RWJBarnabas HEALTH- Corporate Care / Employee Health

1-11-17 Attachment #8 **Physical Examination Form** Today Date: _____

Name: _____ Sex: _____ Date of Birth: _____
(First) (Last)

Height: _____ Weight: _____ B/P: _____ Temp: _____ Pulse: _____ Respiration: _____

	Right Eye	Left Eye	Both	**Color Perception (Pass/Fail):**
Far Vision: With**OUT** Glasses/Contact Lens:	_____	_____	_____	**Ishihara:** _____
WITH Glasses/Contact Lens:	_____	_____	_____	**Red-Green-Yellow:** _____

Clinical Evaluation

Normal	Abnormal	Check each item, "NE" if not evaluated	Comments/Findings
		Eyes	
		Nose	
		Ears	
		Mouth/Throat	
		Head/Neck	
		Thyroid	
		Chest/Lungs	
		Heart	
		Vascular System	
		Breasts	
		Abdomen	
		Hernia	
		Upper Extremities	
		Lower Extremities	
		Back/Spine	
		Skin	
		Lymph Nodes	
		Neuro	
Remarks:			

Date: _____ Signature of Examiner: _____

RWJBarnabas HEALTH- Corporate Care / Employee Health

1-11-17 Attachment #9 **Tuberculosis Screening Record and Respiratory Assessment for Positive TB test**

Name_____ DOB_____

Dept_____EMPLOYEE #_____

Date	Pre-Employ	Annual	Postexp Baseline	12 wk post-exp	Manufacturer/ Lot #/Exp date	Site Forearm	Administered by	Date read	Reaction-mm indur	Read by

RESPIRATORY ASSESSMENT: for **POSITIVE- PPD or Interferon Gamma Release Assay (IGRA) test:**
Have you lived in another country?_____ If yes, what Country? _____ From Age: _____ to _____
Your current Age:_____
Date of **FIRST** Positive PPD Screening:_____. Date of **FIRST** CXR: _____, and Result: _____

Have you taken TB medicine in the past (for example- Isoniazid- INH) for 6 to 9 months? Yes____ No____

Date of MOST RECENT CXR _____, and Result _____.
Date of MOST RECENT IGRA (T-SPOT/QFTG) a TB blood test: _____ , and Result: _____

Do you have Medical Documentation of a prior Positive PPD? If yes, what is Date:_____, Length (mm ind):_____
Is Employee a New Converter per CDC guidelines (> 10 mm increase over baseline value)? (Yes/No): _____

Date	Pre-Employ	Annual	PostExp Baseline	12 wk post-exp	S/Sx TB reported	Y	N	S/Sx TB reported	Y	N	Reviewed by
					Unexplained Wgt Loss Fever/Chills Cough > 3 wks Loss of appetite			Coughing up blood Nights Sweats Tires easily w/o reason			
					Unexplained Wgt Loss Fever/Chills Cough > 3 wks Loss of appetite			Coughing up blood Nights Sweats Tires easily w/o reason			
					Unexplained Wgt Loss Fever/Chills Cough > 3 wks Loss of appetite			Coughing up blood Nights Sweats Tires easily w/o reason			

RWJBarnabas HEALTH - Corporate Care / Employee Health

1-11-17 Attachment #10 **INITIAL** RESPIRATOR Questionnaire and Qualitative Fit Test Record

1. Employee Name: _____ Employee Birth Date:_____

Wearing a respirator, may cause an increase in a person's blood pressure, pulse rate, or respiratory rate. Hence, it is important to make an assessment of their pulmonary and cardiovascular health, to ensure the wearing of a respirator will not cause an adverse health effect. An Initial Respirator medical clearance should be completed by a licensed Nurse Practitioner (NP) or Medical Doctor (MD) and include the following:
- Review the employee's 1910.134: OSHA Respirator Medical Evaluation Questionnaire (Mandatory)
- Examination to include, at least: blood pressure, pulse rate, respiratory rate, heart exam, and lung exam.
- Review the results of any additional tests the examining NP/MD ordered (e.g. ECG, Spirometry, CXR, etc.)

_____ **Filtering Face piece: (N95 Disposable, Dust, etc.)** _____**Half-Face cartridge/canister/filter.**
_____ **Powered air purifying respirator (PAPR)** _____**Full-Face cartridge/canister/filter.**
_____**SCBA (self-contained breathing apparatus; used by firefighters/divers)**

The above named employee has been evaluated and is medically cleared to wear the types of Respirators indicated above. Signature (NP/MD): _____ Date:_____

Sensitivity Testing:
_____ Sensitivity testing completed, requiring ____ squeezes of (Saccharine/Bitter).
_____ Unable to detect solution. Unable to continue with fit test.

Fit Check:
_____ Satisfactory fit check demonstrated.

Fit Test: The following one minute exercises were completed:
_____ Normal Breathing _____ Head side-to-side _____ Head up/down
_____ Deep Breathing _____ Talking _____ Bending

Respirator:
The following respirator brand/model/size was successfully fitted using the above tests:
_____ Kimberly Clark N95 Regular ____ 3M 1860 N95 Regular
_____ Kimberly Clark N95 Small ____ 3M 1860S N95 Small
_____ Other: _____

_____ Unable to complete fit test due to **interference of facial hair**.
_____ Unable to complete fit test due to respirator fit test failure.

_____ Employee agrees to above fit test results- No sweetness/bitterness was detected during their fit test.
_____ Employee acknowledges they completed, in the past, an initial Respirator Questionnaire/Fit Test.

_____ Employee was **not able** to complete the fit test.
Employee must call the (973-322-5092) to make an appointment for PAPR (or other type of respirator) training. Employee must bring this form with them to their appointment.

Medical /Fit test Provider: _____ Date: _____

RWJBarnabas HEALTH- Corporate Care / Employee Health

1-11-17 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 BARNABAS HEALTH - Corporate Care / Employee Health Clinic MEDICAL STAFF only:
Tdap Manufacturer:_____ Lot #:_____ Expir.Date: _____ Dose: _____ (ml)
Time given: _____ Date given: _____ Site: LEFT or RIGHT - deltoid
Healthcare Professional Signature: _____

Save Lives.
IMMUNIZE.

2017 Mandatory Influenza Vaccination Program

RWJBarnabas HEALTH

2017-2018 Consent/Confirmation of Vaccine Received Elsewhere Form for RWJBarnabas Health Facilities

For Clinic/Office Use Please check one: ☐ Flu Shot ☐ Egg-free Flu Shot ☐Intradermal Flu Shot
RWJBH Location: _____
Vaccine manufacturer: _____
Patient Allergies: _____
Lot Number: _____
Exp. Date: _____
Injection Site: ☐ Left ☐ Right Deltoid (Dose: Injection 0.5 ml)
Administering Provider Name: _____
Employee ID _____ Date _____

Facts about Influenza

- Influenza (Flu) is a serious disease. More than 200,000 people are hospitalized each year with flu complications. And approximately 36,000 people, of all ages, die from the flu each year.
- You cannot get the flu from the flu vaccine. The flu vaccine is the most effective way to prevent the flu.
- You should get the flu vaccine if you are pregnant or planning on becoming pregnant.
- The flu vaccine protects against 3 – 4 strains or types of influenza. Every year research is done to determine which types will be in the vaccine.
- An egg free vaccine is available for people with a documented severe allergy to eggs at our Employee Health or Corporate Care locations.
- The flu vaccines offered through RWJBarnabas Health are latex free and preservative free.
- You should NOT get the flu vaccine if you have a past history of a life-threatening reaction or if you developed Guillain-Barre syndrome within 6 weeks after receiving a previous influenza vaccine.

PLEASE COMPLETE

Print name _____ **Employee ID #** _____(*Required for Employees)

Date of Birth _____ **Phone number:** _____

Location – Please check all facilities where you work: ☐ ACC ☐ Behavioral Health ☐ BHMG ☐ Children's Specialized Hospital ☐ CMC ☐ CMMC ☐ Corporate ☐ JCMC ☐ Livingston Services ☐ MMC ☐ MMCSC ☐ NBI ☐ Qualitas ☐ RWJUH Hamilton ☐ RWJUH New Brunswick ☐ RWJUH Rahway ☐ RWJUH Somerset ☐ SBMC

Employee Type – Please check one:

☐ RWJBarnabas Health employee ☐ RWJBarnabas Health volunteer
☐ Physician, Advance Practice Nurse or Physician Assistant NOT employed by RWJBarnabas Health
☐ Contract Personnel (Name of Company) _____ Location_____
☐ Other _____

Please check one:

☐ **I CONSENT TO RECEIVE THE INFLUENZA VACCINE AT THIS TIME.** I have been provided the Vaccine Information Sheet (VIS) for Influenza vaccine 2017 - 2018. I have read it and have had any questions answered. My signature below indicates that I consent to receive the Influenza Vaccine. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s).

☐ **I CONFIRM THAT I HAVE RECEIVED THE INFLUENZA VACCINATION ELSEWHERE.** I am submitting proof of immunization as required.

Acceptable proof for influenza immunization is as follows:

- Document signed by the licensed healthcare practitioner or receipt from whoever administered the vaccine indicating the name of the employee and date of administration.
- Attestation from employer or school

Employees: Please bring this form and proof of immunization to a local flu clinic, your local HR Department, or Corporate Care/ Employee Health.
Volunteers: Please bring this form and proof of immunization to your local flu clinic or your local Volunteer Director.

On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless RWJBarnabas Health, Inc., its staff, agents, successors, assigns, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the Influenza vaccine, including any required reporting, storing, maintaining, disclosing, use of my personal information.

Print Name _____

Signature _____ **Date** _____

If you are under 18 years of age, please have parent/guardian sign below:

The undersigned acknowledge that I/we have read and understand the above guidelines in relation to administration of the Influenza vaccine to our minor child, named above.

_____

Parent/Guardian Relationship to Patient Date

RWJBarnabas HEALTH - Corporate Care / Employee Health

1-11-17 Attachment #12 **Laboratory Request Form**

Requested by: _____ Date _____

Employee Name _____ Date of Birth _____

PRE-PLACEMENT PANEL Antibody Titers
____ Hepatitis B surface Antibody (HepBsAb)
____ Rubella (German Measles) IgG
____ Measles (Rubeola) IgG
____ Varicella Zoster (VZV) IgG
____ Mumps Ab IgG
"SURGEONS" performing Category I procedures:
____ Hepatitis B surface Antigen (HepBsAg) (required)
____ Hepatitis C Antibody (offer)
____ HIV 1/2 combo (HIV Ag/Ab combo) (offer)

BBF Exposure (Blood Body Fluid Exposure)
INITIAL Blood Tests Panel on employee:
____ HIV 1 / 2 Combo (HIV 1 / 2 Ag/Ab)
____ Hepatitis B surface Antibody (HepBsAb)
____ Hepatitis B surface Antigen (HepBsAg)
____ Hepatitis C Antibody (HepC Ab)
____ CMP (Comprehensive Metabolic Panel; includes both liver w/ALT and kidney function)
____CBC w/automated differential, platelets
____ Pregnancy test-Serum (Beta hCG), if female

OTHER:
____ QuantiFERON TB-Gold (tuberculosis test)
____ T-SPOT (tuberculosis test)
____ Urinalysis with microscopic
____ Latex (IgE)
____ Pregnancy test-Urine (Beta hCG)
____ Cholesterol
____ Routine Culture (aerobic):
Source_____
____ Urine Analysis: In-house Dipstick
____ Urine Analysis: Send out:
____ _____
____ _____

INDIVIDUAL TESTS
____Basic Metabolic Panel (BMP) (Na,K,Cl,CO2,Gluc, BUN/Cr)

____Hepatic Function Panel (AlkPhos, AST,ALT,BIL)
____ CMP(Comprehensive Metabolic Profile-includes liver + kidney fx).

____ Lipid Profile

____ Acute Hepatitis Profile (HepBsAg, HepBcoreAb-IgM, HepC Ab, HepA IgM)

____ Hepatitis A Antibody IgM

____ Hepatitis B surface **Antigen** (HepBs**Ag**)
____ Hepatitis B surface **Antibody** (HepBs**Ab**)
____ Hepatitis B **core** Antibody (total)

____ Hepatitis C Antibody
____ Hepatitis C RNA by PCR, Quantitative

____ ALT

____ HIV 1 / 2 combo (HIV 1/2 Ag/Ab Rapid)
____ HIV-1 RNA by PCR, Quantitative
____ HIV Rapid
____ _____
____ _____

RWJBarnabas HEALTH- Corporate Care / Employee Health

1-11-17 Attachment #3: **Employment Medical History Form**

PATIENT HISTORY RECORD

Name:_____ Date of Birth: _____ SS#: _____

Full Address:_____ Home Phone # ( ) _____

Email Address: _____CELL Phone # ( ) _____ (LAB Results called here)

In case of emergency notify (Name):_____ Relationship:_____

Full Address:_____ Phone # ( ) _____ Cell/Home

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 (yellow skin)				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				Anemia/blood disorder				Throat trouble			
Irregular heart beat				Unplanned weight loss				Kidney/bladder problem			
Heart trouble/Heart attack				Diabetes				Eczema/hives/skin probl			
High blood pressure				Seizures, Convulsions, fits				Black stool			
Fainting spells				Headaches				Testicular/prostate trouble			
Frequent indigestion				Paralysis				Breast lump/discharge			
Vomiting of blood				Numbness, tingling				Stoke or TIA			
Hepatitis A				Emotional/mental illness				Any Brain/Neurologic illness			
Hepatitis B				Drug/alcohol problem				Past MRI tests			
Hepatitis C				Latex/chemical sensitivity				Other			
Gallbladder trouble				Wheezing				Other			

List any significant health issues not mentioned above:_____

	YES	NO	Amount Consumed
Alcohol			
Tobacco			
Former smoker?			
Prescription drugs			
Non-prescription drugs			

List ALL present medications:

_____

_____

_____

_____

_____

List injuries, illnesses, Surgeries, or Hospitalizations	Date

Previous occupation(s):_____

Previous work-related injury/illness? Yes_____ No_____

Type:_____

Have you ever been rejected for employment, military service or insurance for health reasons? Yes_____ No_____

Why?_____

_____

Have you ever received workers' compensation benefits?

Yes_____ No_____ Describe:_____

Do you require accommodation/special assistance of any kind?

Yes_____ No_____ Describe:_____

Do you use any aids or assistive devices (prosthesis)?

Yes_____ No_____ Describe:_____

I certify that the 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 applicant or guardian **Date**

Attachment # 4: **OSHA 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: _____

RWJBarnabas HEALTH- Corporate Care / Employee Health

1-11-17 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: _____

RWJBarnabas HEALTH- Corporate Care / Employee Health

1-11-17 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

RWJBarnabas HEATH- Corporate Care / Employee Health

1-11-17 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 RWJBarnabas HEALTH.

Employee Signature: _____ Date: _____

RWJBarnabas HEALTH - Corporate Care / Employee Health

1-11-17 Attachment #13 **Medical Clearance Form- New Employee**

Name:_____ DOB: _____ Date: _____
(LAST name, First name)

Orientation Date (if known): _____

Department: _____

Location (if known): _____

Position (Job Title): _____

_____ NOT medically cleared to work in a BH Hospital/ Medical Center/ Clinics- due to "Non-Compliance" with medical requirements: _____

_____

_____ NOT medically cleared to work.

_____ YES medically cleared to work.

_____ YES medically cleared to work with the following Restrictions/Limitation:

_____

_____

_____

_____ _____
Barnabas Health Nurse Practitioner/Physician (NP/MD) Date

HR Representative: _____

Saint Barnabas Medical Center
Barnabas Health

PATIENT'S NAME: _____

MR# _____

PT# _____

SEX _____ AGE _____

(AFFIX LABEL)

GENERAL CONSENT: INPATIENT, OUTPATIENT & EMERGENCY DEPARTMENT

1. **ADMISSION CONSENT:** I request and authorize Saint Barnabas Medical Center, Attending Physician and such associates, assistants and/or residents as may be selected by the said physician to provide such hospital care and to administer such routine diagnostic, radiological and/or therapeutic procedures and treatment including, but not limited to, the administration of pharmaceutical products, and intravenous medication, as in the judgement of the above physician(s) they deem necessary or advisable in my diagnosis, care and treatment. I am aware that the practice of medicine and surgery is not an exact science and I understand that no guarantee or assurance of beneficial results has been promised or implied as a result of the above-mentioned diagnostic and therapeutic procedures. I certify that I have read and fully understand this consent for diagnostic and/or therapeutic procedures and treatment. I understand that Saint Barnabas Medical Center is a teaching hospital and that medical students and residents may participate in my care and treatment. I understand that no guarantees have been made to me about the outcome of this care.
2. **MATERNITY DIVISION:** If I am admitted to have a baby, this consent shall also apply to the admission and Hospital treatment of the baby(ies) who is/are delivered by me during the hospitalization.
3. **RECURRING VISITS:** If the services rendered qualify me for recurring status, my signature hereon shall be valid for care rendered throughout this period. If, during this period, any of my registration information changes, i.e. address, phone, employment, insurance, guarantor, etc., I will notify the department where the registration originated of the change..
4. **RELEASE FROM RESPONSIBILITY FOR PATIENT'S VALUABLES:** I hereby certify that I have been advised and fully understand that Saint Barnabas Medical Center and its employees are not responsible for any and all personal articles, clothing or cash that I retain in my possession or on my person while a patient in the hospital. I acknowledge being advised not to retain more than $5.00 cash and to deposit valuables in excess of that amount for safekeeping with the hospital.
5. **RELEASE OF INFORMATION:** I understand that my medical records are kept in both hard copy and electronic form and that physicians and persons involved in my care have access to both forms of records. This may include remote access to electronic records from physician offices. The Medical Center may access electronic information about me from pharmacies I use, including prescriptions to treat AIDS/HIV, mental health issues, substance abuse and sexually transmitted diseases, if applicable. The pharmacy information will become part of my hospital medical record. I understand that if I do not wish the Medical Center to access my pharmacy information, I must submit a written request to the Medical Center's Privacy Officer. The Medical Center also participates in electronic health information exchanges (HIEs) with various other health care providers. I authorize the Medical Center and the HIEs with which it participates to share my health information, through the HIE networks, for purposes permitted by law, including my treatment and coordination of my care, with all health care providers that are authorized under the HIEs' policies and applicable law to access my information. I understand and agree that the information about me that may be shared and accessed through the HIEs may include information about HIV/AIDS status, sexually transmitted diseases, family planning, mental health treatment, genetic test results, use of alcohol and other substances and other sensitive categories of my health information. I understand that I have the right to "opt-out" of having my information shared through HIEs, and instructions on how to do that can be found in the Notice of Privacy Practices, or may be requested from the Medical Center's Privacy Officer. The Medical Center may seek, release and verify all or part of my medical and/or financial records to any person, corporation, or government agency which is or may be liable under a statute, regulation, or contract to the hospital, the patient, a family member, or employer of the patient, for all or part of the Medical Center's charges. I consent to the release of medical information for purposes of discharge planning. I consent to the release of my identification, general condition and room telephone number. I understand that limited information about me will be utilized for Medical Center patient satisfaction surveys. I acknowledge that I have the right to designate a Caregiver.
6. **FINANCIAL AGREEMENT:** For and in consideration of services rendered, I agree to make prompt payment to Saint Barnabas Medical Center (SBMC) when billed for any and all charges not covered by valid insurance benefits. I understand that I am responsible for any health insurance deductibles, copayments, and/or coinsurance. If I am classified as a self-pay patient, a deposit will be requested. **I realize it is my obligation to obtain a referral, pre-certification or a second opinion should it be required prior to services.** If SBMC, or my insurance carrier, or its intermediaries, or the Quality Improvement Organization deems that medical and/or professional services to be given or already given are not medically necessary and/or non-covered services, I must pay for those services deemed patient responsibility. I grant permission and consent to Barnabas Health, assignees, and third party collection agents (1) to contact me by phone at any number associated with me including wireless cell numbers, (2) to leave answering machine and voicemail messages for me and include in any such messages, information required by law (including debt collection laws) and/ or regarding amounts owed by me (3) to send me text messages or emails using any email addresses I provide and; (4) to use pre-recorded/ artificial voice messages and/or an automatic dialing device (an auto-dialer) in connection with any communications made to me or any related scheduled services and my account. I HAVE CHECKED ALL DEMOGRAPHIC INFORMATION AND IT IS ACCURATE. **I understand that the Hospital will not deny emergent or urgent treatment and/or admission based on my, or the patient's, inability to pay.**
7. **AUTHORIZATION FOR TESTING:** In the event that any healthcare provider or first responder (including emergency medical service workers and police officers) involved in my care is exposed to my blood or bodily fluids and makes a request for testing and results of such testing, I consent to the drawing of blood for the purpose of testing it for various blood-borne pathogens including, but not limited to, Human Immunodeficiency Virus (HIV) and Hepatitis B and C. I understand and agree that the results of the blood test shall be released to me and the healthcare provider/first responder exposed to my blood or bodily fluids. To the extent possible, these results will be provided to the healthcare provider/first responder without disclosing my name.
8. **ASSIGNMENT OF BENEFITS:** I hereby assign, transfer and sign over to Saint Barnabas Medical Center all and sufficient monies, claims and/or benefits to which I may be entitled from governmental agencies, insurance carriers, union welfare funds or any other parties that are financially liable to pay the charges for the care, treatment and supplies that I was rendered and furnished or that were rendered and furnished to the patient for whom I have financial responsibility.
9. **FINANCIAL ASSISTANCE:** I have received a copy of the notice of Financial Assistance (back of patient copy of consent) and reduced Charge Financial Assistance. I understand I may be eligible for Hospital Care Payment Assistance or other forms of financial assistance but must apply to receive it.
10. **SAINT BARNABAS MEDICAL CENTER RELATIONSHIP TO CERTAIN PHYSICIANS AND PHYSICIAN GROUPS:** I understand that most of the physicians on the staff at Saint Barnabas Medical Center are not agents, servants or employees of the Saint Barnabas Medical Center but, rather are members of its Medical Staff who have been granted the privilege of using its facilities for the care and treatment of their patients. Saint Barnabas Medical Center contracts with independent groups of specialized doctors, who are neither employees nor agents of the Saint Barnabas Medical Center and are separate from the hospital and your private physicians. As such, the Saint Barnabas Medical Center has no direct or indirect liability for any act or omission of these groups or any physician, practitioner, or other employee associated with such groups. These groups may include, without limitation, the group staffing the Emergency Department, Radiology Department, the Laboratory Department, Radiation Oncology, Anesthesia and other physicians called upon to interpret certain diagnostic tests (e.g., EDG's, Echocardiographs, etc.).
11. **MEDICARE-AUTHORIZATION TO RELEASE INFORMATION & PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers or my physician(s) any information needed for this or a related Medicare Claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physicians or organization to submit a claim to Medicare for payment to me. THE SERVICE I RECEIVE MAY NOT BE COVERED BY MY MEDICARE INSURANCE. IN THE EVENT, I WILL BE RESPONSIBLE FOR ALL CHARGES NOT COVERED.

ADVANCE DIRECTIVE:				
				☐ **Under 18**
I have an Advance Directive/Living Will/Health Care Agent	☐ **YES**	☐ **NO**	☐ **UNKNOWN**	
I would like Advance Directive Information	☐ **YES**	☐ **NO**	☐ **UNKNOWN**	
I am providing a copy to Saint Barnabas Medical Center	☐ **YES**	☐ **NO**	☐ **UNKNOWN**	☐ **Requested Copy**

- I acknowledge receipt of the "Important message from TriCare" (back of patient copy of consent) My signature only acknowledges my receipt of this message and does not waive any of my rights to request a review or make me liable for payment.
- I acknowledge receipt of the Patient's Bill of Rights.
- I have been advised of my right to an Advance Directive.
- I understand that if I do not comply with the pre-certification requirements, I will be responsible for hospital charges.
- I acknowledge receipt of the "Privacy Notice."
- I acknowledge receipt of Physician and Physician Group Relationship and Related Billing Information.
- I have read this form, my questions have been answered, and I understand and agree to its content.

Patient Signature/Authorized Representative _____ Relationship _____ Date _____

The Patient is unable to sign because: _____ Witness to signature only _____

MEDICAL RECORDS