University of Maryland Medical Center Employee Health Services
Room T1R05, next to first floor Shock Trauma elevators (Mon - Fri 7 am – 4 pm)
Fax: 410-328-2610 Appointments 410-328-6151 Mgr Phone: 410-328-1788 Regina Hogan

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 health evaluation. This evaluation may occur as **early as 60 days** prior to your start date. The **latest** this can be completed is **two weeks prior** to your start date- these appointments fill up fast. Please check with your residency coordinator about scheduling the health evaluation. For some programs, the residency coordinator will schedule the appointment, for other programs, the resident is expected to make his/her own appointment.

You must bring a picture ID (driver's license or passport) or we will not be able to perform your evaluation.

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 immediately provide a specimen.

Please send all paperwork **(completed health questionnaire, MD note if required, immunization records, TB screening records)** to employee_health@umm.edu as soon as possible (no later than 1 week prior to appointment) for review before your scheduled appointment. This is necessary to ensure medical clearance for employment prior to your start date. You will receive an email confirmation response**.**

1. **Medical History Questionnaire:** Access forms from the Medical Staff website (www.umm.edu/medstaff). Print and complete forms, scan and send to employee_health@umm.edu. **DO NOT MAIL THE COMPLETED FORMS TO YOUR RESIDENCY PROGRAM OR TO EMPLOYEE HEALTH**.
   - If you have **ANY** current medical conditions, which require ongoing treatment (such as but not limited to: s/p recent surgical procedure, physical restriction, ADD, ADHD, Anxiety, Depression), you will be required to provide medical documentation (**use on-line form titled: Treating Physician Pre-placement Medical Review form)** from your treating physician. If you have a question about this, please call Regina Hogan (EHS Manager) 410-328-1788.
   - The documentation (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 or it can be faxed in advance to the confidential fax number on the form 410-328-3079.

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 (Hep B titer results required). 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 send documentation of the result with health questionnaire to employee_health@umm.edu. **Then you will only need to receive 1 TB skin test.** OR
   - Scan and send copy of 2 PPD's. (PPD documentation within 1 year *and* within 3 months of start date).

continued on next page

- 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 employee_health@umm.edu.
- If you have had a positive TB skin test in the past, please scan and send a copy of a chest x-ray report performed in the past 12 months. Otherwise we will repeat the chest x-ray. We will also ask you to complete the UMMC Positive TB Skin Test Symptom Based Questionnaire.
- For your convenience, EHS is 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.
   - Remote urine drug screen: For individuals residing in another state, arrangement can be made for a urine drug screen collection to be performed at a Quest site near your current residence or work location. This collection can be done up to 60 days prior to the UMMC start date. This must be requested when sending Medical History Questionnaire to employee_health@umm.edu. In order to arrange this, UMMC EHS needs the resident current location including zip code, last four SSN, phone number and date of birth.
5. **Respiratory Fit Testing:**
   Respiratory medical clearance and fit testing will be performed. Fit testing may be education on the use of a powered air purifying respirator, or fit testing with a reusable mask or fit testing with a disposable mask depending on the program. Men are required to be clean shaven if fit testing with a reusable or disposable mask is required.

6. **Other**: If you require glasses/contacts to see distance, please bring them to the health evaluation appointment.

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, TB skin test results and Treating Physician Pre-placement Medical Review form if indicated.

Revised 02/10/2016

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.

UNIVERSITY of MARYLAND MEDICAL CENTER

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 Print/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

UNIVERSITY of MARYLAND MEDICAL CENTER

University of Maryland Medical Center
Employee Health Services

Tdap Vaccination Declination Form

I _____ understand that Tetanus, diphtheria and pertussis are
(Please print your name)
vaccine-preventable diseases, and that susceptible health care workers can acquire and transmit diphtheria and pertussis to patients. These diseases may result in serious morbidity or even death in health care workers and in patients. In addition, I understand that pertussis in particular is associated with hospital outbreaks and serious morbidity or even death in patients.

I have been unable to provide a record of prior vaccination of Tdap.

I am aware that Vaccine Information Sheets are available in Employee Health Services should I have any questions. Employee Health Services has offered to vaccinate me against Tetanus, Diptheria and Pertussis, at no charge to me, but I decline it. I acknowledge that it is my responsibility to contact Employee Health Services should I change my mind in the future and decide to be vaccinated, or if I am exposed to a person in the contagious state of the disease and did not wear the appropriate personal protective equipment. I understand that if I am exposed to a case of diptheria or pertussis, I may automatically be relieved from all direct patient contact throughout the incubation period following my exposure.

Reason for declination:

- □ For medical reasons, I am unable to receive the vaccine.
- □ For non-medical reasons, I decline the vaccine.
- □ I have already received the Tdap vaccine on _____ (Please submit proof of vaccination.)

Printed Name: _____ Job Title:_____

Your Signature: _____ Date:_____

Department: _____6 digit Employee ID or full SS #:_____

University of Maryland Medical Center **Today's date:** _____

Initial Employee Health Evaluation

Printed name – First name, Middle name, Last name:	Date of Birth:
_____	_____

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, 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

The Genetic Information Nondiscrimination 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.

Employment Information

Type of job you have been offered: **Job code (if known):**

Can you perform the essential functions of your job? □ **Yes** □ No

Do you have any **CURRENT** disability requiring restricted physical activity? □ **Yes** □ No

IF **YES**, will you require a job modification for a disability? □ **Yes** □ No

State Restrictions:

Are these restrictions: □ Permanent □ Temporary until: _____(provide date) **MD documentation required for any restriction**

Past Work

List your last 3 positions, starting with the most recent:

TITLE	DESCRIPTION	DUTIES	DATE
1.			
2.			
3.			

Exposure History

Mark an **X** in the box next to **ALL** items you **MIGHT** have been exposed to in your **PAST WORK**

□ Asbestos/silica	□ Grease and oil	□ Vibration	□ Hazardous wastes	□ Loud noise (above 85 decibels)
□ Dusts	□ Pesticides	□ Ethylene oxide/other gases	□ Plastics	□ Solvents/degreasers
□ Formaldehyde	□ Laboratory animals'	□ Lead/mercury/cadmium	□ Paints/isocyanates	□ Cytotoxic agents (e.g. chemo)
□ Welding	□ Epoxy resins	□ Benzene	□ Glutaraldehyde	□ Lasers

□ Latex products □ Blood or fluid exposures (HIV, Hep B, Hep C) □ Other chemicals: _____

Did you require medical treatment for the exposure(s) ? □ **Yes** □ No

Work Injuries

Have you ever had and 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?	Yes	No
If 'yes', for how long? _____		
Do you have any ongoing restrictions to your activity?	Yes	No
If 'yes', describe restrictions:		

Current Health Status

Employee name:_____

General Health and Function				
How would you rate your general health? ***Circle one***	Poor	Fair	Good	Excellent
How often do you engage in brisk physical activity that lasts at least 30 minutes? ***Circle one***	Not at all	Rarely	2-3 times/ week	≥ 3 times/ week
Do you smoke? If **'yes'** what do you smoke? *Circle one* Cigarettes E-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 use smokeless tobacco? Specify			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 use illegal drugs now?			Yes	No
Have you ever used illegal drugs in the past? **If yes, what, when, how long?**			Yes	No
Are you now using prescription pain killers?			Yes	No
Are you now or have you ever been 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

Latex Allergy Screening

a. Have you ever been told by a medical professional that you have a latex allergy?	Yes	No
b. Have you ever had difficulty breathing, wheezing or swelling of the face, mouth, lips or throat after contact with latex?	Yes	No
c. After handling latex products, have you ever experienced any of the following?		
Difficulty breathing or wheezing	Yes	No
Runny, itchy nose or congestion	Yes	No
Itching eyes/increased tearing	Yes	No
Systemic hives/rash	Yes	No
Itching or hives on hands	Yes	No
Swelling of hands	Yes	No
Redness of hands	Yes	No
Chapping or cracking of hands	Yes	No
d. Are you allergic to: *Check all that apply* □ Bananas □ Avocado □ Kiwi □ Other foods (list):_____		

Systems Review

Respiratory Clearance		
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
Respiratory		
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

Employee name: _____

Systems Review *cont'd*

Respiratory		
Coughing that:	Yes	No
Produces phlegm (thick sputum)	Yes	No
Wakes you early in the morning	Yes	No
Occurs mostly when you are lying down	Yes	No
Produces blood (in the last month)	Yes	No
Do you have wheezing?	Yes	No
Do you have wheezing that interferes with your job?	Yes	No
Have you ever had claustrophobia (fear of close-in-places) that interferes with wearing a respirator?	Yes	No
Do you have trouble smelling odors?	Yes	No

Cardiovascular		
Have you had any problems with chest pain/tightness:	Yes	No
While you are walking?	Yes	No
While you are resting?	Yes	No
Interfered with my job?	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 not relieved by rest.	Yes	No
Have you ever had chest pain when you breathe deeply?	Yes	No
Do you have fatigue that may interfere with your job?	Yes	No
Musculoskeletal		
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
Neurological		
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 _____ Reading _____Distance _____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

Systems Review *cont'd*

Psychiatric		
Have you ever received treatment for, or missed work because of, any of the following:		
ADD or ADHD?	Yes	No
Depression?	Yes	No
Bipolar disease?	Yes	No
Anxiety?	Yes	No
Post-traumatic stress disorder (PTSD)?	Yes	No
Schizophrenia?	Yes	No
Other psychological/psychiatric disorder or other mental health problem?	Yes	No
Do you have decreased ability in any of the following? (Check all that apply) □ To stay awake or maintain consciousness (due to such causes as seizures, diabetes, or sleep disorder) □ Managing multiple tasks at one time □ Working rotating shifts	Yes	No

Medications

Do you have a history of allergies or sensitivities to medications?	Yes	No

If **'yes'** which medication(s)?

Name of Medication	Reaction	Name of Medication	Reaction

List all medications or nutritional supplements (such as vitamins, minerals, energy drinks) that you are currently taking both prescription **and** over-the-counter:

Name of Medication	Dose	Frequency	Name of Medication	Dose	Frequency

Employee name:_____

Chronic Conditions

Mark an X in the box next to any of the following illnesses you now have or have ever had.						
☐ Heart attack or other heart problem	☐ Back problems/surgery	☐ Diabetes	☐ Lung disease	☐ Diverticulosis	☐ Skin disorder	☐ Liver disease
☐ High blood pressure	☐ Knee problems/surgery	☐ Cancer or tumor	☐ Current or frequent pneumonia	☐ GERD	☐ Hives	☐ Chronic Hepatitis B
☐ Peripheral vascular disease	☐ Ankle problems/surgery	☐ Anemia	☐ Pneumothorax (collapsed lung)	☐ Reflux	☐ Rashes	☐ Hepatitis C
☐ Heart failure	☐ Neck problems/surgery	☐ Kidney/ bladder problems	☐ Asthma	☐ Hernia	☐ HIV	☐ Color Blindness
☐ Stroke	☐ Shoulder problems/surgery	☐ Hypothyroid	☐ Other			
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 _____

****

To be completed by Employee Health Services

Physician/CRNP/RN reviewing medical history _____ Date _____

Outstanding issues:

UNIVERSITY OF MARYLAND MEDICAL CENTER
UNIVERSITY OF MARYLAND MEDICAL SYSTEM

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 _____

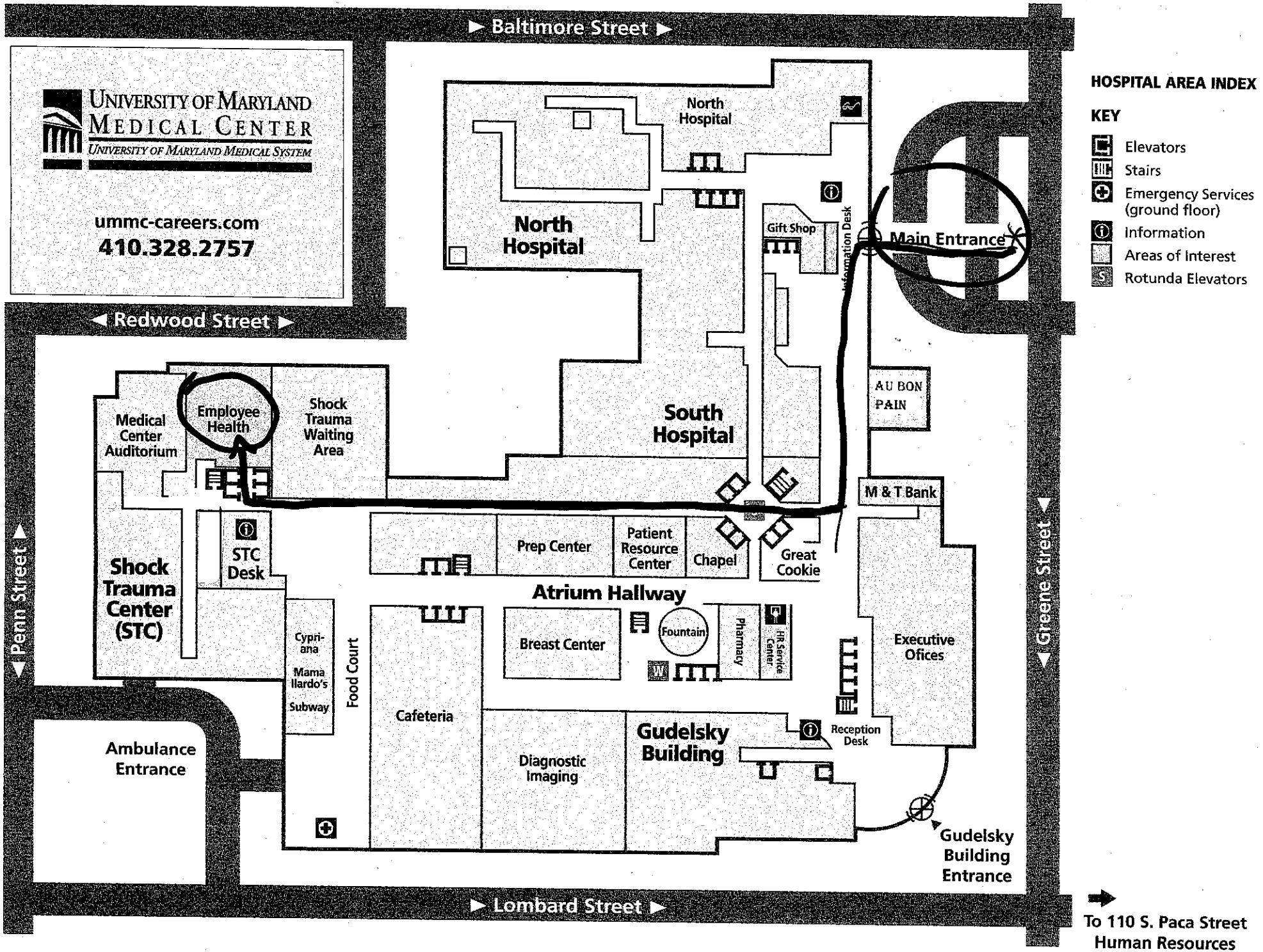
Recruiter: _____ Anticipated Start Date: _____

IN CASE OF EMERGENCY, NOTIFY:

Name: _____ Phone: _____

Address: _____

Revised 5/08


University of Maryland Medical Center
University of Maryland Medical System
ummc-careers.com
410.328.2757
Baltimore Street
Redwood Street
Penn Street
Greene Street
Lombard Street
North Hospital
North Hospital
Gift Shop
Information Desk
Main Entrance
South Hospital
Medical Center Auditorium
Employee Health
Shock Trauma Waiting Area
AU BON PAIN
M & T Bank
Shock Trauma Center (STC)
STC Desk
Prep Center
Patient Resource Center
Chapel
Great Cookie
Atrium Hallway
Cypri-ana
Mama Ilardo's
Subway
Food Court
Cafeteria
Breast Center
Fountain
Pharmacy
HR Service Center
Executive Ofices
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