Lehigh Valley Health Network
A PASSION FOR BETTER MEDICINE.

EMPLOYEE HEALTH SERVICES
Cedar Crest Blvd & I-78
PHONE: (610) 402-8869
FAX: (610) 402-1203

Muhlenberg Campus
PHONE: (484) 884-7098
FAX: (484) 884-7324

LVH.org
610-402-CARE

PRE-EMPLOYMENT/POST OFFER MEDICAL HISTORY AUTHORIZATION AND SUBSEQUENT PHYSICAL FORM

I have reviewed this pre-employment post offer physical examination form and I agree to submit to a physical examination and laboratory studies as a condition of employment at a Lehigh Valley Health Network subsidiary**. I understand that my employment is contingent upon successfully passing the physical examination including laboratory studies; the collection of blood, urine and saliva to screen for the presence of drugs/alcohol, and meeting the Rubeola, Varicella, Rubella, Mumps and influenza immunization requirements.** I acknowledge and understand that if I do not pass the standards established, I will be disqualified as an applicant for employment. I understand that if I am asked to provide additional medical documentation at the time of the evaluation, my physical cannot be completed until the requested documentation is received and evaluated. I understand that my employment cannot commence until my physical is completed.

I understand that if the drug test is positive, the information will be sent to the Medical Review Officer (MRO) for review and interpretation. MRO findings will be discussed with Human Resources.

I understand that my urine will be screened for cotinine, a nicotine metabolite, for the purposes of certifying my tobacco use status, should I elect to take LHVN benefits I understand that the results of the cotinine screening will be shared with the Benefits Counselors in Human Resources, for the sole purpose of benefits administration.

I understand I will be tested for communicable diseases, including tuberculosis, Hepatitis B and Hepatitis C. If the result indicates infection, an assessment of my job duties will be made to determine if I can perform the essential functions of my position with or without reasonable accommodation.

I understand that results of my pre-employment physical exam may be shared with my direct supervisor if they affect my work duty responsibilities.

I understand that any Pre-placement or Work Physical examination is for the determination of work status or ability to perform duties at a Lehigh Valley Health Network subsidiary only. It is not for new diagnosis of medical conditions or routine medical care. This examination and other information contained in my Employee Health file is not intended to be used or relied upon by third parties for their own purposes. This does not take the place of a personal/primary care physician's health care examination or treatment plan and I understand that I must return to my personal/primary care physician for this care.

I also understand that if I have patient contact I will be required to be immunized against influenza unless I request and am granted an exemption because of a valid medical reason or bonafide religious reason.

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.

I AGREE TO INDEMNIFY AND HOLD HARMLESS LEHIGH VALLEY HEALTH NETWORK AND ITS SUBSIDIARIES, TOGETHER WITH ALL THEIR TRUSTEES, OFFICERS, EMPLOYEES AND AGENTS FROM ALL LOSSES, CLAIMS, DAMAGES, AND LIABILITIES ARISING FROM THE USE OF THE INFORMATION CONTAINED IN THIS FORM AND IN MY EMPLOYEE HEALTH FILE BY ANY THIRD PARTY.

Signed: _____ Print Name: _____

If minor (under 18):_____
(Parent or Guardian Signature)

Social Security #:_____ Home Phone #:_____ Cell Phone #:_____

Position Applied For: _____ Dept: _____

Date: _____ Date scheduled for Orientation: _____

I hereby authorize Employee Health Services to release any information regarding my health or physical condition to my designated treating physician(s). I understand that I am responsible for following up with my own treating physicians if provided with any abnormal findings that arise during the pre-employment assessment. I understand that LVHN will not provide follow-up treatment for any such findings.

Signed: _____ Print Name: _____

If minor (under 18):_____
(Parent or Guardian Signature)

Date: _____

Acknowledgement of Lehigh Valley Health Network Influenza Policy *

I understand that if I have patient contact as defined in the LVHN Influenza policy, I will be required to be immunized against influenza on an annual basis as a condition of employment unless I request and am granted an exemption because of a valid medical reason or bonafide religious reason.

Check one:

☐ I have a religious or medical reason preventing me from taking the influenza vaccine.

☐ I do not have a religious or medical reason preventing me from taking the influenza vaccine.

Signed: _____ Print Name: _____

If minor (under 18):_____
(Parent or Guardian Signature)

Date: _____

* **Vaccination (or proof of vaccination if immunized elsewhere) is required if employed during/between October - April**

Pre-placement Assessment and Subsequent Physical Examination Record

_____ _____
(Name) LAST, FIRST, M.I DATE OF BIRTH

_____ _____
Street or Box Social Security Number

_____
City State Zip Code

Current Medical Provider's Name, Address & Phone #

_____

_____

Sex
M ☐ F ☐

Marital Status
S ☐ M ☐ W ☐ D ☐

Have you ever worked for Lehigh Valley Health Network entities (Lehigh Valley Hospital, Lehigh Valley Hospital-Muhlenberg, Spectrum Administrators, Lehigh Valley Hospice/Homecare, Lehigh Valley Physician Group, Health Spectrum Pharmacy, or Health Network Labs) before? ☐ YES ☐ NO

Last Place of Employment _____

Length of Time Employed: **From** _____/_____/_____ **To** _____/_____/_____

Do you have any condition (physical, medical or psychological) that would require special accommodations in order for you to perform your job duties? ☐ YES ☐ NO

-- If YES, please explain: _____

_____

COMMUNICABLE DISEASE EXPOSURES

Have you or anyone in your family or close household ever had:
☐ Tuberculosis ☐ Hepatitis ☐ Other Infectious Disease

-- If YES, please give details: _____

_____

_____
Name, SSN

PAST MEDICAL HISTORY

Have you had any medical illnesses such as diabetes, heart disease, thyroid problem etc., serious injuries or operations? ☐ YES ☐ NO

-- If YES, please note treatment date, physician's name and place of treatment: _____

_____

_____

--If NO treatment was sought or provided, please explain: _____

_____

SOCIAL HISTORY

Have you ever smoked cigarettes, cigars, or a pipe? ☐ YES ☐ NO

If YES, how much _____

If you no longer smoke, when did you quit? _____

Have you used tobacco products (cigarettes, cigars, chew, and e-cigarettes) or nicotine replacement products in the last 3 months? ☐ YES ☐ NO

Do you drink alcohol? ☐ YES ☐ NO

If YES, how many drinks at a time? _____. How many days per week? _____

What do you drink? ☐ Wine ☐ Beer ☐ Hard liqueur ☐ Other _____

Do you feel safe in your current relationship? ☐ YES ☐ NO

If NO, please explain. _____

Is someone making you feel bad about yourself? ☐ YES ☐ NO

If YES, please explain. _____

Within the last year, have you been hit, kicked, punched or otherwise hurt by someone you know? ☐ YES ☐ NO

If YES, by whom. _____

Is there someone making you feel unsafe now? ☐ YES ☐ NO

If YES, do you need assistance? _____

Pre-placement Assessment and Subsequent Physical Examination Record

_____
Name, SSN

DO YOU HAVE or EVER HAD the following:

ALLERGIES:	**YES**	**NO**	***IF YES, GIVE DETAILS***
Hay fever			
Reaction to any substance which resulted in hives, swelling, itching, trouble swallowing or breathing			
Reaction to rubber products (balloons, condoms, diaphragms, dental procedures)			
Reaction to latex gloves			
Reaction to vinyl gloves			
Foods			
Skin rash or history of eczema			
Drug allergies			

GENERAL:	**YES**	**NO**	***IF YES, GIVE DETAILS***
Diabetes			
Stroke			
Cancer			
Hepatitis B			Treatment: Date of last viral load measurement: Viral load measurement:
Hepatitis C			Treatment: Date of last viral load measurement: Viral load measurement:
HIV			Treatment: Date of last viral load measurement: Viral load measurement:
Liver disease, jaundice			
Serious accident			
Operations			
Eye problems – decreasing vision, eye pain, double vision, loss of vision, eye infection, photophobia, eye injury or disease?			
Hearing problems – decreased hearing, pain in ears, ringing or throbbing in ears?			
A hernia or rupture?			
Convulsions or seizure and/or taken medication for seizures?			
Brain trauma/concussion, head injury of any type?			
Received radiation as a treatment?			
Migraine headaches?			
Skin Problems-Eczema, Psoriasis, Rashes			

_____
Name, SSN

DO YOU HAVE or EVER HAD the following:

OCCUPATIONAL HEALTH HISTORY:	YES	NO	*IF YES, GIVE DETAILS*
Exposure in your past or present work to the following: excessive noise, fumes, chemicals, brick/stone or sand dust?			
Are you receiving any disability income? (SSDI, through the VA or Armed Forces?)			
Have you ever been injured on the job or in the course of any current or previous employment? - If YES, indicate date of injury, and any current or past treatment ……			
Filed a workers compensation claim? - If YES, please describe…….			
Received a WC settlement? - If YES, list your permanent restrictions..……			
Are you receiving WC disability payments at this time?			
Have you been rejected or denied insurance, employment or acceptance in the Armed Forces?			
Have you received an "other than Honorable" or dishonorable discharge from the Armed Forces?			
Worked in a stone quarry, foundry, farm, pottery, cotton, flex hemp mill, mine, chemical or cement plant?			
Have you been exposed to asbestos or worked with asbestos?			
Work as a plumber, dry waller or worked in construction?			
Worked with X-ray or radioactive materials?			
Any hobby that exposed you to wood and other dust, gas or fumes such as paints, glues and solvents? - If YES, state the situation……..			
Handled or worked with cytotoxic drugs, such as chemotherapy drugs used to treat cancer?			

_____
Name, SSN

DO YOU HAVE or EVER HAD the following:

MENTAL HEALTH / ADDICTION:	YES	NO	*IF YES, GIVE DETAILS*
Have you ever felt that you had a problem with addiction or substance abuse (e.g., drugs/alcohol), but you did not seek treatment?			
Have you ever had and/or have a history of substance abuse (e.g., drugs/alcohol) or ever been recognized as having substance abuse problem?			
Have you ever been treated for substance abuse or drug/alcohol addiction or abuse, including any mandated program related to DUI? - If YES, specify type of treatment ……			
Attempted suicide?			
Mental or emotional illness?			
Are you at the present time taking any medication for an emotional or psychiatric illness?			
If licensed, have you ever been or are you currently enrolled in the voluntary recovery program or physician health monitoring program?			

HEART	YES	NO	*IF YES, GIVE DETAILS*
Heart disease or heart attack			
High blood pressure			
Treatment for heart condition			
Rheumatic fever or heart murmur			
Passed out or nearly passed out during or after exercise?			
Discomfort, pain or pressure in your chest/neck or arm during exercise?			
Does your heart race or skip beats?			
High cholesterol			
Heart infection			
Has your doctor ever ordered a test for your heart? (e.g., EKG, echo cardiogram, stress test, heart catheterization)			
Phlebitis, varicose veins or blood clots/poor circulation?			
Have you ever refused any medical treatment for any heart-related problems?			

_____
Name, SSN

DO YOU HAVE or EVER HAD the following:

LUNGS	YES	NO	*IF YES, GIVE DETAILS*
Asthma or wheezing?			
Positive skin test for TB?			
Treatment for + TB test? - If YES, documentation must be submitted to LVHN-Employee Health Services @the time of physical			
Have you been exposed to someone who has TB?			
Had a Chest X-Ray?			
Have you ever refused medical treatment for any lung-related disorder? (asthma, bronchitis, pneumonia)			
Productive cough, bloody sputum, excessive sweating at night, chills, fever?			

MUSCLE-SKELETAL	YES	NO	*IF YES, GIVE DETAILS*
Arthritis, rheumatism, neck, back, spine injury or disease?			
Fibromyalgia, rheumatoid arthritis, systemic lupus, nerve disorder or neurological problems?			
Herniated disc?			
Treated for any back problems?			
Recurrent stiffness or back pain?			
Bursitis, tendonitis?			
Recurrent pulled muscles or sprains?			
Hand or wrist injury or problems?			
Any discomfort, pain or numbness in hands?			
Hip or knee injury or problems?			
Ankle or foot injury or problems?			
Shoulder injury or problems?			
Job requiring heavy lifting or standing/sitting for long periods of time?			
Any broken bones? - If YES, please list…….			

_____
Name, SSN

DO YOU HAVE or EVER HAD the following:

SURGERIES/OPERATIONS	YES	NO	*IF YES, GIVE DETAILS*
On your back, neck, arm, leg, knee?			
To treat a hernia?			
Varicose veins?			
Other operations?			
Have you ever been hospitalized?			

BLOOD, OTHER	YES	NO	*IF YES, GIVE DETAILS*
A diagnosis of HIV, Hepatitis A, Hepatitis B or Hepatitis C infection **at anytime in your life**?			
Blood transfusion, needle stick or splash of blood or body fluid? - If YES, when ……			
Bleeding disorder or anemia?			
Difficulty urinating, blood in urine, burning, irritation?			
Anorexia, loss of appetite, difficulty swallowing, chronic indigestion, nausea, vomiting, abdominal pain, chronic diarrhea, chronic constipation, bloody or black bowel movements?			

FOR WOMEN ONLY *	YES	NO	*IF YES, GIVE DETAILS*
Are your menstrual periods regular?			
Ever unable to work due to menstrual pain? - If YES, for how long ……			
Any miscarriages?			
Any children? - If YES, ages of children……..			
Date of last normal menstrual period			
Are you pregnant at the present time?			
Undergoing or planning to undergo fertility treatments within the next 3 months?			
Age of menopause			

* These questions are intended to provide baseline information regarding reproductive health that may be important should you ever be exposed to reproductive health hazards in the course of your job(s) at LVHN.

VACCINATION/COMMUNICABLE DISEASE REQUIREMENTS

I understand I may be screened for immunity to several communicable diseases, depending upon the documentation I provide at the time of my physical. I understand that if acceptable documentation of disease or vaccination is not provided at the time of assessment, my blood will be drawn to determine immunity. If the laboratory test determines I am not immune, I understand I must be immunized **PRIOR** to my start date. I will not be permitted to start employment without the required immunizations. **I understand that ALL network employees are required to be immune to rubella, rubeola and mumps. Varicella immunity is required for network employees with patient contact. MMR & Varicella vaccines will be provided by the hospital free of charge when indicated. Annual tuberculosis screening may be required of some employees.** Influenza vaccine is required of all employees with patient contact. Influenza vaccine is free of charge to all employees. Hepatitis B vaccine is offered free of charge to all employees who are risk for blood and body fluid exposure.

I, THE UNDERSIGNED, DO HEREBY CERTIFY THAT TO THE BEST OF MY KNOWLEDGE, THE ANSWERS I HAVE GIVEN TO THE QUESTIONS ABOVE ARE TRUE AND THAT I HAVE NO PHYSICAL IMPAIRMENTS, CONDITIONS OR CONCERNS EXCEPT AS STATED ABOVE. I UNDERSTAND THAT FAILURE TO PROVIDE ACCURATE AND COMPLETE INFORMATION MAY RESULT IN TERMINATION OF MY OFFER OF EMPLOYMENT OR EMPLOYMENT IF DISCOVERED AFTER I BEGIN WORKING.

Comments: _____

_____

_____

Signed: _____ Date: _____

Print Name: _____

If minor (under 18):_____
(Parent or Guardian Signature)

Witness: _____ Date: _____

APPLICANT, PLEASE WRITE YOUR NAME AND SSN ON THE TOP OF THE REMAINING PAGES OF THIS FORM. OTHERWISE, DO NOT COMPLETE ANY OTHER AREAS OF THE REMAINING FORM. THIS IS FOR LVHN EMPLOYEE HEALTH/OCCUPATIONAL HEALTH USE ONLY

Pre-placement Assessment and Subsequent Physical Examination Record

_____
Name, SSN

APPLICANT, THIS POINT FORWARD IS FOR LVHN EMPLOYEE HEALTH/OCCUPATIONAL HEALTH USE ONLY

Food, Drug or dye
ALLERGIES ☐ Denies Allergies

Drug/Food/Dye	**Reaction**

MEDICATIONS ☐ Denies Medications

List all current prescription medications and include any eye drops, inhalers, medication patches, vitamins, herbal or nutritional supplements or over the counter medications.

	Drug Name	Dose	PROOF of Rx - Check if Provided and Give Rx #		How Often	Reason	Prescriber (Check if by EH)	Date Filled
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								

Pre-placement Assessment and Subsequent Physical Examination Record

_____
Name, SSN

FOR LVHN EMPLOYEE HEALTH/OCCUPATIONAL HEALTH USE ONLY

-- Documentation MUST be presented at time of the evaluation. If NO documentation, titers must be drawn.
IF DOCUMENTATION PROVIDED, PLEASE ATTACH TO THIS FORM AND SEND TO EMPLOYEE HEALTH

I. IMMUNITY TO COMMUNICABLE DISEASE

DISEASE	* IF NOT ACCEPTABLE PROOF OF IMMUNITY PRESENT AT TIME OF PHYSICAL, DRAW BLOOD	YES	NO	Titer Drawn
Rubella	Documented proof of MMR vaccine or 1 dose Rubella or ⊕ titer	☐	☐ → draw Rubella titer	☐
Rubeola	Documented proof of 2 MMR vaccines or 2 doses Rubeola or ⊕ titer	☐	☐ → draw Rubeola titer	☐
Mumps	Documented proof of 2 MMR vaccines or 2 doses Mumps or ⊕ titer	☐	☐ → draw Mumps titer	☐
Varicella	Documented proof of 2 doses of Varicella vaccine, ⊕ titer or history of chicken pox verified by a healthcare provider.*	Physician hx ☐ OR Documented 2 doses vaccine ☐ OR Documented positive Titer ☐	☐ → draw Varicella titer	☐ ☐

** All residents **MUST** have varicella titer drawn*

II.

Occupational risk of blood and body fluid exposure?		**NO** ☐ (no action necessary)	**YES** ☐ → draw Hep B antigen AND antibody	☐
Vaccinated with Hepatitis B Vaccine?		**YES** ☐ If no documentation provided, sign declination and write "vaccinated previously"	**NO, never vaccinated** ☐ **or not sure** ☐ If **NO**, give 1st dose of Hep B vaccine ** **MUST** sign declination if declining Hep B vaccine*	Vaccine #1 given ☐
Hepatitis C Ab	Drawn ☐	**Yes** ☐	**No** ☐	

III.

Tetanus	Date of last Tetanus Booster or Tdap (***circle one***)	_____ / _____ / _____	Offer Tdap regardless of last Td booster if hire will have patient contact. Do not give Tdap if previously received Tdap within 2 years of this exam.	Vaccine given ☐

Pre-placement Assessment and Subsequent Physical Examination Record _____
Name, SSN

FOR LVHN EMPLOYEE HEALTH/OCCUPATIONAL HEALTH USE ONLY

IV. TUBERCULOSIS SCREENING HISTORY

1. **Draw QFT on all new hires *** ☐ DRAWN
   * unless diabetic on immunosuppressive therapy, silicosis, chronic renal failure or blood disorder – then give TST:

   _____ / _____ / _____ RFA LFA Dose _____ Site _____

   Lot # _____ Expiration Date _____

2. Past history of positive TST or QFT? ☐ YES ☐ NO - If no, proceed to Section V
   If yes:
   1. Complete S/S questionnaire ☐
   2. Date of positive test _____ ☐
   3. Give CXR prescription and directions for CXR ☐
      (if employee can provide cxr report done within last 3 months, skip cxr and enclose report)
   4. If yes, has employee received treatment? ☐ YES ☐ NO
   5. Specify treatment below and request documentation be sent to Employee Health Services - CC:

   _____

   _____

   _____

V.

HEIGHT	WEIGHT	BLOOD PRESSURE	PULSE	RESPIRATIONS

VISION

WITHOUT CORRECTION:		WITH CORRECTION: Glasses ☐ Contacts ☐	
L	20 /	L	20 /
R	20 /	R	20 /
BOTH	20 /	BOTH	20 /

COLOR VISION TESTING	Pass ☐ Fail ☐
Comments:	

VI. LABS DRAWN: _____

Technician/RN Signature
Completing Pages 11, 12, 13: _____ Date _____

☐ RN review completed and **NO exam is required.**

☐ Review by, RN - exam by **Physician or CRNP** is required

_____ Date _____
RN Signature

OR

☐ No RN review – exam by **Physician or CRNP** is required.

Pre-placement Assessment and Subsequent Physical Examination Record _____
Name, SSN

FOR LVHN EMPLOYEE HEALTH/OCCUPATIONAL HEALTH USE ONLY

PHYSICIAN / PRACTITIONER EXAM

HEENT:	
Neck:	
Chest/Lungs:	
Heart:	
Abdomen:	
Musculoskeletal:	
Neurological:	
Skin:	
Other:	

Assessment: *(please note any pertinent information relating to YES answers):* _____

_____

_____

_____

As of today _____ / _____ / _____; applicant

1. ☐ Is qualified for unrestricted work
2. ☐ Is qualified for restricted work – List restrictions/accommodations, if applicable: _____

   _____
3. ☐ Cannot be qualified for work at this time pending receipt and review of medical information from personal provider(s).
4. ☐ Is not qualified for work as a _____

_____ _____
Practitioner Signature Date

Complete this section if #3 is checked above:

Review of additional information on _____ / _____ / _____; applicant

☐ Is qualified for unrestricted work
☐ Is qualified for restricted work – List restrictions/accommodations, if applicable: _____

_____

_____

☐ Is not qualified for work as a _____

_____ _____
Practitioner Signature Date

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QUANTIFERON GOLD TESTING QUESTIONNAIRE

Name _____ **Date** _____

SSN _____ **DOB** _____ **Phone Number** _____

* HIV Infection and other medical conditions may cause a tuberculosis skin test to be negative, given though you may be infected with tuberculosis. Please consult your healthcare provider should you have any concerns.

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.

[ ] Employee

[ ] Medical Staff

[ ] Volunteer

YES	NO	**In the last year, have you had any of the following symptoms? (Please explain any "*YES*" answers).**
		Have you ever had a positive TB test (PPD or QFT)?
		Have you ever been told by a doctor or other health care provider that you had active TB?
		Coughing up blood
		Hoarseness lasting three weeks or more
		Persistent cough lasting three weeks or more
		Unexplained, excessive fatigue
		Unexplained, persistent fever lasting three weeks or more
		Unexplained, excessive sweating at night
		Unexplained weight loss
		Has a doctor or healthcare provider ever told you that your immune system is not working right or that you cannot fight infection?
		Have you had pneumonia in the past year?
		Have you ever lived with or had close contact with someone who has/had active tuberculosis disease?
		Have you ever been told that you have an abnormal chest x-ray?
		Have you ever worked where patients with active tuberculosis disease receive care or services?
		Have you ever worked, volunteered or lived in any institution such as a jail, group home or homeless shelter?
		Have you traveled outside the United States in the last 12 months? ***If yes***, identify city, country and timeframe:
		Were you born in the United States? ***If no***, identify the country you were born in:

YES	NO	**QFT Screening**
		Are you diabetic?
		Do you have or have you had silicosis?
		Are you on immunosuppressive therapy? (Steroids, chemo)
		Do you have chronic renal failure?
		Do you have or have you had any blood disorders/leukemia/lymphoma?

_____ _____
Patient/Client Signature Reviewed by Clinician

_____
Parent/Legal Guardian Signature, if client under 18 years of age

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QUANTIFERON GOLD TESTING QUESTIONNAIRE

Name _____ **Date** _____

SSN _____ **DOB** _____ **Phone Number** _____

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.

Limitations of using QuantiFERON-TB Gold as defined by most current recommendations by the Centers for Disease Control and Prevention (CDC) or California Tuberculosis Controllers Association (if applicable).
The CDC currently identifies the following limitations: ***(please initial each line after reading)***

_____As with a negative TST result, negative QuantiFERON-TB Gold result should not be used alone to exclude M. tuberculosis infection in persons with symptoms or signs suggestive of TB disease. The presence of symptoms or signs suggestive of TB disease increases the likelihood that M. tuberculosis is present, and these circumstances decrease the predictive value of a negative QuantiFERON-TB Gold or TST result. Medical evaluation for such persons should include a history and physical examination, chest radiograph, bacteriologic studies, serology for human immunodeficiency virus (HIV), and, when indicated, other tests or studies.

_____The performance of QuantiFERON-TB Gold, in particular its sensitivity and its rate of indeterminate results, has not been determined in persons who, because of impaired immune function, are at increased risk for M. tuberculosis infection progressing to TB disease, impaired immune function can be caused by HIV infection or acquired immunodeficiency syndrome (AIDS); current treatment with immunosuppressive drugs including high-dose corticosteroids, tumor necrosis factor –alpha (TNF-a) antagonists, and drugs used for managing organ transplantation; selected hematological disorders. (e.g., myeloproliferative disorders, leukemia's, and lymphomas); specific malignancies (e.g., carcinoma of the head, neck, or lung); diabetes, silicosis; and chronic renal failure. Each of these conditions or treatments I s known or suspected to decrease responsiveness to the TST, and they also might decrease production of IFN-g in the QFT-G assay. Consequently, as with a negative TST result, negative QuantiFERON-TB Gold result alone might not be sufficient to exclude M. Tuberculosis infection in these persons.

_____Published data are relatively limited concerning the use of QuantiFERON-TB Gold among persons recently exposed to TB (e.g., contacts) and other populations at high risk for Latent Tuberculosis Infection (LTBI). No published data document the performance of QFT-G in children aged < 17 years.

_____With any of the testing methods, persons who have a negative test result can still have LTBI. Those who have a negative result but who are likely to have LTBI and who are at greater risk for severe illness or poor outcomes if TB disease occurs might need treatment or closer monitoring for disease. Potential examples include close contacts who are aged < 5 years, those who are immunocompromised because of HIV infection, or those who will undergo treatment with TBH-a antagonists (which increase the risk for progression from LTBI to TB disease).

_____ _____
Patient/Client Signature Reviewed by Clinician

_____
Parent/Legal Guardian Signature, if client under 18 years of age

Name _____
(PLEASE PRINT)

Department _____

Social Security _____
OR
Employee ID # _____
(At Least One of These Is Required)

Regulations (Standard – 29CFP)
OSHA Respirator Medical Evaluation Questionnaire (Mandatory). – 1910.134 App C

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.

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, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

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:_____
2. Your name:_____
3. Your age (to nearest year):_____
4. Sex (circle one): Male/Female
5. Your height: _____ ft. _____ in.
6. Your weight: _____ lbs.
7. Your job title: _____
8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): Work: _____ Home: _____
9. The best time to phone you at this number: _____
10. Has your employer told you how to contact the health care professional who will review this questionnaire? (circle one): Yes 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-face piece type, powered-air purifying, 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 (please 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

If any yes answers please explain: is it current or past condition?, Is condition controlled by treatment and/or medication?

_____
_____
_____

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

If any yes answers please explain: is it current or past condition?, Is condition controlled by treatment and/or medication?

_____
_____
_____

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 or 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

If any yes answers please explain: is it current or past condition?, Is condition controlled by treatment and/or medication?

_____
_____
_____

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

If any yes answers please explain: is it current or past condition? Is condition controlled by treatment and/or medication?

_____

_____

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 symptoms that you think may be related to heart or circulation problems: Yes No

If any yes answers please explain: is it current or past condition? Is condition controlled by treatment and/or medication?

_____

_____

_____

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 the following space and go 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 health care professional who will review this questionnaire about your answers to this questionnaire: Yes No

FOR EMPLOYEE HEALTH USE ONLY

RESPIRATOR CERTIFICATION FORM

I certify that I have examined_____ in accordance with the applicable OSHA Respiratory Protection Standard (29 CFR 1910.134) and, through:

☐ the medical questionnaire only/ ☐ an examination only / ☐ the medical questionnaire and examination, ☐ Have / ☐ Have Not detected medical conditions which would place the employee at increased risk of material impairment of health from respirator Use.

Recommended work limitations (if indicated):_____

_____

_____

The employee has been informed of the results of the medical review and/or examination and of any conditions requiring further evaluation. The complete questionnaire and examination form for the employee is on file at:

Employee Health Services Lehigh Valley Hospital –CC 1200 S. Cedar Crest Blvd. Allentown, PA 18105-1556	Employee Health Services Lehigh Valley Hospital 2545 Schoenersville Road Bethlehem, PA 18017

(Circle one)

_____	_____	_____
Date	Licensed Health Care Professional	Signature

Lehigh Valley Health Network
A PASSION FOR BETTER MEDICINE.

WORKERS' COMPENSATION INFORMATION

In Pennsylvania, the workers' compensation law provides wage loss and medical benefits to employees who cannot work and/or who need medical care because of a work-related injury.

Benefits are required to be paid by your employer when self-insured or through insurance provided by your employer. Your employer is required to post the name of the company responsible for paying worker's compensation benefits at its primary place of business and at its sites of employment in a prominent and easily accessible place, including, without limitation, areas used for the treatment of injured employees or for the administration of first aid.

You should report immediately any injury or work-related illness to your employer/supervisor. Your workers' compensation benefits could be delayed or denied if you do not notify your employer/supervisor immediately. Your Workers' Compensation Coordinator is located within Employee Health Services, Lehigh Valley Health Network, 1200 S. Cedar Crest Boulevard, 610-402-8869.

If your work-related injury claim is denied, you have the right to file a petition and request a hearing before a workers' compensation judge.

The Bureau of Workers' Compensation cannot provide legal advice. However, you may contact the Bureau of Workers' Compensation for additional general information at:

Bureau of Workers' Compensation
1171 South Cameron Street, Room 103
Harrisburg, Pennsylvania 17104-2501
Telephone number within Pennsylvania (800) 482-2383
Telephone number outside of Pennsylvania (717) 772-4447
TTY (800) 362-4228 (for hearing and speech impaired only)
www.state.pa.us - PA Keyword: workers comp

EMPLOYEE ACKNOWLEDGMENT:

I, _____, employee of Lehigh Valley Health Network, hereby certify that I was provided with the above statement on _____/_____/20____. By signing and dating, this certifies that I have received, read and understood the information provided above. (Retain one copy for your personal records and return the original with your pre-employment medical assessment at the time of your physical).

_____
Employee Signature