University Hospitals
Employee Health

January 19, 2024

Dear Physician,

Congratulations on your offer of employment through the University Hospitals Health System (UH). We hope your experience here will be positive and rewarding!

In an effort to streamline the required Employee Health assessment process, we ask for your participation in the following steps before your visit with Employee Health:

1) **Schedule an appointment:**
    a. Use this link to schedule your appointment. You may use any available Employee Health site: https://www.uhhospitals.org/health-information/classes-and-events?page=1&event=67&showhiddenevents=true
    b. Need help? Call 1-866-789-8424, option 1 Monday-Friday 7a-5p to reschedule your appointment or for other assistance with scheduling.
    c. If you live outside of the USA and cannot use the link or call: Contact EHRecords@uhhospitals.org with your preferred date/time/location and the Employee Health team will assist you.
2) **Complete onboarding forms:** Email completed forms and any supporting records to EHRecords@uhhospitals.org a week before your assessment so that your profile can be made in the Employee Health system. These include:
    a. Employee Registration Form
    b. Post-Offer Health Assessment Form
    c. Respirator Medical Evaluation Questionnaire
    d. TB Positive Test Questionnaire *(Only if you've ever had a positive TB Test)*
        i. Please also send a copy of your most recent chest film result
    e. Vaccine records including MMR, Varicella, COVID-19, TDaP and Hepatitis B (as available).
3) **Have your labs drawn:** A lab requisition along with available sites is included in your onboarding packet.
    a. Print the requisition and complete the top right section with your name, social security number, sex and date of birth as highlighted in green. Take the requisition with you to a UH lab.
    b. Your labs must be completed Monday-Friday as the T-spot (TB) test has to be processed offsite. Plan to have these labs draw at least two days before your assessment if you are able.
        i. If you are not in the Cleveland area prior to your assessment, labs can be done after you complete your assessment with Employee Health.

On the day of your visit with Employee Health, you can expect the following:

1) **Assessment:** Review of your health history, blood pressure screen, color vision screen, and drug screen.
2) **Fit Testing:** Come to your assessment clean shaven unless your facial hair is religious in nature.

Welcome to University Hospitals,

Meredith J. Walters, CNP

Meredith J. Walters, DNP, MSN, FNP-BC
Manager, Employee Health

University Hospitals
Employee Health

Tips for Your Appointment with Employee Health

Bring a photo ID, send your records as noted above to EHRecords@uhhospitals.org. You do not have to fast for this appointment however you will need to complete a urine drug screen. You will need to be clean shaven for your fit test unless your beard is religious in nature.

Checklist for Planning

Completed	Requirement
	Employee Registration Form
	Post-Offer Health Assessment Form
	Respiratory Medical Evaluation Questionnaire
	Hepatitis B Vaccine Series (2 or 3 vaccine series accepted)
	Hepatitis B Surface Antibody
	Hepatitis B Surface Antigen
	Rubeola (Measles) IgG or MMR Vaccine Series
	Mumps IgG or MMR Vaccine Series
	Rubella IgG or MMR Vaccine Series
	Varicella IgG or Varicella Vaccine Series
	TDaP Vaccine
	COVID-19 Vaccine (exemptions discussed at time of assessment)
	TB Test: T-spot or two step skin test within the last 6 months
	TB Positive Test Questionnaire (if needed)
	Chest Film within the last 6 months (if needed will provide at time of assessment)

How to Find Employee Health

Most Employee Health locations are within the hospitals and/or by address which can be entered into your GPS. In most cases, the information desk can point you in the correct direction. For Cleveland and Geauga Medical Centers, please see the additional details below to assist you.

Cleveland: Park in the Visitor's Garage next to Rainbow Babies and Children's Hospital (The garage address is **2121 Adelbert Road Cleveland OH 44106**). Proceed to the front of Rainbow Babies and Children's Hospital (next to the garage). Stop at the front desk and ask for a map to Employee Health which is on the 4th floor of the MCCO building.

Geauga: 12475 Hospital Dr. Room 5 Chardon, OH 44024 Turn in at the sign for the Emergency Department. You will see sets of small office buildings. Employee Health is in Building 2 which looks like a house and is closest to the Emergency Department. You can park in the lot there, walk in and ask for the Employee Health nurse.

University Hospitals
Employee Health

Registration Form

Last Name _____ **First Name** _____ **Middle Name** _____

Alternative Name _____ **Social Security Number** _____ **Date of Birth** _____ (mm/dd/yyyy)

Mailing Address _____ **City** _____ **State** _____ **Zip Code** _____

Home Phone

Cell Phone _____ (please provide mobile phone where you can receive reminders)

Cell Phone Carrier

- ○ AT&T
- ○ T-Mobile
- ○ Verizon
- ○ Other (please list) _____

Email address (where you can receive appointment reminders/communication on lab results _____

Facility where you will work (ie. Cleveland Medical Center) _____

Department (ie. Cardiology) _____

Position (selection one option below)

- ○ Credentialed provider (non-trainee) including physician, nurse practitioner, physician assistant
- ○ Fellow
- ○ Resident
- ○ Employee (list job) _____
- ○ Student
- ○ Volunteer
- ○ Contractor

Have you ever been employed through University Hospitals Health System?

- ○ No
- ○ Yes - Position _____

Date of employment _____

REVISED
2:41 pm, Mar 23, 2023

RESIDENTS & FELLOWS

University Hospitals

Name _____

SSN/MRN _____

Sex: *(circle)* Male Female

DOB: (mm/dd/yyyy) _____

LABORATORY REQUISITION

Location

- [x] Cleveland Employee Health
- [ ] Elyria Employee Health
- [ ] Geauga Employee Health
- [ ] Mentor Employee Health
- [ ] Orange Place Employee Health
- [ ] Parma Employee Health
- [ ] Portage Employee Health
- [ ] St. John Employee Health
- [ ] Beachwood Occupational Health
- [ ] Chardon Occupational Health
- [ ] Mentor Occupational Health
- [ ] Parma Occupational Health
- [ ] Samaritan Occupational Health
- [ ] Streetsboro Occupational Health
- [ ] Volunteer Services Employee Health

Date _____ Collection Time _____ Call Results to # _____

Medical Director: Sean McNeeley, MD Submitted by _____

Other Ordering Provider (Name/Signature) _____

ORDER USING REQUISITION ENTRY

Needlestick Exposure
Source Patient

- [ ] Rapid HIV or HIV ½ antigen/antibody screen with reflex to confirmation

Call back number for results:

- [ ] Hepatitis B Surface Antigen
- [ ] Hepatitis C Antibody

Employee

- [ ] Rapid HIV or HIV ½ antigen/antibody screen with reflex to confirmation
- [ ] Hepatitis B Surface Antibody
- [ ] Hepatitis B Surface Antigen
- [ ] Hepatitis C Antibody
- [ ] HIV RNA, Quantitative, PCR (if indicated per protocol)
- [ ] Hepatitis C RNA, Quantitative, PCR (if indicated per protocol)

Post Exposure Prophylaxis

- [ ] Human Chorionic Gonadotropin, Serum Quantitative (aka HCG) Females only
- [ ] CBC and Auto Differential
- [ ] Comprehensive Metabolic Panel (aka CMP)

Tube color may vary between laboratory locations
Contact your local laboratory for collection requirements

Onboarding Labs

- [x] Mumps Antibody IGG
- [x] Rubeola Antibody IGG
- [x] Rubella Antibody IGG
- [x] Varicella Zoster Antibody IGG
- [x] Hepatitis B Surface Antibody
- [x] Latex IgE
- [x] T-Spot TB

For Credentialing/Dialysis

- [x] Hepatitis B Surface Antigen

VALID FOR 2024 SEASON

Signed protocol orders are on file in Employee Health

EMPLOYEE HEALTH

503886 (11/2023) **Distribution:** **WHITE - Laboratory Copy** **CANARY - Tracking Copy**

EMPLOYEE HEALTH

TB POSITIVE HISTORY QUESTIONNAIRE

Name: _____ Patient ID: _____ DOB: _____

Department: _____ Job: _____

Last Positive PPD Skin Test: _____
Performed By: _____ Date Performed: _____

Last Positive IGRA Blood Test: _____
Performed By: _____ Date Performed: _____

Exam Date: _____ Reason for Exam: _____ ☐ Recent Converter

Last Chest X-ray: _____ Result/Comment: _____

☐ Treatment Medication: _____ Comment: _____

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS?

	Yes	No
Prolonged Productive cough	☐	☐
Night Sweats	☐	☐
Weight Loss	☐	☐
Unexplained Fever	☐	☐
Bloody Sputum	☐	☐
Weakness/Fatigue	☐	☐

Date symptoms were first detected: _____

Comments:

_____ _____ _____
Person Obtaining the Information Signature Date

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UH Lab Services

If you are unable to complete your lab work today, **scan the QR code below** for a list of UH laboratory locations or type the web address into your browser.

Once you select a lab location, call to verify that they can perform your required labs, hours of operation.

If a T-spot TB test is ordered for you, these cannot be done on a Saturday or Sunday, please plan accordingly.

https://www.uhhospitals.org/locations/search-results?q=&type=9&page=1

MW: S-drive UHLabServicesPoster
8/2023

University Hospitals

Employee Health Services

Post-Offer Health Assessment Form

Personal Data

Name (First, M, Last) _____ **Maiden Name**_____

Date of birth: _____ **Age:** _____ **Country of Birth:** _____

UH Job Title and Department _____

Primary Work Location _____

Will you be working entirely remotely**?** _____

Do you have a primary care provider? Yes ☐ No ☐

If no, information about options available to you will be provided at time of your assessment.

Review of Systems

Can you do the essential functions of your job without reasonable accommodation? Yes ☐ No ☐

If you answered "No" and an accommodation is needed, be prepared to present documentation to Employee Health within 2 weeks of your onboarding assessment for further review.

Do you have any of the following?

- ☐ Dizziness/Vertigo
- ☐ Seizure
- ☐ Head injury
- ☐ Stroke
- ☐ Migraines
- ☐ Eye problems
- ☐ Wear glasses/contacts
- ☐ Problem with color vision
- ☐ Hearing loss
- ☐ Cough/shortness of breath
- ☐ Asthma/COPD
- ☐ Heart disease/Heart attack
- ☐ Irregular/skipped heart beats
- ☐ High blood pressure
- ☐ Chest pain/tightness
- ☐ Hepatitis
- ☐ Unexplained weight loss/gain
- ☐ Diabetes or thyroid disease
- ☐ Numbness/tingling in arms/hands
- ☐ Numbness/tingling in legs/feet
- ☐ Neck/back pain
- ☐ Back injuries/ruptured discs
- ☐ Joint pain/swelling/arthritis
- ☐ Skin problems (rash, eczema, psoriasis)
- ☐ Untreated mental health disorder
- ☐ Immunocompromised condition

Have you had any hospital stays or Emergency Dept. visits in the last year? Yes ☐ No ☐

If yes, please explain:

Do you take any prescription, over-the-counter, or herbal medications? Yes ☐ No ☐

If yes, please list

Do you use any products containing nicotine, including nicotine replacement therapy ? Yes ☐ No ☐

Do you drink alcohol? If yes, please list number of drinks per week Yes ☐ No ☐

Have you had any work-related injuries, chemical or body fluid exposures? Yes ☐ No ☐

If yes, please list

If you have any restrictions related to a Workers' Compensation claim, you will be asked to present documentation within 2 weeks of your onboarding assessment.

RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE
Part A

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, Patient ID:_____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 healthcare 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. (please print)

1. Today's Date: _____ 2. Your Name: _____
3. Your age (to nearest year): ____ 4. Sex: ☐ Male ☐ Female
5. Your height: _____ ft. _____ in. 6. Your weight: _____ lbs.
7. Your job title: _____ Job title not in list: _____
8. A phone number where you can be reached by the healthcare 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):
    a. ☐ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
    b. ☐ Other type (for example, half- or full-face piece 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.

	Yes	No
1. Do you *currently* smoke tobacco, or have you smoked tobacco in the last month?	☐	☐
2. Have you *ever had* any of the following 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. Have you *ever had* any of 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. Do you *currently* have any of 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 or incline:	☐	☐
c. Shortness of breath when walking with other people at an ordinary pace or 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:	☐	☐

Part A. Section 2. (Mandatory) (Continued)

	Yes	No
5. Have you *ever had* any of 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. Have you *ever had* any of the following cardiovascular or heart problems?		
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. Do you *currently* take medication for any of the following problems?		
a. Breathing or lung problems:	☐	☐
b. Heart trouble:	☐	☐
c. Blood pressure:	☐	☐
d. Seizures (fits):	☐	☐
8. If you've used a respirator, have you *ever had* any of the following problems?		
a. Eye irritation:	☐	☐
b. Skin allergies or rashes:	☐	☐
c. Anxiety:	☐	☐
d. General weakness or fatigue:	☐	☐
e. Any other problem that interferes with your use of a respirator:	☐	☐
9. Would you like to talk to the healthcare professional who will review this questionnaire about your answers to this questionnaire?	☐	☐

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-face piece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

		Yes	No
10	Have you *ever lost* vision in either eye (temporarily or permanently)?	☐	☐
11	Do you *currently* have any of the following vision problems?		
	a. Wear contact lenses:	☐	☐
	b. Wear glasses:	☐	☐
	c. Color blind:	☐	☐
	d. Any other eye or vision problem:	☐	☐
12.	Have you *ever had* an injury to your ears, including a broken ear drum?	☐	☐
13.	Do you *currently* have any of the following hearing problems?		
	a. Difficulty hearing:	☐	☐
	b. Wear a hearing aid:	☐	☐
	c. Any other hearing or ear problem:	☐	☐
14.	Have you *ever had* a back injury?	☐	☐
15.	Do you *currently* have any of the following musculoskeletal problems?		
	a. Weakness in any of your arms, hands, legs, or feet:	☐	☐
	b. Back pain:	☐	☐
	c. Difficulty fully moving your arms and legs:	☐	☐
	d. Pain or stiffness when you lean forward or backward at the waist:	☐	☐
	e. Difficulty fully moving your head up or down:	☐	☐
	f. Difficulty fully moving your head side to side:	☐	☐
	g. Difficulty bending at your knees:	☐	☐
	h. Difficulty squatting to the ground:	☐	☐
	i. Climbing a flight of stairs or a ladder carrying more than 25 lbs:	☐	☐
	j. Any other muscle or skeletal problem that interferes with using a respirator:	☐	☐

Examiner Comments:

Vaccination History

All employees, regardless of work site, need to complete this section. New employees not working remotely must present vaccine documentation at the time of your onboarding assessment

Have you had:	**Yes**	**No**	**Unsure**
The MMR vaccine (measles, mumps, rubella)?	☐	☐	☐
The disease chicken pox, shingles or the chicken pox vaccine (varicella)?	☐	☐	☐
The TDaP (tetanus, diphtheria, pertussis) vaccine within the last 10 years?	☐	☐	☐
The Hepatitis B vaccination series? (this is a series of 2-3 injections spaced several months apart)	☐	☐	☐
*The current season's COVID-19 vaccine?	☐	☐	☐
*The current season's Flu vaccine?	☐	☐	☐

*The current season is the period from August to April of the following year (example August 2020 to April 2021)

I hereby certify that all answers and statements made on this health history form are complete and true to the best of my knowledge. I understand that any misleading statement, misrepresentation, and/or omission of medications or information may be cause for termination of employment. This post-offer assessment, including drug testing, will be required for employment with University Hospitals Health System. I understand that any job offer is contingent upon successful completion of the assessment and UH's receipt of satisfactory drug screen results and I agree to provide and sign all required authorizations and/or releases.

Patient Signature _____ Date: _____

FOR INTERNAL USE ONLY

My signature indicates that i have reviewed this form in entirety with the person named above.

Clinician Signature: _____ Date: _____

University Hospitals
Employee Health

Please fax this completed form back to Employee Health at 216-844-3990

Guidelines for all employees working with laser equipment in the following departments:

Anesthesiology	Ophthalmology	Cardiac Cath Lab	Radiation
Oncology	Dermatology	Gynecology	Gastroenterology
General Surgery	Otolaryngology	Cardio-Thoracic Surgery	Plastic/Recon Surg
Neuro Surgery	Operative Services	Urology	Clinical Eng.

Employees working in areas using laser technology who are in direct contact with the laser equipment must have an eye examination prior to employment as well as following any suspected laser injury. An appointment for the examination must be made before beginning to work with the lasers.

Please call 440-250-2481 to schedule your appointment.
There will be no charge to you for the visit. Bring this form with you to the exam.

EMPLOYEE NAME:_____**Last 4 digits of SS#** _____

	NORM OU	OD	OS
PAST EYE Hx	Neg.		
FAMILY EYE Hx	Neg.		
C.C.	NONE		
PAST, CURRENT EYE MEDS	NONE		
VISUAL ACUITY (CORRECTED) DIST.	20/	20/	20/
BROWS, LIDS, LASHES CONJUNCTIVA	NORM OU		
CORNEA, SCLERA, IRIS, PUPIL, LENS, (SLIT, LAMP)	NORM OU		
INTRAOCULAR PRESSURE			
(DILATED PUPIL) DISC		C/D	C/D
MACULA	NORM OU		
VESSELS (Retinal)	NORM OU		
MEDIA OPACITIES	NORM OU		
FUNDUS PHOTOS (ONLY IF DISC OR RETINAL ABNORMALITY)		OD DONE	OS DONE

DATE OF EXAM_____EMPLOYEE HOSP. # _____

PHYSICIAN NAME _____/SIGNATURE_____
(Please Print) (Please sign)

I authorize release of this information to University Hospital Employee Health

EMPLOYEE SIGNATURE _____DATE _____