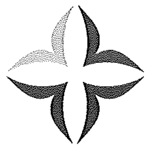



## WorkWise Occupational Health Services

271 Carew Street
Springfield Massachusetts 01104
Phone: 413.748.6869
Fax: 413.748.6077
workwiseohs@sphs.com

## New Employee Occupational Health Packet

The enclosed packet was designed to expedite your Pre-employment Physical and Urine Drug Screen appointment in Occupational Health.
The packet contains:

1. Immunization Requirements
2. Registration Information
3. Drug Screen Procedure
4. Urine Drug Screen Consent
5. Medical & Occupational History Questionnaire
6. Tuberculosis Screening Form
7. OSHA Respirator Medical Evaluation Questionnaire (for Fit testing, where applicable)

### BEFORE the day of your Occupational Health appointment:

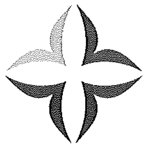
1. Complete all of the forms in this packet
2. Obtain all of your vaccination records and/or proof of immunity

### ON THE DAY of your Occupational Health appointment:

1. Plan to arrive at least ***15 minutes*** before your scheduled appointment.
   ***Late arrivals may have to be rescheduled. Directions are included on the last page of this packet.***
2. Bring the completed forms/this packet with you.
3. Bring all of your vaccination records and/or proof of immunity if they are available.
4. Bring a valid photo ID (driver's license, passport, military ID, or school ID).

***IMPORTANT ***

***YOU WILL NOT*** *be cleared (approved) to attend orientation and begin your employment unless all of the requirements are completed and documents received. If for any reason you need to reschedule your appointment please call Occupational Health at 413.748.6869.*




# IMMUNIZATION REQUIREMENTS

The following is a check list of the immunizations that are a requirement of employment with Trinity Health Of New England's Mercy Medical Center and affiliates.

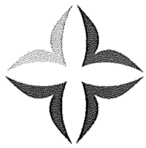
Please bring your immunization records with you to your appointment. If you do not have immunization records or fail to bring them to your appointment, your clearance may be delayed pending blood work results.

**MANDATORY:**

- **MMR** (measles, mumps, & rubella) Proof of two (2) vaccines or positive titers
- **Varicella** (chickenpox) Proof of two (2) Varicella vaccines or positive titer
- **Tuberculosis** Proof of Tuberculin skin test (PPD) or QuantiFERON Gold or T-spot blood test done within the past 12 months
  - *NOTE: if you have had a positive PPD in the past please bring most recent Chest x-ray report*
- **Influenza** (flu) Proof of current seasonal influenza vaccination (required during flu season)
  - *NOTE: seasonal flu vaccination is an annual requirement of employment for THONE MMC and affiliates*
- **Hepatitis B** Vaccination Proof of three (3) doses and a positive titer
- **Hepatitis A** Vaccination Proof of Two (2) vaccines (required for Food Service Workers)
- **Tdap** (Tetanus, Diphtheria, and Pertussis) Proof of one vaccination

**Optional:**

- Hepatitis C Proof of Hepatitis C antibody
- Proof of recent CBC (complete blood count)




## WorkWise Occupational Health Services

## Registration Information

| Last Name | First Name | Middle Initial |
|---|---|---|

**Maiden Name**

| Age | Date of Birth (MM/DD/YYYY) | Social Security Number |
|---|---|---|

**Home Address**

| City | State | Zip Code |
|---|---|---|

**Home Phone:**

**Cell Phone:**

**Email Address:**

**Gender:** ☐ **Male** ☐ **Female**

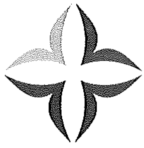
**Race:**

**Marital Status:**

**Do you smoke:** ☐ **Yes** ☐ **No**

**Employer Name:**

**Occupation:**




## WorkWise Occupational Health Services Urine Drug Screening Procedure

You have been asked by your employer or by your prospective employer to provide a urine specimen for drug testing. We would like to explain our procedure to you.

When you come to our office, you will be asked to show **photo identification** to the health care professional who collects your specimen. That person will be wearing their Mercy Medical Center's photo identification badge. Your driver's license is the best form of identification. A military ID, passport, or school photo ID is also acceptable. *Expired ID documents cannot be used.*

Your urine specimen will be collected according to procedures described by the National Institute on Drug Abuse (NIDA) and sent to a NIDA-approved laboratory for analysis.

You will be asked to remove your outer garments and leave them along with any personal belongings outside the bathroom. Valuables such as your wallet or pocketbook will be locked in a cabinet (lockbox) inside the bathroom.

You will be given a container in which to urinate. You will wash and dry your hands in the collector's presence both before and after producing the urine specimen. After washing your hands, the collector will turn off the water in the sink. You will then urinate in the privacy of a locked bathroom without observation. You will be told not to flush the toilet after you void.

You must produce at least **45-60 cc of urine** in the container that we give you. If you feel that you cannot produce this amount of urine, tell the collector. If you do produce a specimen that is less than one ounce, it will be discarded. **You will have up to 3 hours to produce a sufficient new specimen.** You will be provided with up to 40 ounces of fluid to drink. During this time, you must remain at the office.

Within four minutes after you produce the urine specimen, the collector will measure the urine temperature. If the temperature is outside the acceptable range, the collector will take your temperature orally. The collector will inspect the specimen for color, appearance, and signs of contamination.

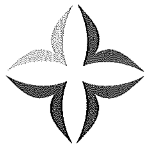
You and the collector will complete the process together by sealing and labeling the specimen bottle. You will initial the label and sign and date the custody form.

The urine specimen will be sent to a NIDA-approved laboratory for analysis. The urine will undergo a 7-panel drug screening.

All test results will be reviewed by a physician, who is certified as a Medical Review Officer, to evaluate drug test results. If the laboratory indicates that the specimen tests positive for one of the seven drugs screened form the Medical Review Officer will call you to discuss the test results.

Only one of the following results will be reported to the Mercy Medical Center's Human Resource Representative: Positive, Negative or Test Not Performed.

We will be happy to answer any questions you may have. Thank you for your cooperation.




## Consent for Urine Drug Testing

I hereby give my voluntary consent for a urine sample to be collected form me and submitted for drug testing. I understand that the specimen will be collected using a chain of custody procedure and will be sent to a NIDA-approved laboratory for testing. The laboratory results will be reviewed by a Medical Review Officer who may contact me to discuss the results and to obtain further information. I give permission to the Medical Review Officer (MRO) to contact my personal physicians to verify medical or prescription information.

I understand that the Medical Review Officer (MRO) will make a final determination of the test result and notify Human Resources of this result. If my urine is determined to be **"Positive"**, I understand that I have 72 hours to request a re-analysis of the same specimen or a split specimen according to company policy at my own cost.

I have read the Urine Screening Procedure Information Sheet and this Consent Form.
Any questions that I had regarding this procedure have been answered to my satisfaction.

Signature: ______________________________ Date: ____________________

Witness Signature: __________________________ Date: ____________________

Contact Information
Please provide the following information in the event the Medical Review Officer needs to contact you for more information to properly interpret your drug screen result.

Last Name: ____________________ First Name: ________________________

Social Security Number: ______________________________________________

Address: _________________________________________________________

Phone number where you can be reached on weekdays between 8 AM to 4 PM: ______________

# OSHA Respirator Medical Evaluation Questionnaire

*This evaluation questionnaire is required by the US Department of Labor for any health care professional who may need to use any type of respirator at work.*

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:

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: **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**

d. 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: **Yes/No**

8. If you've used a respirator, have you *ever had* any of the following problems? (If you've never used a respirator, check the following space and 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 health care 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 or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

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 ear drum: **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**

Part B Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen: **Yes/No**

If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions: **Yes/No**

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals: **Yes/No**

If "yes," name the chemicals if you know them:______________________

______________________________________________________________

______________________________________________________________

3. Have you ever worked with any of the materials, or under any of the conditions, listed below:

a. Asbestos: **Yes/No**

b. Silica (*e.g.*, in sandblasting): **Yes/No**

c. Tungsten/cobalt (e.g., grinding or welding this material): **Yes/No**

d. Beryllium: **Yes/No**

e. Aluminum: **Yes/No**

f. Coal (for example, mining): **Yes/No**

g. Iron: **Yes/No**

h. Tin: **Yes/No**

i. Dusty environments: **Yes/No**

j. Any other hazardous exposures: **Yes/No**

If "yes," describe these exposures:______________________________

____________________________________________________________

____________________________________________________________

4. List any second jobs or side businesses you have:________________

____________________________________________________________

5. List your previous occupations:______________________________

____________________________________________________________

6. List your current and previous hobbies:___________________________

____________________________________________________________

7. Have you been in the military services? **Yes/No**

If "yes," were you exposed to biological or chemical agents (either in training or combat): Yes/No

8. Have you ever worked on a HAZMAT team? **Yes/No**

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications): Yes/No

If "yes," name the medications if you know them:____________________

10. Will you be using any of the following items with your respirator(s)?

a. HEPA Filters: **Yes/No**

b. Canisters (for example, gas masks): **Yes/No**

c. Cartridges: **Yes/No**

11. How often are you expected to use the respirator(s) (circle "yes" or "no" for all answers that apply to you)?:

a. Escape only (no rescue): **Yes/No**

b. Emergency rescue only: **Yes/No**

c. Less than 5 hours *per week:* **Yes/No**

d. Less than 2 hours *per day:* **Yes/No**

e. 2 to 4 hours per day: **Yes/No**

f. Over 4 hours per day: **Yes/No**

12. During the period you are using the respirator(s), is your work effort:

a. *Light* (less than 200 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift:__________hrs.__________mins.

Examples of a light work effort are *sitting* while writing, typing, drafting, or performing light assembly work; or *standing* while operating a drill press (1-3 lbs.) or controlling machines.

b. *Moderate* (200 to 350 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift:__________hrs.__________mins.

Examples of moderate work effort are *sitting* while nailing or filing; *driving* a truck or bus in urban traffic; *standing* while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; *walking* on a level surface about 2 mph or down a 5-degree grade about 3 mph; or *pushing* a wheelbarrow with a heavy load (about 100 lbs.) on a level surface. c. *Heavy* (above 350 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift:__________hrs.__________mins.

Examples of heavy work are *lifting* a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; *shoveling; standing* while bricklaying or chipping castings; *walking* up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator: Yes/No

If "yes," describe this protective clothing and/or equipment:________

______________________________________________________

14. Will you be working under hot conditions (temperature exceeding 77 deg. F): Yes/No

15. Will you be working under humid conditions: Yes/No

16. Describe the work you'll be doing while you're using your respirator(s):

______________________________________________

______________________________________________

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases):

______________________________________________

______________________________________________

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):

Name of the first toxic substance:___________________________
Estimated maximum exposure level per shift:______________________
Duration of exposure per shift:______________________________
Name of the second toxic substance:___________________________
Estimated maximum exposure level per shift:______________________
Duration of exposure per shift:______________________________
Name of the third toxic substance:___________________________
Estimated maximum exposure level per shift:______________________
Duration of exposure per shift:______________________________
The name of any other toxic substances that you'll be exposed to while using your respirator:

______________________________________________

______________________________________________

______________________________________________

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security:

______________________________________________

[63 FR 1152, Jan. 8, 1998; 63 FR 20098, April 23, 1998; 76 FR 33607, June 8, 2011; 77 FR 46949, Aug. 7, 2012]