**

Prior to beginning work at the University of Maryland Medical Center (UMMC), you will need to schedule an appointment to be seen by Employee Health Service (EHS) for a pre-placement evaluation. **You must bring a picture ID** (driver's license or passport) or we will not be able to perform your evaluation. Please bring a copy of your vaccination record and TB skin test.

**Plan about one hour in your schedule to complete the pre-placement evaluation process. The urine drug screen may take up to 3 hours longer if you are unable to provide a specimen.**

1. **Medical History Questionnaire:** Complete (on-line) forms and bring them with you to your scheduled appointment. You will be instructed on how to access these forms online for convenience. **DO NOT MAIL THE COMPLETED FORMS TO YOUR RESIDENCY PROGRAM OR TO EMPLOYEE HEALTH.** Hand carry the forms with you to your appointment.

- If you have **ANY** current medical conditions, which require ongoing treatment, you will be required to provide a note (**documentation , use on-line form titled: Treating Physician Pre-placement Medical Review form**) from your treating physician.
- This note (Treating Physician Pre-placement Medical Review form) should include your diagnosis, treatment, medications, any restrictions to your physical activities or other restrictions. The note should further state that your medical condition is under control and will not interfere with your ability to perform the duties of your residency program in an ongoing, safe and reliable manner. Bring this documentation with you to your appointment.

2. **Vaccination History:**

Measles, Mumps, Rubella, Varicella (chicken pox) and Hepatitis B

Please bring documentation of any vaccinations or lab results indicating you are immune.

- If you cannot show proof of vaccination history or immunity, we will draw your blood to determine whether or not you are immune to measles, mumps, rubella, varicella and Hepatitis B. If you have already received the Hepatitis B vaccination series or wish to decline, you may sign a declination form. (see on-line form)
- If titers indicate that you are **not immune** to any of the above mentioned (you will **not** be cleared to work), you will be notified and instructed to return to EHS to be vaccinated.

3. **Tuberculosis Skin Testing:**

- UMMC requires a 2- step TB skin test.

**OPTIONS:**

- This means we place one TB skin test and as long as it is negative, we place another one 1-2 weeks later to be certain your baseline is negative. **OR**
- If you have had a TB skin test in the last 12 months, please **bring a copy** of the result. **Then you will only need to receive 1 TB skin test. OR**
- Bring copy of 2 PPD's. (PPD documentation within 1 year *and* within 3 months of start date).
- The TB skin test needs to be read or interpreted 48-72 hours after it was administered. You may return to Employee Health or have any RN or MD (but not yourself) document the result as long as there is no redness or induration. Any redness or induration **must** be read by UMMC EHS. Documentation can be hand carried or faxed to Employee Health (410-328-2610) or scanned and sent to rhogan@umm.edu.
- If you have had a positive TB skin test in the past, please bring a copy of a chest x-ray report performed in the past 12 months. Otherwise we will repeat the chest x-ray. Also, complete the UMMC Positive TB Skin Test Questionnaire.
- For your convenience, we are open Mon. – Fri. from 7am -4pm (except holidays).

4. **Drug Screen:**

A urine drug screen will be obtained. Please come to your appointment prepared to provide a urine specimen. This is usually a quick process (15 – 20 minutes). However, it may take up to 3 hours if you are unable to provide a specimen of sufficient quantity and temperature. The urine collection process will not be started after 2:00 pm. The urine drug collection may be scheduled separately from the pre-placement evaluation if there are time constraints.

5. **Respiratory Fit Testing**

Respiratory medical clearance and fit testing will be performed.

If you are unable to keep an appointment and need to reschedule please call 410-328-6151.

Please note that your **start date will be delayed** by failure to return/complete vaccination records, T.B. skin test results and Treating Physician Pre-placement Medical Review form if indicated.



## Employee Health Services Registration Form

**Please Print Clearly**

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

SS #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sex:  Male  Female Race: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ Home Phone: \_\_\_\_\_

State: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Zip Code: \_\_\_\_\_ Email: \_\_\_\_\_

Have you been an employee of the University of Maryland Medical System, in the past?  Yes  No

If so, please list other names used: \_\_\_\_\_

Job Title: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Supervisor: \_\_\_\_\_ Department \_\_\_\_\_

Recruiter: \_\_\_\_\_ Anticipated Start Date: \_\_\_\_\_

### **IN CASE OF EMERGENCY, NOTIFY:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

**University of Maryland Medical Center  
Initial Residents/ Fellows Employee Health Evaluation**

**Today's date:**

Printed name – first name, middle name, last name:	Date of birth:
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*The purpose of this evaluation is to screen you for communicable diseases, determine vaccinations to protect you and your patients, to clear you to use a respirator, to screen you for latex allergy, and to determine whether you have any physical, mental or emotional impairment that could affect your ability to perform the job that you have been offered. This is NOT meant to substitute for the comprehensive health assessments that your private doctor performs for your personal health.*

**Employment Information -- All employee**

Type of job you have been offered:	Job code (if known):
Can you perform the essential functions of your job?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain
Do you have any CURRENT disability requiring restricted physical activity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, will you require a job modification for a disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain
If yes, state restrictions:	
Are these restrictions:	
<input type="checkbox"/> Permanent	<input type="checkbox"/> Temporary until: _____ (provide date)

**Past Work/Exposure History-- All employees**

Mark an "X" in the box next to ALL items you might have been exposed to in your past work:

<input type="checkbox"/> Asbestos/silica	<input type="checkbox"/> Pesticides	<input type="checkbox"/> Lead/mercury/cadmium	<input type="checkbox"/> Loud noise (above 85 decibels)
<input type="checkbox"/> Dusts	<input type="checkbox"/> Laboratory animals	<input type="checkbox"/> Benzene	<input type="checkbox"/> Solvents/degreasers
<input type="checkbox"/> Formaldehyde	<input type="checkbox"/> Epoxy resins	<input type="checkbox"/> Hazardous wastes	<input type="checkbox"/> Cytotoxic agents (e.g. chemo)
<input type="checkbox"/> Welding	<input type="checkbox"/> Blood or fluid exposures (HIV, Hep B, Hep C)	<input type="checkbox"/> Plastics	<input type="checkbox"/> Lasers
<input type="checkbox"/> Latex Products	<input type="checkbox"/> Vibration	<input type="checkbox"/> Paints/isocyanates	<input type="checkbox"/> Other chemicals (list): _____
<input type="checkbox"/> Grease and oil	<input type="checkbox"/> Ethylene oxide/other gases	<input type="checkbox"/> Glutaraldehyde	

If you have been exposed to any of the above, provide further details, including the year, the amount of exposure and medical treatment: \_\_\_\_\_

**Vaccines ---** To be completed by all employees who work within the hospital, and by others who might work in patient care areas

	UNK=Unknown		
a. Have you ever received 3 doses of <u>hepatitis B vaccine</u> ? If 'yes', what year?	Yes	No	UNK
Did you have a post-series antibody titer to determine immunity? If 'yes', were you then considered immune?	Yes	No	UNK
b. Have you had <u>serologic evidence of immunity to varicella</u> ? Have you ever received 2 doses of varicella (chickenpox) vaccine?	Yes	No	UNK
c. Have you ever received 2 doses of live <u>measles vaccine</u> ?*	Yes	No	UNK
d. Have you received at least 2 doses of <u>mumps vaccine</u> ?*	Yes	No	UNK
e. At least 1 dose of <u>rubella vaccine</u> ?*	Yes	No	UNK
f. Was your last tetanus shot within the past 10 years? If 'yes', what year?	Yes	No	UNK
g. When was your last TB skin test:			
h. What was the result?			
i. Do you have documentation	Yes	No	UNK

\*Usually given as 2 doses. Documentation is required by Maryland state regulation. If not available, blood must be drawn for titers

**Work Injuries --- All employees**

Have you ever had an illness or injury that was related to your job?	Yes	No	
If 'yes': What was the injury or illness: Where did it happen (location): What was the date of the injury: Did you miss work? If 'yes', for how long? _____ Do you have any ongoing restrictions to your activity? If 'yes', describe restrictions:	Yes	No	
	Yes	No	

**Latex Allergy Screening --- All employees**

a. Have you ever been told by a medical professional that you have a latex allergy?	Yes	No	
b. Have you ever had an anaphylactic reaction to a latex product?	Yes	No	
c. After handling latex products, have you ever experienced any of the following? Difficulty breathing or wheezing Runny, itchy nose or congestion Itching eyes/increased tearing Systemic hives/rash Itching or hives on hands Swelling of hands Redness of hands Chapping or cracking of hands	Yes Yes Yes Yes Yes Yes Yes Yes	No No No No No No No No	
d. Are you allergic to: Check all that apply <input type="checkbox"/> Bananas <input type="checkbox"/> Avocado <input type="checkbox"/> Kiwi <input type="checkbox"/> Other foods (list):			

**Current Health Status --- All employees**

<b>General Health and Function</b>				
How would you rate your general health? Poor                  Fair                  Good                  Excellent				
How often do you engage in brisk physical activity that lasts at least 30 minutes? Not at all          Rarely                  2-3 times/week $\geq$ 3 times/week				
Do you smoke? If 'yes' what do you smoke?    Cigarettes    Cigars    Pipe  How many/often per day? _____    For how many years? _____  If 'no' have you ever smoked? _____    For how many years? _____    When did you quit? _____	Yes	No		
Do you drink beer, wine, or hard liquor? Average less than 1 drink per day? Average 2 or more drinks per day?	Yes Yes Yes	No No No		
Do you now or have you ever used illegal drugs?	Yes	No		
Are you now using prescription pain killers?	Yes	No		
Are you currently being treated or monitored (e.g. by a licensing board) for substance abuse (including illegal drugs, use of a legal drug that has not been prescribed for you, or alcohol)? If yes, list/describe substance, treatment program (name/location/frequency) and ongoing monitoring (e.g. repeat urine or blood tests):	Yes	No		
<b>Respirator Clearance --- To be completed by all employees ever working in patient care areas</b>				
Have you ever worn a respirator? If 'yes' what type(s)? : _____ Did you have any difficulties when using the respirator (such as eye or skin irritation, anxiety, weakness or fatigue)? Explain:	Yes Yes	No No		
<b>Respiratory (All employees)</b>				
Have you had any chest injuries/surgeries in the past year or that are still causing pain or breathing problems?	Yes	No		

Do you have current shortness of breath? Very short of breath when walking fast on level ground or walking up a slight hill or incline? Very short of breath when walking with other people at an ordinary pace on level ground? Have to stop for breath when walking at your own pace on level ground? Shortness of breath when washing or dressing? Shortness of breath that interferes with your job?	Yes Yes Yes Yes Yes Yes	No No No No No No
Coughing that: Produces phlegm (thick sputum) Wakes you early in the morning Occurs mostly when you are lying down Produces blood (in the last month)	Yes Yes Yes Yes	No No No No
Do you have wheezing?	Yes	No
Do you have wheezing that interferes with your job?	Yes	No
<b>Cardiovascular (All employees)</b>		
Have you had any problems with chest pain/tightness: While you are walking? While you are resting? That interferes with you job?	Yes Yes Yes	No No No
Have you had any chest pain when you breathe deeply?	Yes	No
Do you have an irregular heartbeat or palpitations?	Yes	No
Do you have swollen ankles/feet (not caused by walking)?	Yes	No
Do you have heartburn or indigestion that is not related to eating?	Yes	No
Do you have pain in your legs when walking that is relieved by rest?	Yes	No
<b>Musculoskeletal (All employees)</b>		
Do you have any problems with your joints or muscles?	Yes	No
Do you currently have neck pain, back pain, or pain in any of your joints?	Yes	No
Have you ever had an injury to your neck, back, extremities, or joints?	Yes	No
Have you ever had any broken bones including ribs? If 'yes' what bone and when? _____ If 'yes', is it still causing pain?	Yes Yes	No No
Do you have trouble bending at the waist?	Yes	No
Do you have any lifting restrictions? If 'yes', describe restrictions (e.g. maximum weight you can lift):	Yes	No
Do you have trouble doing a deep knee bend?	Yes	No
Do you have trouble lifting your arms above your head?	Yes	No
Do you have trouble making a fist with both of your hands?	Yes	No
Do you have any limitations in the amount of time you are able to sit, stand, or walk?	Yes	No
Do you have trouble going up and down stairs?	Yes	No
<b>Neurological (All employees)</b>		
Do you have loss of vision in either eye that cannot be corrected?	Yes	No
Do you have loss of vision requiring correction? If 'yes' mark the type of correction      Near      Far      Contact Lenses      Eyeglasses	Yes	No
Do you have hearing loss that requires hearing aids?	Yes	No
Do you have headaches more than twice a month, which limits your ability to work?	Yes	No
Do you have problems with weakness (loss of strength)?	Yes	No
Do you have numbness or tingling in your extremities?	Yes	No
Do you or have you ever had seizures (fits)? If 'yes' when was the last episode?	Yes	No
Do you have episodes of lightheadedness or dizziness? If 'yes' when do these occur?	Yes	No
Have you ever passed out (fainted)? If 'yes' when was the last episode?	Yes	No
Do you ever lose your coordination/balance?	Yes	No
<b>Psychiatric/Other (All employees)</b>		
Have you ever received treatment for, or missed work because of, any of the following: ADD/ADHD? Depression? Bipolar disease? Anxiety? Post traumatic stress disorder (PTSD)? Schizophrenia? Other psychological/psychiatric disorder?	Yes Yes Yes Yes Yes Yes Yes	No No No No No No No

Employee name: \_\_\_\_\_

Do you have decreased ability in any of the following? (Check all that apply) <input type="checkbox"/> To stay awake or maintain consciousness (due to such causes as seizures, diabetes, or sleep disorder) <input type="checkbox"/> Managing multiple tasks at one time <input type="checkbox"/> Working rotating shifts	Yes	No
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**Medications --- All employees**

Do you have a history of allergies or sensitivities to medications?  Yes  No  
 If 'yes' which medication(s)? \_\_\_\_\_

List all medications you are currently taking both prescription and over-the-counter:

**Other Chronic Conditions --- All employees**

Mark an **X** in the box next to any of the following illnesses you now have or have ever had.

<input type="checkbox"/> Skin disorder	<input type="checkbox"/> <b>Heart failure</b>	<input type="checkbox"/> Hive or rashes	<input type="checkbox"/> <b>Other heart problems</b>
<input type="checkbox"/> Peripheral vascular disease	<input type="checkbox"/> <b>Color blindness</b>	<input type="checkbox"/> Liver disease/ hepatitis	<input type="checkbox"/> <b>Hernia</b>
<input type="checkbox"/> <b>Mental health problems</b>	<input type="checkbox"/> Diverticulosis	<input type="checkbox"/> <b>Anemia</b>	<input type="checkbox"/> Current or frequent pneumonia
<input type="checkbox"/> <b>Back problems/surgery</b>	<input type="checkbox"/> <b>Cancer or tumor</b>	<input type="checkbox"/> <b>Neck problems/surgery</b>	<input type="checkbox"/> Pneumothorax (collapsed lung)
<input type="checkbox"/> <b>Diabetes</b>	<input type="checkbox"/> <b>Other lung disease</b>	<input type="checkbox"/> <b>Shoulder problems/surgery</b>	<input type="checkbox"/> <b>Asthma</b>
<input type="checkbox"/> <b>High blood pressure</b>	<input type="checkbox"/> <b>Knee problems/surgery</b>	<input type="checkbox"/> Kidney/ bladder problems	<input type="checkbox"/> <b>Stroke</b>
<input type="checkbox"/> <b>Heart attack</b>	<input type="checkbox"/> <b>Ankle problems/surgery</b>	<input type="checkbox"/> <b>HIV, chronic Hepatitis B or Hepatitis C</b>	
<input type="checkbox"/> <b>Fatigue that may interfere with your job</b>			

\* If you have marked an **X** next to any of the above, provide additional information including: when you were diagnosed with the condition, duration, complications, hospitalizations related to the condition, and any ongoing issues related to the condition:

**By signing this form, I am certifying that to the best of my knowledge I have provided answers truthfully and will provide medical records, as requested, to determine if I am medically fit to perform this job. I understand that misrepresenting facts may forfeit my employment opportunity.**

Your signature \_\_\_\_\_ Date \_\_\_\_\_

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**To be completed by Employee Health Services**

Physician/Physician Assistant/RN reviewing medical history \_\_\_\_\_ Date \_\_\_\_\_

Outstanding issues:

01 17 12 UMMC Initial Residents Fellows EHS Evaluation.doc



Treating Physician Pre-placement Medical Review

Dear Doctor \_\_\_\_\_

Date: \_\_\_\_\_

Your patient, \_\_\_\_\_, was seen at UMMC Employee Health Services for a pre-placement evaluation prior to beginning a position as a resident or fellow. We need additional information in order to recommend him/her for the position of \_\_\_\_\_. Please complete the following form regarding:

By signing this, I am granting permission for my treating physician listed above to provide the requested documentation to Employee Health Services.

Employee's signature \_\_\_\_\_

To be completed by applicant's treating physician

Primary diagnosis:

How this diagnosis was established (e.g. special tests):

Other diagnoses:

Is the patient currently being treated? Yes No

Medications and dosages:

Is the condition medically optimized? Yes No

If 'no', what is the next step in the treatment plan?

Other treatment:

In your professional opinion, are you aware of any past performance issues related to this diagnosis(es)?

Yes No If 'yes', describe:

In your professional opinion, can he/she safely, regularly and reliably perform the essential duties?

Yes No If 'no', describe any restrictions:

Other comments:

Treating Physician's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone number: \_\_\_\_\_ Fax # \_\_\_\_\_

Please fax completed form ASAP to 410-328-3079. For questions, call 410-328-0958.

Melissa Frisch, M.D., MPH, Medical Director

Annique Nonnon-Jameson, CRNP

**A. General Information and Instructions:**

The University of Maryland Medical System (UMMS) is offering recombinant hepatitis B vaccine, a non-infectious subunit virus vaccine, to all at risk UMMS employees FREE of charge. Immunization against hepatitis B can prevent acute hepatitis B as well as reduce illness and death from chronic active hepatitis B, cirrhosis and liver cancer.

If you have any questions regarding hepatitis B or the recombinant vaccine, contact the Employee Health Office @ 8-0958 or the Office of Infection Control @ 8-5757

**B. Instructions:**

Complete the required information below. A copy of this completed form will be provided for your records upon your request.

NOTE: By your signature below, you acknowledge that you have read the information about hepatitis B vaccine contained in this document and understand the risk of acquiring hepatitis B infection in the workplace. Your signature also indicates you have had an opportunity to ask questions about hepatitis B and the vaccine & understand the benefits and risks of the hepatitis B vaccine.

**C. Employee Information & Verification**

- Yes! I am interested in and willing to receive the hepatitis B vaccine
- I have already received all three (3) doses of the hepatitis B vaccine
- No! I do NOT desire vaccination against hepatitis B and will NOT agree to receive the hepatitis B vaccine series.

[If you have indicated NO above, read and initial the hepatitis B statement below]

**Hepatitis B Statement:**

I understand that should I sustain an occupational exposure to blood or bodily fluids or other potential infectious materials, I may be at risk for acquiring hepatitis B (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine free of charge or cost to me. HOWEVER, I decline the hepatitis B vaccine at this time. I understand that by declining this vaccine I continue to be at risk of acquiring hepatitis B viral infection, a serious disease with possible serious outcomes. If in the future I desire vaccination with the hepatitis B vaccine, I may do so by contacting the office of Employee Health Services @ extensions 410-328-0958 or 410-328-8632.

Initials \_\_\_\_\_

Signature	Printed Name	Title
Department	Date	Social Security No.

**The Disease:**

**Information About Hepatitis B Vaccine**

Hepatitis B is a viral infection caused by the hepatitis B virus (HBV). Most people with hepatitis B recover completely, though approximately 5% to 10% of infected adults and most infected newborns become chronic carriers of the virus. Many of these people have no symptoms, but can continue to transmit the disease to others. Some develop chronic hepatitis and cirrhosis. HBV also appears to be a causative factor in the development of hepatic carcinoma (liver cancer). It is estimated that about 5,000 persons in the United States of America alone, die each year from causes related to HBV. Thus, immunization against hepatitis B can prevent acute hepatitis and also reduce sickness and death from chronic hepatitis, cirrhosis and liver cancer.

**The Vaccine:** Recombivax-HB or Enerix B is a non-infectious subunit viral vaccine derived from hepatitis B surface antigen (HBsAg) produced yeast cells using recombinant DNA technology. A portion of the hepatitis B virus genome coding for HnsAg is cloned and purified by a series of physical and chemical methods. It is a genetically engineered vaccine and is free of any association with human blood or blood products. It has been tested for safety and efficacy in humans and found to be safe and efficacious. A high % of healthy people who receive three (3) doses of vaccine, achieve high levels of protective surface antibody (HBsAb). Full immunization requires three doses of the vaccine over a six month period, although about 5% of vaccinated persons may not develop immunity even after three doses. The duration of immunity provided by this vaccine is unknown at this time.

**Contraindications:** Hypersensitivity to yeast proteins, formalin, aluminum hydroxide or (mercury derivative) thimerosal

**Precautions:** Pregnancy and Nursing mothers: studies have not been done on this vaccine in these settings. Therefore, it is not known whether or not Recombivax-HB or Enerix B can cause fetal harm to be excreted in human milk.

**Possible Side Effects:** The incidence of side effects is 10% at the injection site (soreness, tenderness, erythema, swelling, and bruising) Systemic complaints occur in 15% and include fatigue, weakness, headache, fever and malaise. The possibility exists that other S.E.'s may be identified in the future.