Health Questionnaire

To the Applicant: You have been made an offer of employment, conditioned on the satisfactory completion of this questionnaire and on the results of health screening. The purpose of this inquiry is to determine whether you currently have the physical and mental qualifications necessary to perform the job that has been offered, whether and what reasonable accommodations may be necessary, and whether you can perform the job without posing a direct threat to the health or safety of yourself or others. This information will be kept confidential in a separate medical file, apart from your personnel file.

Last Name: _____ First Name: _____ Middle: _____

Address: _____ Phone: _____

Position Applied For: _____ Ministry/Department: _____

Section A – General Information

1. Are you a previous employee of St. Joseph Health or Covenant Health? ☐ Yes ☐ No
   If yes, year of termination: _____

2. Do you currently have a contagious disease or infection that would pose a significant risk of transmission to others, and that cannot be accommodated by postponing your employment starting date?
   ☐ Yes ☐ No If yes, identify restriction: _____

3. Have you ever been tested for tuberculosis? ☐ Yes ☐ No
   If yes, date of last skin test or x-ray: _____
   a. Have you lived outside of the United States? _____
   b. Have you ever had the BCG (Bacillus Calmette–Guérin) vaccine? _____
   c. Have you ever been treated for TB? _____

4. Do you currently have any sensitivities to chemicals or materials typically found in a hospital environment (i.e., formaldehyde, latex, radiation, etc.)? ☐ Yes ☐ No
   If yes, please list the chemicals/materials you are sensitive to and any reasonable accommodations you may need: ___

5. I have reviewed the Job Description (if applicable) for _____ (insert Job Title) ☐ Yes ☐ No
   Describe any physical or mental impairment that may restrict your ability to perform any Key Functions of the job: _____

   If a reasonable accommodation is necessary, please describe: _____
   _____

Section B – Attendance

6. Are you currently able to meet, with or without reasonable accommodation, the required hours of work and times of work for the position for which you have received a conditional job offer? ☐ Yes ☐ No
   If a reasonable accommodation is necessary, please describe: _____

Section C – Vaccine Information

7. **Hepatitis B (vaccination strongly recommended)**
   Have you received a Hepatitis B vaccine? ☐ Yes ☐ No
   Complete Series ☐ Yes ☐ No
   Incomplete Series ☐ Yes ☐ No - Number of doses received: _____
   Antibody Testing Performed ☐ Yes ☐ No
   Hepatitis B Surface Antibody ☐ Positive ☐ Negative ☐ Unknown
   Hepatitis B Surface Antigen Positive ☐ Yes ☐ No ☐ Unknown

8. **Mumps**
   Have you ever had Mumps? ☐ Yes ☐ No ☐ Unknown
   Have you had a MMR vaccine booster: ☐ Yes ☐ No ☐ Unknown

9. **Rubeola (measles)**
   Have you ever had Rubeola? ☐ Yes ☐ No ☐ Unknown
   Date of last MMR vaccine booster: _____

10. **Rubella (German measles)**
    Have you ever had Rubella? ☐ Yes ☐ No ☐ Unknown
    Have you had a MMR vaccine booster? ☐ Yes ☐ No ☐ Unknown
    Result of serology test: _____

11. **Varicella (Chickenpox)**
    Have you ever had Chickenpox? ☐ Yes ☐ No ☐ Unknown
    Result of serology test: _____
    Have you had varicella vaccine? ☐ Yes ☐ No ☐ Unknown

12. **Tetanus/Diphtheria/Pertussis**
    Date of last Tetanus vaccine: _____
    Have you received a Tetanus/Pertussis vaccine? ☐ Yes ☐ No ☐ Unknown
    Date of last Tetanus/Pertussis vaccine booster: _____

Section D – Drug Use

13. Do you currently use any illegal drugs or controlled substances? ☐ Yes ☐ No

14. Do you currently abuse any legally prescribed drugs or controlled substances? ☐ Yes ☐ No

15. Do you currently take any legally prescribed drugs or controlled substances that may affect your ability to perform the essential functions of the job you have been offered? ☐ Yes ☐ No
    If yes, please explain: _____

Section E – Declaration

I hereby certify that the above statements are true, to the best of my knowledge. I further understand and agree that any intentional misstatements of fact may result in the withdrawal of my conditional offer of employment or the immediate termination of my employment. I hereby consent to post-offer pre-placement examination and test by a Physician or other qualified Healthcare Professional appointed by Covenant Health/St. Joseph Health. The examining facility is authorized by me to release the contents and findings of the examination to the above-named employer.

Date: _____ Applicant's Signature: _____

RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE (MANDATORY)

EMPLOYEE: 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. Your employer must tell you how to send or deliver this questionnaire to the health care professional who will review it.

Part A. Section 1. (Mandatory) Every employee selected to use any type of respirator must provide the following information (please print).

Date: _____

Name: _____

Job title: _____

Age: _____ Sex: M ☐ F ☐ Height: _____ Weight: _____

Phone number: ( ) _____

A phone number where the health care professional can reach you (include the Area Code): ( ) _____

The best time to phone you at this number: _____

Has your employer told you how to contact the health care professional who will review this questionnaire (check one)? ..... Yes ☐ No ☐

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 type, powered-air purifying, supplied-air, self-contained breathing apparatus).

Have you worn a respirator (check one)? ..... Yes ☐ No ☐

If "yes," what type(s)? _____

Part A. Section 2. (Mandatory) Every employee selected to use any type of respirator must answer questions 1 through 9 below (please check "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 ☐

3. Have you *ever* had any of the following pulmonary or lung problems?
   a. Asbestosis ..... Yes ☐ No ☐
   b. Silicosis ..... Yes ☐ No ☐
   c. Asthma ..... Yes ☐ No ☐
   d. Pneumothorax (collapsed lung) ..... Yes ☐ No ☐
   e. Chronic bronchitis ..... Yes ☐ No ☐
   f. Lung cancer ..... Yes ☐ No ☐
   g. Emphysema ..... Yes ☐ No ☐
   h. Broken ribs ..... Yes ☐ No ☐
   i. Pneumonia ..... Yes ☐ No ☐
   j. Any chest injuries or surgeries ..... Yes ☐ No ☐
   k. Tuberculosis ..... Yes ☐ No ☐
   l. Any other lung problem that you have been told about ..... Yes ☐ No ☐

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 ☐

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 problems that you have been told about ..... Yes ☐ No ☐

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 2 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 ☐

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 have used a respirator, have you *ever* had any of the following problems? (If you have *never* used a respirator continue to question 9)
   a. Eye irritation ..... Yes ☐ No ☐
   b. Skin allergies or rashes ..... Yes ☐ No ☐
   c. Anxiety ..... Yes ☐ No ☐
   d. General weakness of fatigue ..... Yes ☐ No ☐
   e. Any other problem that interferes with your use of a respirator ..... Yes ☐ No ☐

9. Would you like to discuss your answers with the health care professional who will review this questionnaire? ..... Yes ☐ No ☐

Dear Healthcare Professional:

If you wish to waive one of your meal periods please select option 1, complete, sign and submit. If you wish to revoke a previous waiver, please select option 2, complete, sign and submit. You may also submit via fax to your Quality Management Specialist at (877) 282-0425.

Please sign one of the following options:

Option 1: Waive one of your meal periods

I understand the Company provides two 30-minute, uninterrupted meal periods to any California Clinician who works more than ten hours in any workday and that the first meal period will be provided before the end of my fifth hour of work and the second no later than the end of the tenth hour. I further understand that when I work more than ten hours in a day, I may voluntarily waive one of the two 30-minute meal periods. If I waive one of my meal periods, I will take the remaining meal period no later than the end of my tenth hour of work. By signing below I am voluntarily waiving one of the two 30-minute meal periods. I also understand that I, or the Company, may revoke this waiver at any time by submitting a Revocation of Waiver Form, and any change will become effective upon the next shift worked after submission to the Company. This waiver will remain in effect until it is revoked. I understand that meal periods are not considered hours worked and are not compensated. I will ensure that all meal periods and hours worked are accurately reported on my timesheet.

I acknowledge that I have read this document, understand it and agree to its provisions.

For more information on meal periods please consult your handbook.

_____ XXX-XX-__ __ __ __

Healthcare Professional Signature Last 4 digits of our Social Security Number

_____ _____

Print or Type Name of Healthcare Professional Date

Option 2: <u>Revocation</u> of meal period waiver

I revoke any previously filed Meal Period Waiver Form. I understand that this revocation will remain in effect unless I file another waiver form to change my election. Any change will become effective upon the next shift worked after the Company receives the form.

I acknowledge that I have read this document, understand it and agree to its provisions.

For more information on meal periods please consult your handbook.

_____ XXX-XX-__ __ __ __

Healthcare Professional Signature Last 4 digits of our Social Security Number

_____ _____

Print or Type Name of Healthcare Professional Date

Please return the attached Meal Period Form for California Employees by fax to your Quality Services Analyst as soon as possible.

You may submit a new Form If you wish to change the option you have chosen. For questions, please call Customer Service at 877-777-8086.

1. Has your license or certification ever been investigated or suspended? Y or N
   If yes, please explain:

Yes

Healthcare Professional: _____
Date: _____

PROVIDENCE
Health & Services

Declination of Seasonal Influenza Vaccination 2017-2018

Providence Health & Services offers the influenza vaccine free of charge to caregivers, volunteers, students, employed & non-employed providers, and contracted employees in accordance with the annual CDC recommendations. By being vaccinated, you are protecting yourself, your patients, your family, and the community.

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease that kills an average of 36,000 persons and hospitalizes more than 200,000 persons in the United States each year.
- Influenza vaccination is recommended for me and all healthcare workers to protect our patients from influenza disease, its complications, and death.
- If I contract influenza, I will shed the virus for 24-48 hours before influenza symptoms appear. My shedding the virus can spread influenza disease to patients in this facility.
- If I become infected with influenza, even if my symptoms are minimal or resemble a cold, I can spread severe illness to others.
- I understand that the strains of virus that cause influenza infection change almost every year, which is why a different influenza vaccine is recommended each year.
- I understand that I cannot get influenza from the influenza vaccine.
- The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including my patients and other patients in this healthcare setting, including my coworkers, my family, and my community.
- Side effects of the vaccine are almost universally mild and of short duration.
- I understand that I can change my mind at any time and accept influenza vaccination, if vaccine is available.

I have read and fully understand the information on this declination form.

I am declining the flu vaccine because of:

☐ My Licensed Independent Practitioner documented allergy or medical contraindication to the vaccine
☐ My religious beliefs or my sincerely held moral or ethical beliefs

Despite the information provided I am choosing to decline influenza vaccination right now.

Signature_____ **Date**_____

Name (print) _____ **Birth Date** _____

Department _____ **ID #/Practitioner #** _____

Facility Name_____ **Daytime Phone:** _____

PROVIDENCE Health & Services

Employee Health Services

Tetanus, Diphtheria, acellular Pertussis (Tdap) Combined

Caregiver Name:	ID Number:
Date:	Department/Position:

The Advisory Committee on Immunization Practices (Centers for Disease Control) recommends that all health care personnel regardless of age, should receive a single dose of Tdap as soon as feasible if they have not previously received Tdap and regardless of the time since last Td dose. Pertussis is highly contagious and vaccine is highly recommended and is offered free from Employee Health Services to all Providence caregivers. We would like to encourage you to review the information provided by the Employee Health nurse and consider getting the vaccine.

Acceptance/Declination Statement

I have read the information about the Tdap vaccine. I have had the opportunity to ask questions or consult with my physician, if desired. Any questions were answered to my satisfaction. I understand the benefits and risks of the vaccine. I understand the Tdap vaccine is available to me at no cost upon request through Employee Health Services.

☐ REQUEST that the combined Tdap vaccine be given to me.

☐ PREVIOUS IMMUNIZATION: I have received the combined Tdap vaccine as an adult booster since 2006 and I have provided the supporting documentation.

☐ I DECLINE: I understand that by declining the vaccine, I am at risk of being exposed and/or contracting Pertussis. If I am exposed to Pertussis, I will not be allowed to work during the incubation period or during the resulting illness. In the future, if I want to be vaccinated with Tdap, I can receive the vaccination from Providence Employee Health Services at no cost to me.

Health History Questions	Yes	No	If yes, describe briefly:
Have you ever had a life threatening allergic or neurologic reaction (coma or seizure) after a dose of DPT, Dtap, DT, or TD?	☐	☐	
Do you have epilepsy or another nervous system problem, such as Guillain Barre' Syndrome (GBS)?	☐	☐	
Have you ever had severe swelling or pain after a DPT, Dtap, DT, TD or Tdap vaccine? (A 'severe' problem means unable to perform usual activities and/or required medical attention)	☐	☐	
Are you pregnant?	☐	☐	
Are you moderately or severely ill today?	☐	☐	
Do you have a known allergy or sensitivity to latex?	☐	☐	

Caregiver Signature:	**Date:**

EHS USE ONLY

Tdap Lot :	**VIS Version & Date:**	
Expiration Date:	**Route: IM Deltoid**	**Deltoid: Left Right (circle one)**
Vaccine Administrator Signature:		**Date:**

Latex Allergy Screening Questionnaire

Risk Factor Assessment: Circle Y or N

Exposure History:

Are you a health care worker? Y N

Do you wear latex gloves regularly or are you otherwise exposed to latex regularly? Y N

Do you have a history of eczema or other rashes on your hands? Y N

Do you have a medical history of frequent surgeries or invasive medical procedures? Y N

Did these take place when you were an infant? Y N

Do you have a history of "hay fever" or other common allergies? Y N

Do your fellow workers wear latex gloves regularly? Y N

Do you take a beta-blocker medication? Y N

Circle any foods below that cause hives, itching of the lips or throat, or more severe symptoms when you eat or handle them:

avocado	apple	pear	celery	carrot	hazelnut
kiwi	papaya	pineapple	peach	cherry	plum
apricot	banana	melon	chestnut	nectarine	grape
fig	passion fruit	tomatoes	potatoes		

Contact Dermatitis Assessment: (for patients who wear latex gloves frequently)

Do you have rash, itching, cracking, chapping, scaling, or weeping of the skin from latex glove use? Y N

Have these symptoms recently changed or worsened? Y N

Have you used different brands of latex gloves? Y N

If so, have your symptoms persisted: Y N

American Latex Allergy Association

Have you used non-latex gloves? Y ☐ N ☐

If so, have you had the same or similar symptoms as with latex gloves? Y ☐ N ☐

Do these symptoms persist when you stop wearing all gloves? Y ☐ N ☐

Contact Urticaria (Hives) Assessment: (for patients who wear latex gloves frequently)

When you wear or are around others wearing latex gloves do you get hives, red itchy swollen hands within 30 minutes or, "water blisters" on you hands within a day? Y ☐ N ☐

Aerosol Reaction Assessment:

When you wear or are around others wearing latex gloves, have you noted any:

Itchy, red eyes, fits of sneezing, runny or stuffy nose, itching of the nose or palate: Y ☐ N ☐

Shortness of breath, wheezing, chest tightness or difficulty breathing? Y ☐ N ☐

Other acute reactions, including generalized or severe swelling or shock Y ☐ N ☐

History of Reactions Suggestive of Latex Allergy:

Do you have a history of anaphylaxis or of intra-operative shock? Y ☐ N ☐

Have you had itching, swelling or other symptoms following dental, rectal or pelvic exams? Y ☐ N ☐

Have you experienced swelling or difficulty breathing after blowing up a balloon? Y ☐ N ☐

Do condoms, diaphragms or latex sexual aids cause itching or swelling? Y ☐ N ☐

Do rubber handles, rubber bands or elastic bands or clothing cause any discomfort? Y ☐ N ☐

This questionnaire is intended for screening purposes only. See an allergist or physician for diagnosis.

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

►**START HERE:** **Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.**

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	**OR**	**List B** Identity	**AND**	**List C** Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			**B.** Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any)* *(mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative