Sheridan Memorial Hospital
Taking Your Health to Heart

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: _____

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
COMPLIANCE PROGRAM

CODE OF CONDUCT ACKNOWLEDGEMENT

The effectiveness of the Sheridan Memorial Hospital Compliance Program depends upon the willing and complete participation of all employees.

All employees, as a condition of their employment, are required to comply with all policies and standards of Sheridan Memorial Hospital. Sheridan Memorial Hospital has implemented a Compliance Program representing its commitment to compliance with all billing and claims submission, fraud and abuse laws and regulations. All employees are therefore expected to comply with the policies of the Compliance Program which includes, but is not limited to:

- Attending and/or completing all required education and training relating to the Compliance Program.
- Being aware of all procedures of the Compliance Program, including the mandatory duty of all employees to report actual, or potential, violations of all billing and claims submission fraud and abuse laws and regulations.
- Understanding and adhering to the policies of the Compliance Program, especially those which relate to the employee's functions within Sheridan Memorial Hospital whether the policies are Compliance Program specific or departmental/facility specific.

To document the facility's efforts with respect to education and training of employees as to the Compliance Program, employees shall acknowledge in writing their acceptance and understanding of the program and its requirements.

Failure to follow the policies of Sheridan Memorial Hospital's Compliance Program (including the duty to report misconduct) may be cause for disciplinary action, up to and including termination of employment.

I hereby acknowledge that I will complete all required HIPPA, Corporate or Professional Compliance Education and agree to abide by Sheridan Memorial Hospital's Compliance Program and its Code of Conduct.

		N/A	
Print Name	**Signature**	**ID#**	**Date**

SMH
Personnel Form: Non-Employees

Name:		**DOB:**
Mailing Address:		
City:	**State:**	**Zip:**
Physical Address		
City:	**State:**	**Zip:**
Email Address:		
Home Phone:	**Cell Phone:**	

Category:

☐ Medical Student Year: _____

☐ PA or NP Student Year: _____

☐ Resident Physician Year: _____

☐ Health Science Student

☐ Job Shadow/ High School Student (Observation)

Specialty: _____

School/Organization (if applicable): _____

Dates onsite at SMH: _____

Participant Signature: _____ Date: _____

Sheridan Memorial Hospital

CONFIDENTIALITY AGREEMENT

Sheridan Memorial Hospital (SMH) recognizes the importance of the protection of confidential information concerning patients, their families, medical staff, co-workers and the operations of the Hospital. It is the intent of Sheridan Memorial Hospital and the undersigned individual to maintain the privacy of Protected Health Information (PHI) in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the privacy regulations published by the U.S. Department of Health and Human Services (DHHS), and any other applicable State and Federal laws and/or regulatory agency rules and regulations.

"Confidential Information" denotes **all information** acquired by an individual in the course and scope of their employment and/or their association with Sheridan Memorial Hospital whether that information is obtained by discussion (direct or overheard), consultation, examination, treatment, and or direct access to records.

It is the obligation of the undersigned individual to maintain the confidentiality and privacy of PHI to the best of their ability and to divulge/share only the minimum amount of PHI necessary for another authorized individual with a valid "need to know" to do their assigned tasks.

As a member of Sheridan Memorial Hospital's workforce, 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.

I have read and agree to adhere to the conditions of this confidentiality agreement. 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

Taking Your Health to Heart

Employee Emergency Information

Employee Name: _____Date:_____

Whom should we call in case of emergency?

Name of person to contact?_____

Phone Number:_____ Alternate Phone Number:_____

Address (Optional):_____

Relation to Employee:_____

If we cannot reach the person above, whom should we call?

Name of person to contact:_____

Phone Number:_____ Alternate Phone Number:_____

Address (Optional):_____

Relation to Employee:_____

Consider wearing a medical alert bracelet if you have any medical conditions or allergies to medication that should be made known to emergency personnel.

Physician Name: (Optional)_____Physician Phone:_____

_____ _____

Employee Signature Date

Sheridan Memorial Hospital
Taking Your Health to Heart

Name Badge Request

_____ / _____

Name to appear on name badge *(Please print)*

Full Name *(first & last)*

_____

Position Title

Examples: Registered Nurse
CNA
Phlebotomist
Nutrition Serv. Aide

_____ _____

Employee Signature **Date**

For non-employee authorization-HR Use Only

Department (Check all that apply)

- ☐ **No Security Access Needed** *(ID Only)*
- ☐ **Cath Lab**
- ☐ **Emergency Department**
- ☐ **Facilities**
- ☐ **ICU**
- ☐ **Information Technology**
- ☐ **Lab**
- ☐ **Medical/Surgical**
- ☐ **Outside Doors Only**
- ☐ **Medical Arts Complex (MAC)**
- ☐ **Radiology**
- ☐ **Pediatrics**
- ☐ **Surgical Services**
- ☐ **Welch Cancer Center** *(Mechanical)*
- ☐ **Welch Cancer Center** *(Outside Doors)*
- ☐ **Women's Health**
- ☐ **Other:** _____
  (please indicate area)

_____ _____

Manager Signature **Date**

Office Use Only:

Employee #: _____ **User ID:** _____

Security Card #: _____ **Date Card Printed:** _____

Access Level #: _____ **Date Security Levels Entered:** _____

Authorized Payroll Deduction: ☐ **Yes** ☐ **No**

Rev. 3.1.16

Sheridan Memorial Hospital

POLICY ACKNOWLEDGEMENT

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 *(Assigned by P&P)*	Title **Medical Staff Preceptees Application, Roles, Responsibilities, and Patient Care Activities**			
Departments Affected: *Hospital-wide*		Effective Date 00/00/00	Revision Date 00/00/00	Review Date 00/00/00	Page 1 of 6
Approvals: Medical Executive Committee – 11/30/2016		Policy Author: Medical Staff Services Manager			

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

II. DEFINITIONS:

1. **Preceptee** – a practitioner trainee or student who is doing a clinical rotation at Sheridan Memorial Hospital (SMH), and who is affiliated with an ongoing approved training program. Preceptees include Medical Students: Pre-Clinical MS year 1&2 and for-credit MS year 3-4; physician interns, residents and physician assistant & nurse practitioner students.
2. **Supervising Physician** – one or a group of physicians (ie 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.
3. **Supervision** – all practice is performed under the direction of the overseeing medical staff member or their designee and in accordance with the Medical Staff Bylaws, Rules and Regulations.
4. **Observational Preceptees** include high school students who are enrolled in a training program with a school agreement and proof of liability insurance and wish to observe a SMH privileged physician, physician assistant or nurse practitioner at Sheridan Memorial Hospital. 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.
5. **Clinical Preceptees** include Clinical year 1-4 medical students, physician assistant, nurse practitioner students, or physician intern, or resident, 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 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:

1. 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.
2. Preceptees must be associated with academic programs that have a formal written affiliation agreement with Sheridan Memorial Hospital as a clinical training site.
   a. 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.
      i. 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.
3. 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.
4. Prior to a rotation, preceptees works with the Medical Student Coordinator to complete the Hospital Human Resource orientation items as necessary.
   a. Element of this orientation include adhering to the code of conduct, emergency procedures and code designations, confidentiality agreement, background investigations consent, drug screening policy, hospital safety and bloodborne pathogen training, EMR orientation, fit testing and submission of current immunization records.
5. 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.
6. 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.

7. The Medical Student Coordinator or designee will provide preceptees with a tour of Sheridan Memorial Hospital facilities.
8. 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.
9. Observational Preceptee Experience
   a. 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.
   b. Observation within restricted areas of the hospital (e.g. surgery, ICU, WH) shall be at the request of the medical staff member, with approval of the Department Manager or designee.
10. Hospital staff and Departments will report any patient safety or quality of care issues involving preceptees to the Quality and Medical Staff Services Department, 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.
11. 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.
12. **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 (CMS), Wyoming state laws and Sheridan Memorial Hospital Bylaws, Rules and Regulations, and Policies.
    a. 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.

b. 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.
c. Appropriate to their level of training, preceptees may perform medical history and physical examinations 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.
    i. 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.

13. *Documentation* within the **medical record** follows regulations specific to CMS and billing service regulations.
    a. When physicians are billing for services, those services must have been performed by and documented by the billing physician rather than the preceptee.
    b. Attending and consultant physicians must document that they, rather than the preceptee, have personally performed the key components of each medical encounter.
    c. Observational students are not allowed to document in the medical record.
    d. 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, 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.
    e. Interns and Residents, appropriate to their level of training, may be 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:

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

14. **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.
    a. Attending physicians have the right to prohibit preceptee participation in the care of their patients without penalty.
    b. 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; obtain consultations.
    c. 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.)
    d. The mechanisms by which the supervisor shall make decisions about each participant's progressive involvement and independence in specific patient care activities include:
        i. Direct observation of the preceptee by the supervisor(s),
        ii. Consultation by the supervisor with the preceptee and other caregivers working with the preceptee regarding the preceptee's performance,
        iii. Review of the preceptee's documentation in patients' medical records by the supervisor,
        iv. Proctoring of the preceptee by the supervisor in specific patient care activities,
        v. Simulation of specific patient care activities,
        vi. Testing the preceptee regarding specific patient care activities.
15. **Qualifications of a Supervising Physician** include the following:
    a. Maintain Active or Consulting Medical Staff membership and privileges in good standing at SMH,

b. Be familiar with the core curriculum of the preceptee's respective program,
c. Accept the responsibility for onsite supervision of preceptee,
d. Evaluate all patients seen by the preceptee,
e. Assure that the documentation in the patient's medical record is appropriate,
f. Agrees to abide by the content of this procedure and associated regulations.

16. **It is the preceptee's responsibility to communicate effectively** with his/her Supervising Physician(s) regarding the following:
    a. The findings of his/her evaluation, physical examination, interpretation of diagnostic tests and intended interventions on a continuous basis,
    b. Notify the appropriate attending or consulting physicians of any change in a patient's condition
17. 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.
18. Preceptees are expected to attend and participate in Medical Staff educational activities offered during their SMH clinical rotation.

IV. ATTACHMENTS:

V. RESOURCES:

1. The Joint Commission, Medical Staff Standards MS 04.01.01
2. CMS, Department of Health and Human Services Guidelines for Teaching Physicians, Interns, and Residents
3. WY Board of Medicine Rules and Regulations
4. 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.

Sheridan Memorial Hospital
Taking Your Health to Heart

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

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

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 _____

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: _____