Occupational Health
Pre-Employment Screening Form

ECU HEALTH

Social Security #: _____ - _____ - _____ Employment/Orientation Date: _____ / _____ / _____

Date of Birth: _____ / _____ / _____ Sex: ☐ Male ☐ Female
Month Day Year

Name: _____ _____ _____
Last First Middle

Address: _____ Phone: _____ _____
Street/Apt./Box City State Zip Cell Home

_____
Personal Physician's Name and Address

_____ _____ _____
Name of Emergency Contact Relationship Phone #

Job Title: _____ Job Code: _____ Email Address: _____

Department: _____ ☐ Part-Time ☐ Full-Time Manager: _____

Hello Candidate,
First, congratulations on your job offer with ECU Health! The ECU Health-Occupational Health Clinic is excited to start this next phase of the onboarding journey with you. We're going to ask a lot of questions as you navigate through the pages of this packet, but rest assured, the team at the clinic are here to assist you and make this process as seamless as possible.

OCCUPATIONAL HEALTH SCREENING REQUIREMENT

1. **Documents & Forms:**
   - Proof of Identification:
     - Must show valid Government issued ID (State issued Driver's License, Passport, Military ID, etc.).
   - Copy of Immunization Records: ECU Health requires the following immunizations.
     - 2 MMR vaccines (Measles, Mumps, Rubella) or proof of positive titers
     - 2 varicella vaccines or proof of positive titer
     - TDAP (adult) vaccine
     - HEP-B vaccine series and proof of positive titer
     - Annual Flu vaccine (2024-2025 Flu Vaccine Record)
     - COVID vaccination status (Covid Vaccination is not required, however if received vaccination, provide documentation)
   - Physical Demands Analysis:
     - Review and sign the consent form agreeing you can meet all the physical demands required for your new role.
   - OSHA Questionnaire: Please complete and return.
2. **QuantiFERON-TB Gold (QFG):** blood test to check for TB exposure. If you have TB skin test results within the last year or a QFG within the last 90 days, please have copies to share.
   - If history of positive TB skin test or QFG, please send a copy of recent chest x-ray report (within the last 2 years).
3. A urine drug screen is required of all candidates.
4. **Vision and Respiratory-N95 Fit testing:**
   - If required for your role, Vision and Respiratory testing will need to be completed at our Occupational Health Clinic during your in-person appointment.

PERSONAL HEALTH HISTORY

ALLERGIES: (Medication, Food, Latex, Soaps, Etc.)_____

_____

_____

1. Have you ever had surgery or been a patient in a hospital in the past 10 years? ☐ **YES** ☐ **NO**
If yes, please list: _____

2. Are you receiving any medical treatment at the present time? ☐ **YES** ☐ **NO**
If yes, give reason and physician's name: _____

3. Have you ever been turned down for military service, life insurance, or employment for health reasons?
☐ **YES** ☐ **NO** *If yes, explain*: _____

4. Have you ever received benefits and/or a permanent impairment rating as a result of a job-related injury or illness?
☐ **YES** ☐ **NO** *If yes, explain and provide disability breakdown documentation (to include Veteran Administration)*:

_____

_____

5. Have you lost any time from work for illness or injury during the past 5 years? ☐ **YES** ☐ **NO**
If yes, explain: _____

6. Have you ever had any work or activity restrictions due to your health? ☐ **YES** ☐ **NO**
If yes, explain: _____

7. Have you ever been injured in a motor vehicle accident? ☐ **YES** ☐ **NO**
If yes, explain: _____

8. Do you have any physical, mental, or emotional condition which could impact your ability to perform the job for which you were hired? ☐ **YES** ☐ **NO** *If yes, explain***:** _____

9. Do you require any accommodation or special consideration for any condition? ☐ **YES** ☐ **NO**
If yes, explain: _____

10. Do you have any condition (illness, infection, or medication) which affects your immune system, making you more susceptible to infection? ☐ **YES** ☐ **NO** *If yes, explain***:** _____

11. Do you smoke, use tobacco products, or vape? ☐ **YES** ☐ **NO**
If yes, how much: _____

12. Do you drink alcohol? ☐ **YES** ☐ **NO**
If yes, how much: _____

13. Do you drink coffee or caffeinated drinks? ☐ **YES** ☐ **NO**
If yes, how much: _____

Take **ANY** Medication? ☐ **YES** ☐ **NO** Please list all medications you have taken in the last 2 weeks:

_____

_____

_____

_____

_____

_____

_____

CONFIDENTIAL

Have you ever been treated for problems related to any of the following?
Please answer by placing a large "X" in the yes or no box.

YES	NO	CONDITION	YES	NO	CONDITION
☐	☐	1. Alcohol Dependence	☐	☐	26. Hernia (Rupture/Repair)
☐	☐	2. Anxiety/Depression/Nervous Breakdown	☐	☐	27. Immunocompromised (HIV/AIDS)
☐	☐	3. Arthritis / Bursitis	☐	☐	28. Jaundice
☐	☐	4. Asthma, Bronchitis, Emphysema	☐	☐	29. Joints-Upper (elbow/shoulder/wrist)
☐	☐	5. Autoimmune Dz (Lupus, Celiac, MS)	☐	☐	30. Joints-Lower (hip/knee/ankle)
☐	☐	6. Back/Spine/Neck (Strains, fractures)	☐	☐	31. Kidney Disease (CKD, PKD, other)
☐	☐	7. Bleeding Disorder (anemia, Hemophilia)	☐	☐	32. Latex Allergy/Reaction
☐	☐	8. Blood Pressure issues (High or Low)	☐	☐	33. Lung Disease/Respiratory
☐	☐	9. Bone (Breaks or fractures)	☐	☐	34. Mental Health (Bipolar, Panic Attacks)
☐	☐	10. Brain/Head	☐	☐	35. Muscle Strains/Sprains
☐	☐	11. Cancer	☐	☐	36. Neuro/Muscular Condition
☐	☐	12. Carpal Tunnel Syndrome	☐	☐	37. Organ Transplant
☐	☐	13. Chronic Coughing (Cough up blood)	☐	☐	38. Painful Feet or Heels
☐	☐	14. Chronic Pain Disorder	☐	☐	39. Rheumatism
☐	☐	15. Currently/possible Pregnant	☐	☐	40. Seizures/Fits/Convulsions
☐	☐	16. Deafness/Hearing Difficulty	☐	☐	41. Shortness of Breath
☐	☐	17. Diabetes (Type 1 or 2, use Insulin Pump)	☐	☐	42. Sickle Cell Anemia
☐	☐	18. Dizziness/Fainting Spells/Vertigo	☐	☐	43. Skin (Rash, Dermatitis, Psoriasis)
☐	☐	19. Drug Abuse (Prescription/Other)	☐	☐	44. Sleep Disorder
☐	☐	20. Endocrine (Thyroid, Pituitary)	☐	☐	45. Spine (Disc Disease, Stenosis)
☐	☐	21. Eye Disorders (Infection, Color Blind)	☐	☐	46. Stroke
☐	☐	22. Frequent Headaches/Migraines	☐	☐	47. Swollen Ankles
☐	☐	23. Gut Disorder/Disease	☐	☐	48. Tendonitis
☐	☐	24. Heart (Heart Attack or Surgeries)	☐	☐	49. Tuberculosis (TB)
☐	☐	25. Hepatitis (A, B, C, D, or E)	☐	☐	50. Other Disorders or Diseases

Please list number and details of illnesses, injuries, or other health problems marked **"YES"** above:

***example**: # 17 – Type 1 diabetes, maintained with insulin pump since 2015*

DERMATITIS / LATEX ALLERY HISTORY - Please answer the questions by placing a large "X" in the yes or no box:

YES	NO	
☐	☐	1. Are you allergic to rubber, latex, or powdered gloves?
☐	☐	2. Do your lips swell up or itch after you blow up a balloon?
☐	☐	3. Do you have reactions during dental procedures? (i.e. swelling, itching, trouble breathing, swallowing, or hives)
☐	☐	4. Have you ever reacted to condoms or diaphragms?
☐	☐	5. Have you ever had eczema or rashes on your hands caused by latex or powder? • If "yes", have you seen a physician? • Diagnosis: _____
☐	☐	6. Do you have asthma caused by latex or powder? • If "yes", what triggers it? _____
☐	☐	7. Are you allergic to any tropical fruits (avocado, bananas, Kiwi, or strawberries)? • If "yes", list: _____

Please explain any "Yes" answers:

_____

_____

IS RESPIRATORY-FIT TESTING REQUIRED FOR YOUR ROLE?

Not required to answer if 100% remote or hybrid status.
Please answer by placing a large "X" in the yes or no box.

YES	NO	
☐	☐	1. Does your hired or flex role require "direct patient contact" while working at ECU Health?
☐	☐	2. Does your hired or flex role require that you enter rooms with isolation precautions?
☐	☐	3. Does your hired or flex role require that you work in aerosol-generating procedures? • Examples: Intubation, cough induction procedures, Bronchoscopies, some dental procedures and exams, CPAP aerosol-titrating procedures=Sleep Center Staff, invasive specimen collection on known or suspected COVID-19 patients.
☐	☐	4. Does your hired or flex role require that you work with microbiology specimens?
☐	☐	5. Does your hired or flex role require you to have a risk of respiratory exposure to hazardous drugs? A "yes" to either question below equals "yes" to question #5. • Pharmacy Techs – will you perform regular cleaning with Peridox-RTU or perform terminal cleaning? • Pharmacist & Pharmacy Techs– will you be compounding Hazardous Drugs?

IS VISION SCREENING REQUIRED FOR YOUR ROLE?

Please answer by placing a large "X" in the yes or no box.

YES	NO	
☐	☐	1. Is your role classified as 100% Remote (live out of state and will never come on campus)?
☐	☐	2. Is your role classified as Hybrid status (majority of work completed remotely, but required to attend some meetings in person)?
☐	☐	3. Is your role Clinical or performed in a Clinical Setting?
☐	☐	4. Is your role non-clinical but you have received specialized training that impacts patient safety? • Example: Non-Violent Crisis Intervention (NVCI) certification is required for the role of Patient Observer.
☐	☐	5. At any time, will you be driving a company vehicle in your role? • Examples: Police Officer/Public Safety Officer, Ambulance Driver, Grounds Dept, CDL Drivers, Transportation Mechanics, Shuttle Drivers, EVS staff (floor wax stripper),

REVIEW OF SIGNS/SYMPTOMS OF TUBERCULOSIS -

Have you ever had a **positive** TB skin test? ☐ **YES** ☐ **NO**
If yes, when, what medication was prescribed, and for how long?

_____

_____

Do you **currently** have any of the following symptoms?
Please check **ALL** that apply by placing a large "X" in the yes or no box:

YES	NO	
☐	☐	1. UNEXPLAINED productive cough?
☐	☐	2. UNEXPLAINED weight loss?
☐	☐	3. UNEXPLAINED appetite loss?
☐	☐	4. UNEXPLAINED fever?
☐	☐	5. UNEXPLAINED night sweats?
☐	☐	6. UNEXPLAINED shortness of breath?
☐	☐	7. UNEXPLAINED chest pain?
☐	☐	8. UNEXPLAINED fatigue?
☐	☐	9. Within the last 90 days have you traveled out of the country?

- If yes, where _____, and did you stay >/= 1 month?
- If yes, was this trip a Medical Mission trip that lasted >/= 14 days?

Please explain any "Yes" answers:

_____

_____

"Reasonable accommodations may be provided for individuals with disabilities to the extent they do not impose an undue hardship. Such requests will be reviewed on a case-by-case basis and may require supporting documentation."

"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 individuals' or family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services".

I understand and acknowledge that ECU Health relies on the truth of the information that I have provided herein as a basis for my continued employment and that falsification of any of the information I have provided shall be grounds for my immediate dismissal. To that end, I certify that the information I have given herein is true and complete and that I have been given an opportunity to ask any questions I might have about the information requested. I understand that my employment is conditioned upon my separate written authorization to disclose the health information provided by me, the results of this post-offer, pre-placement health examination and ongoing health information during the course of my employment to the management of ECU Health for the purposes of evaluating my fitness for employment and for other reasons deemed by management as necessary for the protection of health or safety purposes management to be necessary for health and safety purposes.

_____ _____

Signature of Conditional Employee **Date**

Occupational Health Section

Section A

<u>This Section to be completed by Occupational Health Nurse</u>: (review of TB information):

	PPD	QFG	CXR	Referral to OH MD
Date				
Results				

This is to certify the above-named person completed adequate TB related surveillance and if required underwent specific tuberculosis testing. Currently, this person has no symptoms suggestive of active tuberculosis and no known recent exposure to tuberculosis. Further testing (annual chest x-ray) for tuberculosis is not indicated currently.

Section B

<u>This section to be completed by Occupational Health Nurse</u>: (review & summary of health history)

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Signature – Occupational Health Nurse **Date**