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SMH Personnel Form: Students

DEMOGRAPHICS		
Name:	**DOB:**	
Mailing Address:		
City:	**State:**	**Zip:**
Email Address:	**Phone:**	

EDUCATION

- ☐ Medical Student Year: _____
- ☐ PA or NP Student Year: _____
- ☐ Health Science Student (Nursing, MLT, Radiography, etc.)
- ☐ Job Shadow/ High School Student (Observer)

School/Organization (if applicable):	Specialty (if applicable):
Program Director/ Instructor:	Phone Number:

EMERGENCY CONTACT

Emergency Contact: (Name, Relationship)	Phone Number:
Emergency Contact: (Name, Relationship)	Phone Number:

Dates onsite at SMH _____ to _____

CONFIDENTIALITY AGREEMENT and PRECEPTEE POLICY

I, (Print Name) _____ do hereby agree that I will:

1. Protect the confidentiality of patient and hospital information.
2. Not divulge/share unauthorized information to any source.
3. Not access or attempt to access information other than that information which I have authorized access to, and a need to know, in order to complete my assigned tasks.
4. Report breaches of this confidentiality agreement by others to Sheridan Memorial Hospital's Compliance Officer. I understand that failure to report breaches is an ethical violation which may subject me to disciplinary action up to and including termination.

_____ _____

SIGNATURE DATE

I have read and agree to adhere to the conditions of the Medical Staff Preceptee Policy, outlining the roles, responsibilities and patient care activities. I also acknowledge that any violation of the above conditions can result in disciplinary action up to and including termination.

_____ _____

SIGNATURE DATE

Sheridan Memorial Hospital	Number ***13001.101***	Title **Medical Staff Preceptees Application, Roles, Responsibilities, and Patient Care Activities**			
Departments Affected: *Hospital-wide*		Effective Date 11/01/02 03/07/16 04/14/17	Revision Date 07/23/14 01/01/16 02/08/17	Review Date 07/23/14 01/01/16 02/08/17	Page 1 of 6
Approvals: 1. Medical Executive Committee – 11/30/2016 2. Leadership – 03/29/17 3. Officer – CMO – 03/29/17		Policy Author: Amy Ligocki, Medical Staff Services Manager			

I. POLICY: It is Sheridan Memorial Hospital's (SMH) responsibility to promote patient safety, determine that preceptees are practicing within their appropriate level of competency, and assure that preceptees have an appropriate level of involvement in patient care and an optimal education experience.

II. DEFINITIONS:

A. **Preceptee:** A practitioner trainee or student who is doing a clinical rotation at Sheridan Memorial Hospital, and who is affiliated with an ongoing approved training program. Preceptees include Medical Students (MS): Pre-Clinical MS year 1&2 and for-credit MS year 3-4; physician interns, residents and physician assistant, and nurse practitioner students.

B. **Supervising Physician:** One physician, or a group of physicians (e.g. Hospitalists), who hold Active or Consulting staff membership and unrestricted clinical privileges at Sheridan Memorial Hospital. They have immediate oversight responsibility of all aspects of patient care rendered by the preceptee. In most cases, the Supervising Physician is also the attending physician or consultant on the case.

C. **Supervision:** All practice performed under the direction of the overseeing medical staff member, or their designee, and in accordance with the Medical Staff Bylaws, Rules and Regulations.

D. **Observational Preceptees:** Include high school students who are enrolled in a training program, with a school agreement and proof of liability insurance, and who wish to observe an SMH privileged physician, physician assistant, or nurse practitioner at SMH. They are under the direct supervision of their physician sponsor(s) and may function in an observational capacity, only without the ability to provide any direct or indirect patient care. An observational student will not be allowed to have any conversation with the patient about the patient's medical status or care, or have physical contact with the patient without the presence of their Supervising Physician. The patient and/or family member(s) should verbally consent to receive care observed by the observer. They will not be involved in the performance of any procedures and will not make any entries in any patient chart.

E. **Clinical Preceptees** Include Clinical year 1-4 medical students, physician assistants, nurse practitioner students, physician interns, or residents, who are training under the direction of a Supervising Physician and in conjunction with an ongoing training program, approved by the appropriate Department Chair, and described in a written agreement between the Hospital and the preceptees' training program. Clinical preceptees are not members of the Medical Staff or Non-Physician Professional staff, and will not be granted

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clinical privileges, but may provide such patient care services as are dictated by the preceptee's academic institution and must be agreeable to Sheridan Memorial Hospital (Medical Staff Bylaws Article VII).

III. PROCEDURES:

A. This procedure applies to observational and clinical preceptees only, and does not apply to licensed independent physicians, other students in health related fields, such as nursing students, physical therapy students, radiology technologist students, or pre-medical students that are not currently enrolled in an accredited training program. Please refer to the Medical Staff Bylaws or Human Resources for the procedures in this regard.

B. Preceptees must be associated with academic programs that have a formal written affiliation agreement with Sheridan Memorial Hospital as a clinical training site.
   1. The preceptee or his/her academic institution that has an affiliation agreement with Sheridan Memorial Hospital, and proof of liability insurance, will notify the Medical Staff Services Department of the preceptee's clinical rotation plans, Supervising Physician(s) and obtain application materials.
      a. A copy of the affiliation agreement, or training institution letter of agreement, will be reviewed to verify preceptee, Hospital, and education facility responsibilities.
      b. Sheridan Memorial Hospital will assist preceptees with housing needs to the extent dictated by the agreement between Sheridan Memorial Hospital and the preceptees' academic programs.

C. The Medical Staff Services department verifies the credentials of the preceptee to include licensure status, as required by the State of Wyoming, and in line with training program requirements.

D. Prior to a rotation, preceptees works with the Medical Student Coordinator to complete the Hospital Human Resource orientation items as necessary.
   1. Elements of this orientation include the code of conduct, emergency procedures and code designations, confidentiality agreement, background investigations consent, drug screening policy, hospital safety and blood borne pathogen training, EMR orientation, fit testing, and submission of current immunization records.

E. Preceptees will be issued Hospital name tags and are expected to wear appropriate attire during their time on-site. Preceptees are required to return their name tags at the completion of their rotation, along with keys to housing facilities offered by SMH, as instructed at orientation.

F. Hospital staff will be notified of long term preceptees, prior to the beginning of the rotation period, to include the preceptee's name, rotation description, specialty, location, training institution, program name, time frame, and Supervising Physician(s) assigned. Designated Hospital Leaders have the authority to prohibit approval of preceptees for good reason.

G. The Medical Student Coordinator or designee will provide preceptees with a tour of Sheridan Memorial Hospital facilities.

H. Supervising physicians will provide preceptees with constructive feedback on the preceptee's performance, which will include a formal written evaluation, as required by the preceptee's academic institution, as well as continuous feedback to the preceptee.

I. Observational Preceptee Experience
   1. A member of the Medical Staff may request permission, through Medical Staff Services Department, for a student to accompany him/her in their daily work.
   2. Observation within restricted areas of the hospital (e.g. Surgery, Intensive Care Unit (ICU), Women's Health (WH)) shall be at the request of the medical staff member, with approval of the Department Manager or designee.

J. Hospital staff and Departments will report any patient safety or quality of care issues involving preceptees to the Quality and Medical Staff Services Departments, who will in turn advise the Chief Medical Officer and the Chief of Staff for Medical Executive Committee review. The Chief of Staff and Chief Medical Officer will oversee the resolution of any issues that arise. Immediate action will take place to correct a situation where a preceptee's actions endanger patient care.

K. In the event that supervision is felt to be inadequate, the Chief of Staff or Department Chair will review the situation. If it is determined that the Supervising Physician failed to appropriately supervise the student, the practitioner may forfeit their ability to supervise the student at SMH/Clinics.

L. **Roles, Responsibilities, and Patient Care Activities:** The scope of the preceptees' roles, responsibilities, and patient care activities are defined by the Medical Staff and are in accordance with the preceptee's training program level of training, federal (Centers for Medicare and Medicaid Services (CMS)), Wyoming state laws, and Sheridan Memorial Hospital Bylaws, Rules and Regulations, and Policies.
   1. Appropriate to their level of training, preceptees **may evaluate patients in the hospital**, affiliated practices, outpatient departments and emergency department; make patient rounds on the units, see

appropriate consults, attend routine deliveries, and be in attendance at surgical procedures.

2. Appropriate to their level of training, preceptees may assist at surgery, and during other invasive procedures, only if the preceptee has received approval from the Supervising Physician and/or operating surgeon, based upon documented evidence of a surgical rotation and instruction during his/her academic training, and under the direct supervision and physical presence of a Supervising Physician, with appropriate privileges, and after orientation to the OR by OR staff.
3. Appropriate to their level of training, preceptees may perform medical history and physical examinations (H&Ps), as a learning experience, under the supervision of the requesting physician, or a designated member of the medical staff, who has agreed to serve as the Supervising Physician.
    a. Exceptions: Physical examinations may not be performed unless the Supervising Physician is present on critically ill patients, ICU patients, or Emergency Department patients, unless the patient's primary attending practitioner gives permission. Patients must give consent to the interview and examination.

M. **Documentation** within the **medical record** follows regulations specific to CMS and billing service regulations.

1. When physicians are billing for services, those services must have been performed by, and documented by, the billing physician, rather than the preceptee.
2. Attending and consultant physicians must document that they, rather than the preceptee, have personally performed the key components of each medical encounter.
3. Observational students are not allowed to document in the medical record.
4. Medical students year 1-4, Physician Assistant and Nurse Practitioner students who choose to document in the medical record, as a learning experience, will function under the Supervising Physician and must have the H&P and diagnostic and treatment orders submitted as proposed orders within the medical record. These proposed orders will then be reviewed and signed by the Attending or Supervising Physician, prior to being carried out, and within 24 hours. In all cases, the Supervising Physician will review, sign, and document acceptance of all orders and prescriptions with the preceptee.
5. Interns and Residents, appropriate to their level of training, may be

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in good standing at SMH
2. Be familiar with the core curriculum of the preceptee's respective program
3. Accept the responsibility for onsite supervision of preceptee
4. Evaluate all patients seen by the preceptee
5. Assure that the documentation in the patient's medical record is appropriate
6. Agree to abide by the content of this procedure and associated regulations.

P. **It is the preceptee's responsibility to communicate effectively** with his/her Supervising Physician(s) regarding the following:
1. The findings of his/her evaluation, physical examination, interpretation of diagnostic tests and intended interventions on a continuous basis
2. Any change in a patient's condition, by notifying the appropriate attending or consulting physicians

Q. Preceptees may attend Medical Staff department/committee meetings at the discretion of the Department Chair (not including executive sessions), but may not vote on matters brought before the Medical Staff.

R. Preceptees are expected to attend and participate in Medical Staff educational activities offered during their SMH clinical rotation.

IV. ATTACHMENTS:

A. None.

V. RESOURCES:

A. The Joint Commission, Medical Staff Standards MS 04.01.01
B. CMS, Department of Health and Human Services Guidelines for Teaching Physicians, Interns, and Residents
C. WY Board of Medicine Rules and Regulations
D. Sheridan Memorial Hospital Medical Staff Bylaws

VI. DISCLAIMER (As applicable):

Clinical situations may warrant adaptation due to unique patient characteristics and will be evaluated on a case by case basis.

VII. PREVIOUS VERSIONS:

A. MSA 0050 - Preceptee

allowed to dictate their findings; perform and dictate history and physical examination; write admission and discharge notes; order prescriptions; and write progress notes and orders in the medical record for both Inpatient and Outpatient areas under the following guidelines:

a. Orders are treated as standard orders, co-signed by the Supervising or Attending physician, within time limits set forth by the Hospital and CMS Rules and Regulations.

N. **All aspects of patient care are ultimately the responsibility of the Supervising or Attending Physician and involved consultants**. Appropriate to their level of training, the Supervising Physician, and/or group of Physicians, will assess the capabilities of the preceptee and assign responsibilities accordingly.

1. Attending physicians have the right to prohibit preceptee participation in the care of their patients without penalty.
2. When allowing care for their patients by preceptees, attending physicians and consultants do not relinquish their rights or responsibilities to examine and interview; admit or discharge; write orders, progress notes and discharge summaries; and obtain consultations.
3. Preceptees will work under the direct supervision of physicians who hold clinical privileges that reflect the patient care responsibilities given to the preceptee (e.g. a preceptee who is allowed to take a history and physical must be supervised by a practitioner with H&P privileges.)
4. The mechanisms by which the supervisor shall make decisions about each participant's progressive involvement and independence in specific patient care activities include:
   a. Direct observation of the preceptee by the supervisor(s)
   b. Consultation by the supervisor, with the preceptee and other caregivers working with the preceptee, regarding the preceptee's performance
   c. Review of the preceptee's documentation in patients' medical records by the supervisor
   d. Proctoring of the preceptee by the supervisor in specific patient care activities
   e. Simulation of specific patient care activities
   f. Testing the preceptee regarding specific patient care activities

O. **Qualifications of a Supervising Physician** include the following:

1. Maintain Active or Consulting Medical Staff membership and privileges

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Sheridan Memorial Hospital

Code of Conduct

1401 W. 5th Street Sheridan, Wyoming 82801 (307) 672-1000

Sheridan Memorial Hospital (SMH) prides itself in providing quality, competent, and excellent patient-centered care. To help achieve our organizational vision, we are committed to holding all members of SMH to the highest legal and ethical standards. Those SMH Members include everyone from the Board of Directors, to senior level administrative staff, physicians, vendors, and all employees.

This Code of Conduct serves as a guide to SMH Members regarding the responsibility we all share to provide quality patient-centered health care and to conduct all patient care and business activities ethically, with integrity, and consistent with applicable laws and regulations. It is also intended to help SMH Members recognize, understand, and fulfill their responsibilities in preventing and detecting violations of SMH policies and procedures, regulations, and the law.

This Code of Conduct provides a summary of the conduct expected of all SMH Members. SMH Members should also consult specific SMH policies and procedures which apply to their duties at SMH. All SMH Members are responsible for being familiar with, and abiding by, this Code of Conduct and other policies/ procedures governing their conduct at SMH.

MISSION OF THE COMPLIANCE DEPARTMENT

The Compliance Department is committed to preventing, detecting, and resolving improper, unethical, and illegal conduct, and violations of law, regulations, and policies and procedures. Through an effective Compliance Program, the Compliance Department will help maintain the integrity of the organization by requiring compliance with applicable regulations and laws and evaluating the effectiveness of the Compliance Program and any policy and procedure through independent investigations and audits.

SMH MEMBER CONDUCT

SMH Members shall adhere to the following conduct:

1. **Non-retaliation:** SMH will not take any adverse action or retribution against any employee due to the good faith reporting of a suspected violation or issue.
2. **Scope of Practice:** Conducting NO activity that is outside of your profession's scope of practice.
3. **Duty to Report Illegal and Unethical Activity:** SMH Members shall obey and report any suspected violations of the following:
   a. Federal, state, and local laws and government regulations
   b. Health system policies and procedures
   c. Organizational rules and regulations
   d. Compliance Program
   e. Code of Conduct
4. **Clinical Documentation:** All clinical professional services will be documented in the medical record, and all documentation will comply with applicable payer regulations. At a minimum, the medical record should establish medical necessity and only reflect treatment for services actually rendered.
5. **Accurate Coding and Billing:** All clinical professional services will be coded to accurately reflect the documentation in the medical record. All claims shall be submitted in compliance with applicable payer regulations or requirements.
6. **Kickbacks and Bribes:** SMH Members will not knowingly and willfully solicit, receive, offer or pay anything of value directly or indirectly, in cash or in kind, in exchange for patient referrals.
7. **Cooperation in Government Investigations:** SMH Members will not knowingly and willfully:
   a. Falsify, conceal, or cover up a material fact
   b. Make any false, fictitious, or fraudulent statement or representation, or

c. Make or use false writing or documents known to contain false, fictitious, or fraudulent statements in information submitted to the government; this includes submitting claims for services not medically necessary or not actually provided.

8. **Conspiracy to Commit Fraud:** SMH Members will not conspire to defraud any government agency or healthcare benefit program in any manner, for any reason.
9. **Emergency Medical Treatment and Active Labor Act (EMTALA):** No person shall be denied emergency medical treatment or denied medical services when in active labor, regardless of his or her ability to pay.
10. **Health Insurance Portability and Accountability Act (HIPAA):** SMH Members shall not disclose any protected health information without proper consent from the patient, for any purpose outside of treatment, payment, or hospital operations.
11. **Other Applicable Laws, Regulations, Policies and Procedures:** SMH Members shall be familiar with, and abide by, other laws, regulations, policies and procedures governing their conduct at SMH.

REPORTING VIOLATIONS

SMH Members should feel confident in reporting any transaction or conduct which is, or may be a violation of any SMH policies and procedures, this Code of Conduct, or any federal, state or local law. For compliance issues, employees may report concerns to any of the following resources:

- Immediate supervisor
- Compliance Officer at 675-2669, or by email at: compliance@sheridanhospital.org
- Anonymous Reporting Hotline: 307-673-2410
- Mail: Attn: Compliance Officer
  1401 W 5th Street
  Sheridan, WY 82801

Any good faith reports regarding violations of SMH policies and procedures, this Code of conduct, and any federal, state, or local law are subject to SMH's policy on Non-Retaliation. It is important to note, however, that any abuse of this system to knowingly report false information subjects the employee to disciplinary action. Failure to follow SMH policies and procedures, this Code of Conduct and any federal, state, or local law may be grounds for disciplinary action.

Anyone, including SMH Members, may use the anonymous reporting hotline for any known or perceived violations of this Code of Conduct, or any SMH policy and procedure, or any federal, state or local laws.

CONFIDENTIALITY

At the request of the reporting party, and to the extent we are able, we will maintain the anonymity of the person who reports the violation. However, when the law compels us to do so, we will disclose the identity of the reporting party.

CONCLUSION

This Code of Conduct is about both empowerment to do the right thing, and accountability when errors are found. SMH Members are expected to take the initiative and obtain answers for their questions. No concern is too small or unimportant if it is believed to involve violations of SMH policies and procedures, regulations, or the law.

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ATTESTATION / ACKNOWLEDGMENT

My signature below acknowledges that I have read and reviewed this Code of Conduct and that I understand and agree to comply with the standards contained therein and all related policies and procedures. I acknowledge that the Code of Conduct is only a statement of principles for individual and business conduct, and does not constitute an employment contract. I will report any potential violation of which I become aware promptly to my Manager / Supervisor or the Compliance Officer. I understand that any violation of Sheridan Memorial Hospital policies, this Code of conduct, and any federal, state, or local law may be grounds for disciplinary action.

_____ _____

Employee Signature Date

Sheridan Memorial Hospital
Taking Your Health to Heart

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EMPLOYEE HEALTH SURVEY / IMMUNIZATION STATUS

Name: _____ **Date**: ____/_____/_____

Date of Birth: ____/____/_____ **Department**: _____

Health Questionnaire:

1. **Have you had or do you have…** *(If you do not know, please leave unanswered)*

   a. HIV Infection..... ☐ Yes ☐ No
   b. Hepatitis B..... ☐ Yes ☐ No
   c. Hepatitis C..... ☐ Yes ☐ No
   d. Cirrhosis ..... ☐ Yes ☐ No
   e. Splenectomy ..... ☐ Yes ☐ No
   f. Congenital Immunodeficiency ..... ☐ Yes ☐ No
   g. Leukemia ..... ☐ Yes ☐ No
   h. Lymphoma..... ☐ Yes ☐ No
   i. Measles..... ☐ Yes ☐ No
   j. Mumps..... ☐ Yes ☐ No
   k. Rubella..... ☐ Yes ☐ No
   l. Chickenpox..... ☐ Yes ☐ No
   m. If you have NOT had chickenpox were you exposed to a sibling or child with chickenpox?..... ☐ Yes ☐ No
   n. Please list below any other infection control-related conditions, illnesses, or treatments:

      _____

2. Vaccine History: **Have you had the following vaccines and/or titers?** (*Please attach documentation of immunization or immunity for vaccines you have received.*)

   a. Measles, Mumps, and Rubella (MMR) ..... ☐ Yes ☐ No
   b. MMR titer..... ☐ Yes ☐ No
   c. Hepatitis B Vaccine (HBV)..... ☐ Yes ☐ No
   d. HBV Titer..... ☐ Yes ☐ No
   e. Varicella Zoster (Chickenpox) ..... ☐ Yes ☐ No
   f. Laboratory Evidence of Varicella Immunity..... ☐ Yes ☐ No
   g. Recent Vaccine (Smallpox)..... ☐ Yes ☐ No

   h. Other Vaccines or Titers: _____

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3. TB Protection History: **Have you had …**
   a. TB test in the last 12 months *(Provide Documentation)* ... ☐ Yes ☐ No
   b. BCG vaccine for TB ..... ☐ Yes ☐ No
   c. Been fitted for an N95 Mask..... ☐ Yes ☐ No
   d. Had changes in weight for facial shape since fitting ..... ☐ Yes ☐ No
   e. Had a history of TB disease ..... ☐ Yes ☐ No
   f. Had a positive TB test ..... ☐ Yes ☐ No
   g. Received treatment for a positive TB test or TB ..... ☐ Yes ☐ No

   Please Describe Treatment: _____

   _____

3. **Are you allergic to latex?**..... ☐ Yes ☐ No

4. **Please list and describe anything else you want the hospital to know about your health?**_____

   _____

Please be aware that all employee health information is kept confidential under HIPAA and OSHA regulations.

You are responsible for updating your health information as it changes.

Employee Signature: _____ **Date: ____/____/_____**

Reviewed by: _____ **Date: ____/____/_____**

Sheridan Memorial Hospital
Taking Your Health to Heart

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Attachment C

FACILITIES OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

Name: _____ (Please Print) Department: _____

Date: _____ Weight: _____ lbs. Age: _____ Sex: _____ Height: _____

Job Title: _____

The type of respirator you will use is: half and/or full face-piece type

Have you worn a respirator? ☐ Yes ☐ No
If yes, what type? _____

Questions 1 through 9 below must be answered by every employee who has been selected to wear any type of respirator.

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. 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 problems about which you have been told? ☐ Yes ☐ No
      Explain: _____

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, 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 about which you have been told ☐ 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 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

7. Do you currently take medication for any of the following problems?
a. Breathing or lung problems ☐ Yes ☐ No
b. Heart problems ☐ Yes ☐ No
c. Blood pressure ☐ Yes ☐ No
d. Seizures ☐ Yes ☐ No

8. If you have used a respirator, have you had any of the following problems? If you have never used a respirator, 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 healthcare professional who will review this questionnaire about your answers to this questionnaire? ☐ Yes ☐ No

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator.

10. Have you ever lost vision in either eye (temporarily or permanently): ☐ Yes ☐ No

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11. Do you currently have any of the following vision problems?
    a. Wear contact lenses: ☐ Yes ☐ No
    b. Wear glasses: ☐ Yes ☐ No
    c. Color blind: ☐ Yes ☐ No
    d. Any other eye or vision problem: ☐ Yes ☐ No

12. Have you ever had an injury to your ears, including a broken eardrum: ☐ Yes ☐ No

13. Do you currently have any of the following hearing problems?
    a. Difficulty hearing: ☐ Yes ☐ No
    b. Wear a hearing aid: ☐ Yes ☐ No
    c. Any other hearing or ear problem: ☐ Yes ☐ No

14. Have you ever had a back injury: ☐ Yes ☐ No

15. Do you currently have any of the following musculoskeletal problems?
    a. Weakness in any of your arms, hands, legs, or feet: ☐ Yes ☐ No
    b. Back pain: ☐ Yes ☐ No
    c. Difficulty fully moving your arms and legs: ☐ Yes ☐ No
    d. Pain or stiffness when you lean forward or backward at the waist: ☐ Yes ☐ No
    e. Difficulty fully moving your head up or down: ☐ Yes ☐ No
    f. Difficulty fully moving your head side to side: ☐ Yes ☐ No
    g. Difficulty bending at your knees: ☐ Yes ☐ No
    h. Difficulty squatting to the ground: ☐ Yes ☐ No
    i. Climbing a flight of stairs or a ladder carrying more than 25 lbs: ☐ Yes ☐ No
    j. Any other muscle or skeletal problem that interferes with using a respirator: ☐ Yes ☐ No

_____ _____
Physician/Designee Signature Employee Signature

_____ _____
Date Date

For Infection Control Only:

Questionnaire review: ☐ No medical exceptions note. No additional medical follow-up indicated. Employee medically able to wear half and full face tight fitting masks.
☐ Yes, medical exceptions noted. **(Request for medical clearance for respirator use form to physician).**

Date: _____ Physician: _____

Date Response Received: _____

Employee is medically exempt from wearing respirator. ☐ Yes ☐ No
(Medical Clearance form attached).

2/2010

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TUBERCULOSIS RISK SCREENING QUESTIONNAIRE

Today's Date: _____ (Information will remain confidential)

EMPLOYEE INFORMATION

Name: _____ Job Title: _____ Gender: _____

Date of Birth: _____Birth Place: ☐ United States ☐ Other (please identify country) _____

Address: _____ City: _____ State: _____ Zip: _____

Primary phone/contact number: _____ Work extension: _____

Ethnicity: ☐ Non-Hispanic/Latino ☐ Hispanic/Latino

Race: ☐ White ☐ Black/African American ☐ Native American/Alaskan Native ☐ Asian ☐ Unknown ☐ Other_____

PREVIOUS TB SCREENING AND/OR TREATMENT

Have you ever had a TB skin test (or IGRA): ☐ YES ☐ NO Date of last test _____ Result: ☐ Positive ☐ Negative

Have you ever received treatment for TB infection or disease: ☐ YES ☐ NO If **YES**, provide dates (including start/stop dates), location, and medications of treatment: _____

Have you had vaccine for TB (BCG): ☐ YES ☐ NO If **YES**, provide country and date of vaccine: _____

Note: This vaccine is not given in the United States

In the last 30 days, have you had a live viral vaccine (e.g. MMR, Chickenpox, Flu, or Yellow Fever)? ☐ YES ☐ NO Date: _____

TB SYMPTOM REVIEW

Symptom assessment conducted annually serves as a review for all employees

Pulmonary TB System Assessment					
Yes	**No**	Signs and Symptoms	**Yes**	**No**	Signs and Symptoms
		Prolonged cough (>2-3 weeks) with or without production of sputum that might be bloody			Diagnosis of community-acquired pneumonia that has not improved after 7 days of treatment
		Chest pain			Unexplained weight loss
		Chills			Weakness or easily fatigued
		Unexplained fevers			Loss of appetite
		Night sweats			Other _____

If you answered **YES** to any of the above questions, please explain in more detail: _____

_____

_____

Yes	No	Have You Been Employed In Any of the Following (if YES, indicate facility including state)
		Correctional/Detention _____
		Hospital/Health Care _____
		Homeless Shelter _____
		Long Term Care _____
		Mental Health _____
		Other _____

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Yes	No	Behavioral Risk (please identify country or facility as necessary)
		Have you ever been a patient in a high-risk congregate setting (Long-term care facilities, mental institutions)?
		Have you ever been confined or incarcerated in a detention or correctional facility?
		Have you ever been homeless or lived in a homeless shelter?
		Have you ever used illicit or recreational drugs?
Yes	**No**	**Travel Risk**
		Do you spend a significant amount of time with someone who was born outside of the United States? **If NO, skip to Contact Investigation. If YES, What country is the person from you spend significant time with:**_____
		Have you traveled in a high risk country (Latin America, the Caribbean, Africa, Asia, Eastern Europe, Russia)? Please specify
		While traveling outside the United States did you routinely have contact with hospital, prison, or homeless populations?
		While traveling outside the United States did you do mission, healthcare, or disaster relief work?

Please indicate: Year (s) of travel _____

Duration of stay _____

Yes	No	Contact Investigation
		Have you been exposed to, or are you involved in a contact investigation for someone with TB? If **YES,** please provide dates and details _____ _____

Presence of the following clinical conditions or immunocompromising conditions can increase the risk for progression to active TB disease if already infected with latent TB.

Yes	No	Clinical/Immunocompromising Conditions	Description
		HIV Infection	
		Silicosis	
		Diabetes Mellitus	
		Chronic renal failure/end-stage renal disease	
		Hematologic/reticuloendothelial disease	
		Cancer of the head, neck, or lung	
		Low body weight (10% or more below ideal body weight)	
		Prolonged corticosteroid use	
		Other immunosuppressive therapy (e.g. prednisone or tumor necrosis factor-alpha antagonists)	
		Organ transplantation	
		Intestinal bypass or gastrectomy	
		Chest radiograph findings suggestive of previous TB infection	

Employee Certification

I hereby certify that the answers that I have given on the Tuberculosis Risk Screening Questionnaire are true to the best of my knowledge. I understand that this information is used by my employer to assess risk for TB infection/disease and that I may be asked to complete further follow-up, including TB testing, based on my answers on this form.

Employee Signature: _____ Date: _____

For Employee Health Only:	
	No Risk Identified – No Test Required
	Risk Identified – Testing Needed: ☐ PPD Appointment _____ ☐ IGRA Lab Request Faxed _____
	Other Follow-Up Needed:_____

Nurse Signature: _____ Date: _____