Attachment #1: **Consent and Authorization to Treat Form.**

Name (Please Print): ____ Birthdate:____________

I hereby give my consent for diagnostic testing and a physical examination to evaluate my suitability for employment within RWJBarnabas HEALTH. I understand that this exam and subsequent exams are to determine my placement and continued work status and not intended to take the place of personal medical care. Additionally, these exams should not be considered complete health assessments; for that I must contact my personal physician.

I further consent to diagnostic procedures and/or treatment for any injury or illness that occurs in relationship to my employment, or for any other conditions for which I seek care in the Employee Health Department.

I understand that my medical records will be maintained in a confidential manner. If I transfer to an alternate site within RWJBarnabas HEALTH, I agree that my employee medical records may be transferred to the Employee/Occupational Health Department responsible for the site at which I am working. Medical records pertaining to a work-related occurrence may be made available to the workers' compensation insurance carrier.

My responses to the employee Medical History Record Questionnaire will be used to evaluate suitability for employment and/or whether a reasonable accommodation for any disability will be needed.

I understand that it is important to provide all medical information to the best of my knowledge. If there is information I am uncertain of in this application to this request, I must discuss it with a representative from Employee Health Services. Omitting information or providing false information on the medical history form is grounds for withdrawal of an employment offer or termination of employment.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information.

"Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

________________________________ __________
Employee Signature Date

For Minors: ________________________ __________________________ ________
Parent/Guardian Signature Parent/Guardian Printed Name Date

________________________________ __________
Witness Signature Date

( ) I have received and read this Consent and Authorization to Treat Form and do NOT provide consent for diagnostic testing and a physical examination.

________________________________ __________
Employee Signature Date

Attachment #2: **Conditions of Employment Form**

Employee Name: ______________________________ **D.O.B.**: ______________

In order to protect your health and that of RWJBarnabas HEALTH patients, medical clearance to work is contingent upon:

1. Successful completion of a physical examination performed or approved by the Corporate Care / Employee Health Department.
2. A negative drug screen.
3. Pre-placement testing including laboratory work, a 2-step Mantoux (PPD) tuberculin test (or other documentation), and other diagnostic studies, as indicated.
4. Demonstration of Measles, Mumps, Rubella, and Varicella immunity by quantitative antibody titer level. Employees that are susceptible will be vaccinated (unless contraindicated) at no cost. Proof of immunity may require one or more vaccinations.
5. Demonstration of Hepatitis B immunity by a 'positive' antibody titer level. New employees that are susceptible will be vaccinated (unless contraindicated) at no cost. The hepatitis B vaccine series requires 3 immunizations given over 6 months. A follow-up blood test, to ensure immunity, is drawn 1 to 2 months after the last immunization. Note: if a new employee declines the hepatitis B vaccines, they are required to sign the OSHA Hepatitis B Vaccine Declination Statement.
6. Demonstration of a Td**ap** (Tetanus, diphtheria, **pertussis**) vaccination given as an adult. Employees that do not have medical documentation of a Td**ap** vaccination (as an adult) will be vaccinated (unless contraindicated) at no cost.
7. Influenza vaccination during the influenza season (usually September 1st through March 31st).
8. Tuberculosis screening at intervals determined by my facility based on a risk assessment.
9. Other follow-up as clinically indicated.
10. I understand that if I have a work-related occurrence my medical records may be made available to the worker's compensation insurance carrier.
11. I understand that information regarding my physical condition may be revealed to supervisors on a need-to-know basis if a potential for harm to myself or others exists.

I have read the above and I have had an opportunity to ask any questions which I may have. I understand that failure to comply with this policy will prevent my being employed and/or result in my termination from RWJBarnabasHEALTH.

Employee Signature: ______________________________ Date: __________

Attachment #3: **Employment Medical History Form**

PATIENT HISTORY

Name:______________________ Date of Birth: __________ SS#: ______________

Full Address:______________________________ Home Phone # (   ) __________

Email Address: ______________________CELL phone # (   ) __________ (lab results)

In case of emergency notify (Name):__________________ Relationship:______________

Full Address:______________________________ Phone # (   ) __________

Allergies:______________________

Do you now have or have you ever had any of the following? Check YES or NO. If yes, give year of occurrence.

	Yes	No	Year		Yes	No	Year		Yes	No	Year
Recurrent cough				Rectal bleeding				Back trouble			
Coughing up blood				Jaundice				Arthritis			
Shortness of breath				Leg pains				Joint pains			
Emphysema				Ankle swelling				Broken bones			
Asthma				Hernia				Osteoporosis			
Abnormal chest x-ray				Urine problem				Ear trouble, deafness			
Tuberculosis History				Cancer or tumor				Eye/vision trouble			
Dizzy spells				Blood transfusion				Nose trouble			
Chest pain / Angina				Blood disorder				Throat trouble			
Irregular heart beat				Weight loss				Kidney problem			
Heart trouble				Diabetes				Skin problem			
High blood pressure				Seizures				Black stool			
Fainting spells				Headaches				Prostate trouble			
Frequent indigestion				Paralysis				Testicular trouble			
Vomiting of blood				Numbness, tingling				Breast disorder			
Hepatitis A				Mental illness				Stoke or TIA			
Hepatitis B				Drug/alcohol problem				Brain/Neuro illness			
Hepatitis C				Latex/chemical sensitivity				Past MRI tests			
Gallbladder trouble				Wheezing				Other			

List any significant health issues not mentioned above:______________________

1. Alcohol- Yes / No (If yes, how much?__________)
2. Tobacco- Yes / No (If yes, how much? __________)
3. Prescription drugs- Yes / No (If yes, list all below.)
4. List ALL medications, both Prescription / Nonprescription:
____
____
____
5. List ALL past injuries-illnesses-surgeries-hospitalizations/Date
______________________ / ______
______________________ / ______
______________________ / ______
6. Previous occupation:______________________
7. Prior Work Injury/Illness? Yes / No. If yes, describe: ______
____
8. Ever been rejected for employment, military service, or insurance for health reasons? Yes / No. If yes, why: _____
____
9. Ever received Workmen's Compensation Benefits? If yes, describe: ______________________
10. Do you require Accommodation/special assistance ? If yes, describe: ______________________
11. Do you use any aids/assistive devices (prosthesis)? If yes, describe: ______________________

I certify that all answers to the above questions are true, correct, and complete. I understand that any false, incomplete, or misleading information, may be considered sufficient grounds for immediate rejection or termination when discovered.

SIGNATURE of APPLICANTE or guardian: ______________________ Date: __________

Attachment # 4: **OSHA INITIAL Respirator Questionnaire Form**
- Appendix C to Sec. 1910.134: OSHA Respirator Medical Evaluation Questionnaire-Mandatory.
- Use for Medical Clearance for: N-95 Disposable, PAPR, and half-face negative pressure.

Please answer ALL of the questions on the following pages.
To the employee: Can you read (circle one): Yes/No
Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Part A. Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Today's date:________________
2. Your name:____
3. Your age (to nearest year):______________
4. Sex (circle one): Male / Female
5. Your height: __________ ft. __________ in.
6. Your weight: ____________ lbs.
7. Your job title:____
8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): ______________________________________
9. The best time to phone you at this number: ____
10. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): 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-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).
12. Have you worn a respirator (circle one): 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 (please circle "yes" or "no").

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 problem that you've been told about: Yes/No

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 or walking 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 problem that you've been told about: 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 trouble: Yes/No
   c. Blood pressure: Yes/No
   d. Seizures (fits): Yes/No
8. If you've used a respirator, have you ***ever had*** any of the following problems:
   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 health care professional who will review this questionnaire about your answers to this questionnaire: Yes/No

Employee Signature: ______________________________________ Date: ____________

Attachment #5 **Latex Allergy Screening Form**

1. Are you allergic to any of the following types of GLOVES?

LATEX Yes / No (If yes, please explain:______________________________.)

VINYL Yes / No (If yes, please explain:______________________________.)

NITRILE Yes / No (If yes, please explain:______________________________.)

If you are allergic to any of the above, do you know the Specific Name of the glove you are allergic to? ____

2. When wearing Latex, or Vinyl, or Nitrile GLOVES, do you develop any rash, itching, cracking, chapping, scaling, or weeping of the skin, on your hands and/or wrists? Yes / No

(If Yes, what is the Name and Type of glove? ______________________________.)

Employee Signature: ____________________________________ Date: ___________

Attachment #7 **Tdap** (Tetanus, diphtheria, acellular pertussis) **Vaccine Consent Form**

Patient Name (PRINT) ______________________________ Birthdate ____________

Tetanus, diphtheria and pertussis are very serious diseases. Tdap vaccine can protect us from these diseases. And, Tdap vaccine given to pregnant women can protect newborn babies against pertussis. Tdap vaccine is given once during each pregnancy, ideally between 27 and 36 weeks gestation (but it can be given anytime during pregnancy if it is medically indicated- for wound care or during a community pertussis outbreak).

TETANUS (Lockjaw) causes painful muscle tightening and stiffness, usually all over the body.
DIPHTHERIA can cause a thick coating to form in the back of the throat and can lead to breathing problems, heart failure, paralysis, and death.
PERTUSSIS (Whooping Cough) causes severe coughing spells, which can cause difficulty breathing, vomiting and disturbed sleep. It can also lead to weight loss, incontinence, and rib fractures. Up to 2 in 100 adolescents and 5 in 100 adults with pertussis are hospitalized or have complications, which could include pneumonia or death. It is spread from person to person through secretions from coughing or sneezing.

The Center for Disease Control (CDC) recommends that all healthcare personnel receive one (1) dose of the Tdap vaccine regardless of the time since their most recent Td vaccination.
The Tdap adult vaccine became available in 2005; common names for it are Adacel ® and Boostrix ®.

PLEASE ANSWER THE FOLLOWING QUESTIONS (circle your response):

1. Have you ever had a life-threatening allergic reaction after a previous dose of any diphtheria, tetanus or pertussis containing vaccine (they are routine childhood vaccines with last dose given at age 11 or 12)? Yes No

2. Have you ever had coma or long repeated seizures within 7 days after a childhood dose of DTP or DTaP, or a previous dose of Tdap? Yes No

3. Do you currently have seizures or another nervous system problem? Yes No

4. Do you have a history of severe pain or swelling after any vaccine containing diphtheria, tetanus or pertussis? Yes No

5. Have you ever had a condition called Guillain-Barre Syndrome (GBS)? Yes No
6. Do you feel ill today? Yes No

I have been given and have read the most recent version of the Center for Disease Control (CDC) Vaccine Information Sheet (VIS) for Tdap; and have had the opportunity to ask questions.

Patient/Employee Signature ______________________________ Date ____________

For MEDICAL STAFF only:
Tdap Manufacturer:______ Lot #:____________ Expir.Date: __________ Dose: _______ (ml)

Time given: __________ Date given: ____________ Site: LEFT or RIGHT - deltoid /IM.

Healthcare Professional Signature: ______________________________