Employee Health and Wellness
The Central Maine Medical Family

OSHA Latex Allergy Assessment:

Do you wear latex gloves or come in contact with latex products at home?	Yes ☐	No ☐
Are you in another occupation that exposes you to latex or rubber products?	☐	☐
Do you have a history of eczema, rash, itching, cracking of the skin on your hands after wearing latex products?	☐	☐
Do any of the following foods below cause urticaria (hives), itching of the lips or throat or more severe symptoms (circle each) avocado, kiwi, sweet chestnut, banana, hazelnut, tomato, potato (problems after eating or peeling).	☐	☐
Do you have spina bifida OR did you undergo frequent surgeries or medically invasive procedures as a child?	☐	☐
Have you experienced an allergic reaction during a surgical procedure?	☐	☐
Have there ever been unexplained events that occurred during previous operations?	☐	☐
Have you ever had any itching, swelling, rash or other symptoms after dental, rectal or pelvic examinations?	☐	☐
Have you had any of the symptoms below when you have been in contact with latex or rubber products (balloons, rubber gloves, condoms, rubber bands, new pencil erasers, please underline) itchy red eyes, sneezing, runny or blocked nose, rash, swelling, wheezing, chest tightness, or difficulty breathing? (please circle)	☐	☐

Signature: /s/_____Date:_____

RN Reviewer: /s/_____ Date: _____

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TUBERCULOSIS & RESPIRATOR FIT TEST SURVEILLANCE

Employee Health, Wellness & Safety
(207) 795-2830 Office
(207) 795-5688 FAX

Instructions:

1) Type name, Department, DOB & date below.
2) Date & Digitally Sign (/s/ then TYPE YOUR NAME Example: /s/John Doe) in the ***Consent*** section.
3) **ALL EMPLOYEES – with and without patient contact must complete the questionnaire.**
4) **Please save or print a copy for yourself prior to sending it to Employee Health.**
5) ***If History of Positive TB Skin test – Review Signs/Symptoms – Then sign – Return form to Employee Health.***
6) If **Negative history, have TB Skin test done.** After it is read, return the completed form to Employee Health.

Employee Name	Department Name	DOB:	Date:

Tuberculosis is a mycobacterial disease that is responsible for disability and death in many parts of the world. The CDC and Joint Commission recommend routine Tuberculosis screening of Healthcare Workers.

- The agent used for the TB skin test is an aqueous solution of a purified protein fraction isolated from culture filtrates of human type strains of mycobacterium tuberculosis.
- In highly sensitive individuals or those with prior positive tests, strong positive reactions including vesication, ulceration, necrosis or scarring may occur at the test site.

TB History and Respiratory System Review			
	NO	**YES**	
Do you have direct patient contact?			If no and no history of positive PPD, please sign, date and return to Employee Health.
Have you ever had BCG vaccine (TB vaccine)?			When?
Have you ever had a positive TB skin test?			Year first positive _____
Have you had TB, the disease?			When?
Were you treated with medication?			With what & how long?
Have you ever had an allergic reaction to the PPD solution?			When?

In the last 12 months, have any of the following occurred?

TB Signs/Symptoms + reactors	**NO**	**YES**	**For those using Respiratory Protection/N 95's/Fit tested EE's**	**NO**	**YES**
Chronic cough (3 weeks or longer)?			Used a Face Mask (Isolation) at work? (if ***NO***, STOP here, if ***YES***, answer the following)		
Coughing up blood?			Had difficulty using the mask (respirator)?		
Chronic fatigue (tiredness)?			Grown facial hair? (new Mustache or Beard)		
Persistent night sweats?			Been fitted with dentures?		
Fever, chills?			Had a change in facial structure?		
Involuntary weight loss?			Gained or lost weight affecting facial size or shape?		
Are you being treated for a serious medical condition?			Developed a medical condition such as asthma, emphysema, bronchitis, fainting, shortness of breath, high blood pressure, diabetes, stroke?		
Are you taking Prednisone or chemotherapy?					
Explain ***YES*** response:					

CONSENT

I have read the above statement about TB skin testing and the special precautions. I have had the opportunity to ask questions and understand the benefits and risks of TB skin tests. I understand that, should I develop any of the above symptoms, I am to report to Employee Health Services immediately.
I understand TB testing and surveillance is a condition of employment with Central Maine Healthcare (CMHC). Failure to comply with the TB surveillance program can result in disciplinary action up to and including termination.

Employee Signature:_____ RN Signature:_____ Date:_____

Tspot	Date Drawn:	Date Result Rcvd:	Result:

PPD TB SKIN TEST

Tubersol 0.1 ml ID		Given		Site	Given by	Read		Induration mm x mm	Read By
Lot #	Exp. Date	Date	Time			Date	Time		
								mm	

For PPD, read induration 48-72 hours after test applied/Record Induration as (number) mm.

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Hood: Facial Hair or Failed Test

OSHA Respirator Medical Evaluation Questionnaire

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

To the employee: Can you read: 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.

1. Today's date:
2. Your name:
3. Date of birth:
4. Your sex: Male Female
5. Your height: ft. in.
6. Your weight: lbs. Weight loss or gain > 10lbs. in past year? Yes No
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):
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:
    Yes No
11. Check the type of respirator you will use (you can check more than one category):
    - N, R, or P disposable respirator (filter-mask, non-cartridge type only).
    - Other type (for example, half- or full-facepiece-type, powered-air purifying, supplied-air, self-contained breathing apparatus).
12. Have you worn a respirator: 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 (answer by checking the box if the answer is YES.

1. I currently smoke tobacco, or have you smoked tobacco in the last month:

2. I have had the following medical conditions:
    a. Seizures (fits):
    b. Diabetes (sugar disease):
    c. Allergic reactions that interfere with your breathing:
    d. Claustrophobia (fear of closed-in places):
    e. Trouble smelling odors:

3. I haver had the following pulmonary or lung problems:
    a. Asbestosis:
    b. Asthma:
    c. Chronic bronchitis:
    d. Emphysema:
    e. Pneumonia:
    f. Tuberculosis:
    g. Silicosis:
    h. Pneumothorax (collapsed lung):
    i. Lung cancer:
    j. Broken ribs:
    k. Any chest injuries or surgeries:
    l. Any other lung problem that you've been told about:

4. I currently have the following symptoms of pulmonary or lung illness:
    a. Shortness of breath:
    b. Shortness of breath when walking fast on level ground or walking up a slight hill/incline:
    c. Shortness of breath when walking with other people at an ordinary pace on level ground:
    d. Have to stop for breath when walking at your own pace on level ground:
    e. Shortness of breath when washing or dressing yourself:
    f. Shortness of breath that interferes with your job:
    g. Coughing that produces phlegm (thick sputum):
    h. Coughing that wakes you early in the morning:
    i. Coughing that occurs mostly when you are lying down:
    j. Coughing up blood in the last month:
    k. Wheezing:
    l. Wheezing that interferes with your job:
    m. Chest pain when you breathe deeply:
    n. Any other symptoms that you think may be related to lung problems:

5. I haver had the following cardiovascular or heart problems:
    a. Heart attack:
    b. Stroke:
    c. Angina:
    d. Heart failure:
    e. Swelling in your legs or feet (not caused by walking):
    f. Heart arrhythmia (heart beating irregularly):
    g. High blood pressure:
    h. Any other heart problem that you've been told about:

6. I have had the following cardiovascular or heart symptoms:
    a. Frequent pain or tightness in your chest:
    b. Pain or tightness in your chest during physical activity:
    c. Pain or tightness in your chest that interferes with your job:
    d. In the past two years, have you noticed your heart skipping or missing a beat:
    e. Heartburn or indigestion that is not related to eating:
    f. Any other symptoms that you think may be related to heart or circulation problems:

7. I currently take medication for the following issues:
    a. Breathing or lung problems:
    b. Heart trouble:
    c. Blood pressure:
    d. Seizures (fits):

8. I have used a respirator and had the following issues:
    a. Eye irritation:
    b. Skin allergies or rashes:
    c. Anxiety:
    d. General weakness or fatigue:
    e. Any other issue that interferes with your use of a respirator:

9. I would like to talk to the health care professional who will review this questionnaire about my answers to this questionnaire?

Part A. Section 3: <u>Mandatory</u> - Questions about previous work or hobbies

1. List any second jobs or side businesses you have:

2. List your previous occupations:

3. List your current and previous hobbies:

4. Have you been in the military services:

5. Have you ever worked on a HAZMAT team:

6. Other than medications for breathing and lung problems, heart trouble, blood pressure and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications):

    If "yes," name the medications if you know them:

All “Yes” answers (other than to questions in Section 1, and to question 9 in Section 2 of Part A,) have been reviewed by an RN.

Employee Signature: /s/

Date:

EHS staff Reviewer Signature: /s/

Date:

POST-JOB OFFER MEDICAL QUESTIONNAIRE

Employee Name:
Date of Birth:
Address (Street, State, Zip):
Emergency Contact Name:

Social Security Number:
Phone Number:

Emergency Contact Number:

NOTICE TO OFFEREES: In compliance with the Americans with Disabilities Act of 2008 (ADA), you have received a conditional offer of employment. This medical history statement is required of all offerees. The answers to the medical history statement and any medical examination will be kept confidential and in separate files in compliance with the ADA requirements. The job offer, which you have received, is conditioned upon satisfactory completion and review of this medical questionnaire and any required medical examination or follow up.

GINA DISCLOSURE: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by 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" 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 AFFIRMATION: I herewith affirm that the employer has made me an offer of employment, conditioned on, among other things, the satisfactory completion of this questionnaire. The purpose of this inquiry is as follows: (1) to determine whether I currently have the physical qualifications necessary to perform the essential functions of the job that has been offered; (2) to determine what accommodations, if any, may be necessary for me to perform the essential functions of the job; and (3) to determine whether I can perform the essential functions of the job without posing a significant direct threat to the health and safety of myself and others. This information will be kept strictly confidential in a separate medical file (though managers and supervisors may be told about necessary restriction or accommodations, first aid and safety personnel may be told if emergency treatment might be required, and information may be shared with certain government officials)., apart from my personnel file. I hereby affirm that the questions in the medical questionnaire have not been asked of me by anyone with the employer until after I have signed this statement and been given a conditional offer of employment. The job duties of the position for which I have received a conditional offer have been adequately described to me, and I have had an opportunity to ask questions regarding the duties.

EH NOTES:

1. Have you ever had or been treated for any of the following conditions or diseases?

Surgery

Herniated Disc
Surgical removal of disc or spinal fusion
Hernia or rupture
Neck Injury, pain, or problems
Shoulder Injury
Arm/Hand Injury
Repetitive Motion Disorder Tendinitis
Amputations
Asthma
Back pain
Diabetes
Heart attack
Hepatitis, cirrhosis or liver disease
Musculo-skeletal problems
Shortness of breath
T.B. positive
Wear glasses/contacts
Knee Injury
Back Injury
Diseased process of the spine
Chest Pain
Arthritis or Rheumatism
Wrist Problems (Including Carpal Tunnel)
Broken Bones
Head Injury
Epilepsy, fainting spells, or dizziness
Serious allergies
Bronchitis
Emphysema
Heart disease
Jaundice
Nose bleeds
Sleep disorders
Vision problems
Ankylosis (immobility) of any major weight bearing joints (ankle, knee, hip)

2. Have you sought treatment from a healthcare provider for any of the above injuries and/or medical conditions?

YES NO

3. Are you capable of performing the essential functions of this position with or without a reasonable accommodation?
YES NO

If 'YES' do you require an accommodation? YES NO If 'Yes' what accommodation do you need:

4. Do you have any injury or condition that requires a reasonable accommodation in order for you to perform the essential functions of this position?
YES NO

If 'YES' what accommodations do you need to perform the essential functions of the position:

5. Please indicate the amount of weight you can comfortably lift unassisted:

<15 lbs 15-25 lbs 25-40 lbs >40lbs

6. Are you currently restricted or limited in your ability to sit, stand, push, pull, or lift anything at the direction of a healthcare provider?
YES NO

If 'YES' what are the restrictions or limitations:

7. Has a Healthcare Provider limited the amount of weight you can lift?
YES NO

If 'YES' what is that limit:

8. Are you taking any prescribed drugs or medications that would interfere with your ability to perform your job?
YES NO

If 'YES' what drugs or medications are you taking:

I attest that the information provided in this questionnaire in connection with my offer of employment are accurate, complete, and provided willingly and intentionally. I understand that failure to disclose relevant information related to any of these questions could negatively effect my employment.

NAME

DATE

EH Nurse Signature:

Date: