THE GEORGE WASHINGTON UNIVERSITY HOSPITAL

Volunteer Applicant
Health Clearance Checklist

Employee Health Contact Information

Office Phone: (202) 715-4275; Fax: (202) 715-4587; Email: gwuehs@medcor.com
Walk-in hours: M-F 8:00 a.m. – 12:00 p.m. & 1:00 p.m. – 4:00 p.m.

Please email or fax the following items to Employee Health.

- ☐ Completed and Signed **"Pre-Placement Physical Exam"** Form – The physical exam form must be completed and signed by you <u>and</u> your provider within the last 3 months.
- ☐ Completed and Signed **"Medical Evaluation for Respirator Use"** Form – Please fill out and sign the form and return it to GWUH Employee Health. A provider at GWUH Employee Health will sign the form and place it in your record.
- ☐ Completed and Signed **"Pre-placement Latex Sensitivity Questionnaire"** – Please fill out and sign the questionnaire and return it to GWUH Employee Health. A provider at GWUH Employee Health will sign the form and place it in your record.
- ☐ Completed and Signed **"TB Skin Test History"** Form – Please fill out and sign the form and return it to GWUH Employee Health. A provider at GWUH Employee Health will sign the form and place it in your record.
- ☐ Signed documentation of 2 TB Skin Tests (PPDs), **<u>OR</u>** proof of receipt or 2 PPDs within the timeframes listed below:
  - The first PPD should be given within the last 1 year
  - The second PPD should be given within the last 3 months
- ☐ Most recent Chest X-Ray (**<u>only</u>** if you have had a positive PPD)
- ☐ Signed documentation of 2 MMR vaccines **<u>OR</u>** All 3 Titers
- ☐ Signed documentation of 2 Varicella Vaccines **<u>OR</u>** Titer
- ☐ Signed documentation of 3 Hepatitis B Vaccines **<u>OR</u>** Titer
- ☐ Signed documentation of Tetanus (Td or Tdap) Vaccine
- ☐ Influenza Vaccine (during Flu season only)

Employee Health Service
George Washington University Hospital
900 23rd Street, NW, Suite G-1092 • Washington, DC 20037
Phone: 202/715-4275 • Fax: 202/715-4587 • Email: gwuehs@medcor.com

Name______________________________ ☐ Male ☐ Female Date of Birth________________

Address______________________________ City______________________

State________ Zip code___________ Phone_____________________ Social Security #____________________

Email ______________________________ Start Date______________________

Department______________________ Position______________________ Supervisor______________________

MEDICAL HISTORY

Do you have any allergies to food, medications, or other substances? ☐ No ☐ Yes ☐ If yes, please list:

____

Do you take any medications on a daily basis? ☐ No ☐ Yes ☐ If yes, please list:

____

Do you have any medical conditions? ☐ No ☐ Yes ☐ If yes, please list:

____

Have you had any operations? ☐ No ☐ Yes ☐ If yes, please list:

____

Have you had any work-related injuries or blood/body fluid exposures? ☐ No ☐ Yes ☐ If yes, please list:

____

HEALTH BEHAVIORS

For Women	For Men	For Both
Do you practice monthly breast exams? ☐ Yes ☐ No Date of last pap smear: __________ Date of last mammo: ___________ Date of last colon test:___________	Do you practice monthly testicular exams? ☐ Yes ☐ No Date of last prostate exam: __________ Date of last colon test:_____________	Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per week? ________ Do you exercise? ☐ Yes ☐ No If yes, how many times per week? ________ Do you smoke now? ☐ Yes ☐ No If yes, how much? _________ ppd Do you have regular dental visits? ☐ Yes ☐ No

FAMILY MEDICAL HISTORY

Does anyone in your family have: high blood pressure __________, diabetes __________, colon cancer __________, breast cancer __________, heart disease __________, prostate cancer __________

THE GEORGE WASHINGTON UNIVERSITY HOSPITAL

Patient Label

PRE-PLACEMENT PHYSICAL EXAMINATION

TO BE COMPLETED BY EXAMINER

Height	Weight	BMI	BP	Pulse

	Normal (✓)	Comments for abnormal findings
General appearance		
Skin		
Eyes		
ENT		
Mouth/teeth/gums		
Neck		
Lungs/Chest		
Heart		
Abdomen		
Upper extremities		
Lower extremities		
Back/spine		
Neurologic		
Mental status		

ASSESSMENT/PLAN:

- ☐ PPD planted
- ☐ PPD read:____________ Neg:____ Pos.____
- ☐ ROS for h/o + PPD negative for active disease
- ☐ ROS for h/o + PPD positive for active disease
- ☐ Respiratory mask: ☐ N/A
  Style:____________ Size:____________
  PAPR:____________________________
- ☐ Color blind test: ☐ Pass ☐ Fail

- ☐ CXR ordered
- ☐ CXR attached
- ☐ Immunizations reviewed and documentation attached
- ☐ Immunization(s) given: ☐ Td/Tdap ☐ MMR
  ☐ Other:______________________________
- ☐ Titers ordered: ☐ measles ☐ mumps ☐ rubella
  ☐ varicella ☐ HBsAb ☐ HBsAg

-------------------------------- **Final Clearance** ---------------------------------

____ Discussed healthy lifestyle: ☐ diet/exercise ☐ smoke cessation ☐ health maintenance:____________________

____ Advised to follow-up with PCP regarding:______________________________________

____ Person is qualified to continue to perform the essential functions of the job, with or without accommodation.
Accommodation needed, if any: ______________________________________

____ Person is not qualified to continue to perform the essential functions of the job, with or without accommodation, for the following reason:______________________________________

____ ____________________

SIGNATURE OF EXAMINER PRINT NAME TITLE DATE

Patient Label

THE GEORGE WASHINGTON UNIVERSITY HOSPITAL

PRE-PLACEMENT PHYSICAL EXAMINATION

80-634

Employee Health Services
George Washington University Hospital
900 23rd Street, NW, Suite G-1092 • Washington, DC 20037
202/715-4275 (Phone)
202/715-4587 (Fax)

Name ______________________________ **Date** ______________________

Occupational Health and Safety Administration (OSHA) regulations state that all Health Care Workers who will be assigned, or may perform tasks requiring a respirator mask (i.e. during the care of patients with TB) are required to complete a medical evaluation of their use, and periodically thereafter. As part of this evaluation process, please complete the following questionnaire. Please answer all questions and provide explanations for any "Yes" answers. If you have questions, please ask for assistance from the EHS.

Have you worn a respirator mask to care for patients before? ☐ Yes ☐ No

Please describe the testing: ______________________________

Have you had, or do you currently have, any of the following:

Lung or breathing problems	☐ Yes	☐ No
Heart problems	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Skin problems	☐ Yes	☐ No
Claustrophobia (fear of being in closed places)	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Any other chronic medical conditions that require treatment	☐ Yes	☐ No

Explain any "Yes" answers: ______________________________

Do you take any medications on a regular basis? ☐ Yes ☐ No

Please list: ______________________________

Do you smoke? ☐ Yes ☐ No

For how many years? ____________ Pack per day smoked: ____________

If not current, how many years ago did you quit? ____________

Do you have a beard or mustache? ☐ Yes ☐ No

______________________________ ______________________________
Your Signature Signature of EHS Provider

May use respirator mask without restrictions ☐ Yes ☐ No

Restrictions: ______________________________

____

Further medical evaluation ☐ Yes ☐ No

Not approved for respirator use for the following reason(s): ______________________________

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MEDICAL EVALUATION FOR RESPIRATOR USE

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George Washington University Hospital
900 23rd Street, N. W., Suite G-1092
Washington, DC 20037
202-715-4275

Name:____________________

TB Skin Test History

Part of the initial screening at GWUH Employee Health is a TB skin test (PPD). It is important for our department to know if you ever had a positive reaction to the test, and any treatment or follow-up that you received. Please answer the following questions so we can determine the best way to screen you.

The BCG vaccine is given to many foreign-born persons during childhood for Tuberculosis (TB) disease prevention. *(Please note that the BCG vaccine is* ***NOT*** *the same as the TB skin test (PPD) placed on the forearm and used to screen for TB exposure).*

1. Have you ever received the BCG vaccine? Yes No
2. Have you ever had a positive PPD (TB) skin test reaction?

   Yes No If so, when________________

3. If positive, did you have a chest x-ray done? N/A Yes No If so, when__________
4. Have you ever taken anti-tuberculosis medicine following exposure to TB?

   N/A Yes No If so, when_____________

   How long did you take this medication for? __________

5. Have you ever been told you should not receive a TB skin test because of an adverse or allergic reaction?

   Yes No

6. Do you live with or have you been in close contact with someone who was recently diagnosed with active TB (roommate, close friend, relative)?

   Yes No

____________________ Your Signature ____________________ EHS Provider Signature __________ Date

Date ___/___/___

Should I get the **Tdap** vaccine?

1. Are you a healthcare provider in direct contact with patients? ☐ Yes ☐ No

   (ie. Doctor, nurse, therapist, aide, technician, etc.)

2. Are you in close contact with infants? ☐ Yes ☐ No

   (ie. Are you a mother, father, sibling, grandparent)

3. Are you an employee in a school or child-care setting? ☐ Yes ☐ No

   (ie. Babysitter, tutor, coach, bus driver, etc.)

4. Was your last tetanus booster a Td or Tdap? (Please circle one)

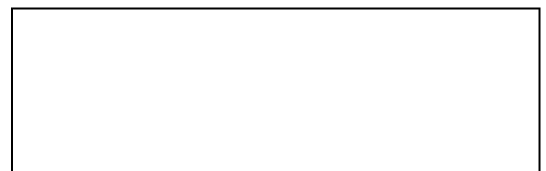
Spread of **Pertussis** has been documented in various healthcare settings, including hospitals and emergency departments serving pediatric and adult patients, outpatient clinics, nursing homes, and long-term care facilities.

Healthcare personnel who have direct patient contact should receive a single dose of Tdap if they have not previously received Tdap as an adult. Tdap can be administered regardless of interval since the previous Td dose. However, shorter intervals between Tdap and last Td may increase the risk of mild local reactogenicity.

Healthcare personnel include but are not limited to physicians, other primary care providers, nurses, aides, respiratory therapists, radiology technicians, students (e.g., medical, nursing, and pharmaceutical), dentists, social workers, chaplains, volunteers, and dietary and clerical workers.

Tdap vaccination can protect healthcare personnel against pertussis and help reduce transmission to others. Priority should be given to vaccinating healthcare personnel who have direct contact with babies younger than 12 months of age.

Information taken from the CDC website http://www.cdc.gov/pertussis/about/prevention.html. accessed on 6/17/11.



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Pre-placement Latex Sensitivity Questionnaire

Name____ Date_______________

1. Do you have any allergies to medication or food? . . . . Yes No

   If yes, please list ____

2. Have you suffered from any of the following?

   Allergic rhinitis (runny nose) . . . . Yes No
   Allergic conjunctivitis . . . . Yes No
   Asthma . . . . Yes No
   Difficulty breathing . . . . Yes No
   Eczema . . . . Yes No
   Hives . . . . Yes No
   Seasonal allergies . . . . Yes No
   Sinus problems . . . . Yes No

3. List any medications you take, including inhalers ______________________________

   ____

4. Have you ever had any skin rashes or breathing problems after handling, eating or being exposed to the following:

   Gloves (latex or vinyl) . . . . Yes No
   Band-Aids . . . . Yes No
   Balloons, condoms, or other rubber products . . . . Yes No
   Bananas, kiwis, papayas, chestnuts, avocado, passion fruit . . . . Yes No
   Potatoes, oranges, peaches, or other tropical fruit . . . . Yes No
   Dental, surgical, or gynecology exams . . . . Yes No

_______________________________ _______________________________
Your Signature Signature of EHS Provider