Jefferson Healthcare

STATUS: Official
CREATED: 03/08/16
ARCHIVED: N/A
OWNER: Employee Health
PURPOSE: Vaccine/Testing Requirements

New Hire Immunization and Testing Requirements

Welcome to Jefferson Healthcare. The following is a list of required items for employees, providers, students, volunteers, and contracted employees. A complete occupational health file is a condition of employment. Records can be obtained from Employee Health at your current place of employment, from your school, or the clinic where you receive immunizations. If immunization and testing requirements are not met by the first 10 calendar days of employment, you may be pulled from the work schedule. The exception would be if you are working with Employee Health to complete the requirements.

Urine Drug Screening:
Depending on your position, we may test you for drug usage at your appointment with Employee Health. Some employees/providers may be tested at an off-site laboratory if they currently reside out of the area. We test for THC (marijuana), amphetamines, methadone, cocaine, morphine, PCP, benzodiazepines, barbiturates, oxycodone, methamphetamines, and fentanyl.

Tuberculosis Testing (PPD): Documentation of a Gamma Release Assay (IGRA)- T-Spot or QuantiFERON Gold (1 test within 12-months) **OR** a 2-step TB Skin Test (2 tests within 12-months). If you are a positive reactor to the skin TST test or IGRA, please provide proof of the positive, if any INH treatment taken, and a negative chest x-ray completed after identification of positive result. A medical provider clearance will be required, Employee Health will provide document for you and your provider.

Hepatitis B: (For direct caregivers)
- ☐ Positive titer, and
- ☐ 3 Hepatitis B immunizations (Engerix-B) or 2 Hepatitis B immunizations (Heplisav-B)

COVID-19: (Coronavirus)
- ☐ 1 Updated (after 9/2023) dose & any other COVID immunizations you have received

Influenza
- ☐ current season immunization

Measles (Rubeola):
- ☐ 2 doses of MMR immunization, or
- ☐ Positive Measles (Rubeola) titer

Mumps
- ☐ 2 doses or MMR immunization, or
- ☐ Positive Mumps titer

Rubella (German Measles):
- ☐ 2 doses of MMR immunization, or
- ☐ Positive Rubella titer

Tetanus/Diphtheria/Pertussis (Tdap):
- ☐ 1 dose of Tdap immunization

Varicella
- ☐ 2 doses of Varicella immunization, or
- ☐ Positive Varicella titer

Jefferson Healthcare

STATUS: Official
CREATED: 3/15/16
ARCHIVED: N/A
OWNER: Employee Health
PURPOSE: Release of Records

EMPLOYEE HEALTH SERVICES
RELEASE OF INFORMATION

Name:_____ Date of Birth:_____

Permission is hereby granted for the release of information from:

NAME:_____
LOCATION:_____
FAX:_____

To: Jefferson Healthcare
Employee Health Services
915 Sheridan Street
Port Townsend, WA 98368
Fax: 3 60-344-1006

I give permission for this information to be used for the purpose of supplementing my occupational health record, for job-related functions, and for the scope of any resultant accommodations. I request the following information be released:

X_ Most Recent PPD(s)/ T-Spot/ Quantiferon Gold Lab
X_ Hepatitis B/ Measles/ Mumps/ Rubella/ Varicella Titers
X_ Hepatitis B Vaccinations(s)
X_ MMR/ Varicella Vaccination(s)
X_ Current annual Influenza/ TDaP/ COVID-19 Vaccination(s)
☐ Medical Records (Specify): _____
☐ Previous Injury: Must have a completed Return to Work Authorization form.
Date of Injury: _____ Claim # _____

This authorization expires 90 days from the date signed. This consent is subject to revocation at any time by me in writing except to the extent that action has been taken.

_____ _____
Signature Date

_____ _____
Witness Signature Date

Jefferson Healthcare

CREATED: 3/2/16
ARCHIVED: N/A
OWNER: Employee Health
PURPOSE: New Hire Questionnaire

New Hire Screening Questionnaire

Name: _____ **Date of Birth**: _____
Position/Dept: _____
Personal Email: _____
Latex Sensitivity Allergy: ☐ Yes ☐ No

Do you have a history of:	**No**	**If yes, please explain**
Asthma, Shortness of Breath, or Lung problems	☐	
Heart, blood pressure problems	☐	
Seizures	☐	
Hepatitis	☐	
Diabetes	☐	
Allergic reactions that interfere with breathing.	☐	
Claustrophobia	☐	

Work Related Injury/Exposures

A previous workers' compensation claim, or disability WILL NOT prevent you from working at Jefferson Healthcare if you are able to perform the essential functions of the job with or without reasonable accommodation.

1. Do you currently have an open Workers' Compensation (L&I) claim? ☐ Yes ☐ No
If Yes, please explain_____

2. Have you ever had a blood borne pathogen exposure? ☐ Yes ☐ No
If Yes, please explain: _____

HEPATITIS B VACCINATION DECLINATION FORM
OSHA REGULATION (Standard- 29 CFR 1910.1030 App A)

FOR JOBS WITH POTENTIAL EXPOSURE TO BLOOD AND BODY FLUIDS

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I **decline** hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

I **decline** the Hepatitis B vaccination at this time, due to:

☐ Have had vaccination series and will be awaiting titer results ☐ Have full vaccination series & positive titer

☐ Position does not expose me to blood or infectious material ☐ Allergic ☐ Starting series

_____ _____
Employee Signature **Date**

_____ _____
EH Staff Signature **Date**

New Hire Screening Questionnaire

Bloodborne Pathogen Consent:

In the event a health worker is exposed to my blood or body fluids in a manner posing a risk for transmission of a blood-borne infection, I give consent to be tested for infections such as HIV, Hepatitis B, and Hepatitis C at no cost to me, so that the healthcare worker may be treated promptly. I authorize the release of applicable information to the healthcare worker, their healthcare provider, and Employee Health.

_____ _____

Signature **Date**

Washington State Immunization Information System Consent:

I authorize JH Employee Health Department to retrieve any vaccination records from the Washington State Immunization Information System to supplement my vaccination completion list for my occupational health record.

_____ _____

Signature **Date**

Jefferson Healthcare

CREATED 3/3/16
ARCHIVED: N/A
OWNER: Employee Health
PURPOSE: Respiratory Questionnaire

RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE
(Required and Adapted from WISHA/OSHA Respiratory Protection Program 29 CFR 1910.134)

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 director or supervisor must not look at or review your answers. This is kept in your occupational health record in Employee Health which is separate from your personnel file kept in Human Resources.

PART 1

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

NAME_____ DOB_____ BADGE NUMBER_____

DEPT _____ TODAY'S DATE_____ GENDER ☐ Male ☐ Female

Height _____ Ft _____ In WEIGHT_____ JOB TITLE _____

A phone number where you can be reached by the health care professional who reviews this questionnaire (include Area Code)_____

WHAT TYPE OF RESPIRATOR(S) WILL YOU BE USING? (you can check more than one) ☐ N95 disposable respirator (filter mask, non-cartridge only) ☐ Other type (half/full face mask, PAPR, SCBA, Surgical)

Have you ever worn a respirator? ☐ No ☐ Yes, what type(s) _____

Part 2 (Mandatory): QUESTIONS 1-9 BELOW MUST BE ANSWERED BY EVERY EMPLOYEE WHO HAS BEEN SELECTED TO USE ANY TYPE OF RESPIRATOR.

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? Yes ☐ No ☐

2. Have you ever had any of the following conditions?
   ☐ Seizures (fits) ☐ Diabetes (sugar disease) ☐ Allergic reactions that interfere with your breathing ☐ Trouble smelling odors
   ☐ Claustrophobia (fear of closed-in places)
   ☐ NONE OF THE ABOVE

3. Have you ever had any of the following pulmonary or lung problems?
   ☐ Asbestosis ☐ Asthma ☐ Chronic bronchitis ☐ Emphysema ☐ Pneumonia ☐ Tuberculosis (TB) ☐ Silicosis
   ☐ Pneumothorax (collapsed lung) ☐ Lung cancer ☐ Broken ribs ☐ Any chest injuries or surgeries
   ☐ Any other lung problems you've been told about_____
   ☐ NONE OF THE ABOVE

4. Do you currently have any of the following symptoms of pulmonary or lung illness?
   ☐ Shortness of breath ☐ Shortness of breath when walking on level ground or walking up a slight hill or incline
   ☐ Shortness of breath when walking with other people at an ordinary pace on level ground
   ☐ Have to stop for breath when walking at your own pace on level ground ☐ Shortness of breath when washing or dressing
   ☐ Shortness of breath that interferes with your job ☐ Coughing that produces phlegm (thick sputum)
   ☐ Coughing that wakes you early in the morning ☐ Coughing that occurs mostly when you are lying down
   ☐ Coughing up blood in the last month ☐ Wheezing ☐ Wheezing that interferes with your job
   ☐ Chest pain when you breathe deeply ☐ Any other symptoms that you think may be related to lung problems
   ☐ NONE OF THE ABOVE

5. Have you ever had any of the following cardiovascular or heart problems?
   ☐ Heart attack ☐ Stroke ☐ Angina ☐ Heart failure ☐ Swelling in your legs or feet (not caused by walking)
   ☐ Heart arrhythmia (irregular heartbeat) ☐ High blood pressure ☐ Any other heart problems you've been told about
   ☐ NONE OF THE ABOVE

6. Have you ever had any of the following cardiovascular or heart symptoms?
   - ☐ Frequent pain or tightness in your chest ☐ Pain or tightness in your chest during physical activity
   - ☐ Pain or tightness in your chest that interferes with your job ☐ past two years, noticed your heart skipping or missing a beat
   - ☐ Heartburn or indigestion not related to eating ☐ Any other symptoms that you think may be related to heart problems
   - ☐ NONE OF THE ABOVE

7. Do you currently take medication for any of the following problems?
   - ☐ Breathing or lung problems ☐ Heart trouble ☐ Blood pressure ☐ Seizures (fits)
   - ☐ NONE OF THE ABOVE

8. If you have used a respirator, have you ever had any of the following?
   - ☐ Eye irritation ☐ Skin allergies/rashes ☐ Anxiety ☐ General weakness/fatigue
   - ☐ Any problem that interferes with your use of a respirator ☐ Any significant structural changes to your face/head
   - ☐ NONE OF THE ABOVE

9. Would you like to talk with a healthcare professional who will review this questionnaire about your answers to this questionnaire?
   ☐ YES ☐ NO

JEFFERSON HEALTHCARE EMPLOYEE HEALTH SERVICES

*I have been educated on *the instructions for use, reasons for usage, donning and doffing, storage, and replacement indicators for this respirator(s).* *

Badge ID#:_____ Dept: _____

Name: _____ DOB: _____

Employee Signature: _____Date:_____

Mask fitted for: 3M 1860S/ 1804/ 1870+/ 1860/ CAPR/ Surgical Mask

Fit Process: Qualitative Saccharin/Biterex or Quantitative Machine Fit Test

◯ Voluntary N95 usage: OSHA Appendix D to Sec. 1910.134 form provided: _____

Person reviewing this questionnaire/performing testing/educating employee:

(EH Staff/Designee) _____ Date_____

Jefferson Healthcare

CREATED: 3/7/16
ARCHIVED: N/A
OWNER: Employee Health
PURPOSE: TB Medical Screen

TB SYMPTOM SCREENING SAFETY PROGRAM
MEDICAL QUESTIONNAIRE SURVEILLANCE

PURPOSE:

Tuberculosis (TB) screening through use of this medical questionnaire is required for all employees as an assessment tool who are a new hire or have had a prior positive TB skin test or positive Interferon Gamma Release Assay (IGRA) lab test. An annual chest x-ray is not recommended by the Centers for Disease Control unless employee is symptomatic. TB is transmitted by people with active TB who cough, sneeze, talks, or sings in the vicinity of others. Latent tuberculosis has the potential to activate in times of stress or when the body is immunocompromised and spread disease to others, including friends, family, and patients. Latent TB is treatable! If you have been diagnosed with latent TB It is highly recommended to see your medical provider if you have not been treated for latent TB infection (LTBI).

YOU MAY FAX THIS FORM TO 344-1006, BRING IN, OR SEND ORIGINAL IN INTEROFFICE MAIL.

NAME:_____ **BADGE#:**_____ **DATE:**_____

DEPT:_____ **SIGNATURE:**_____

Have you ever had or do you now have any of the following:

		*YES	NO
1.	Persistent cough longer than 3 weeks	☐	☐
2.	Night sweats	☐	☐
3.	Unexplained weight loss	☐	☐
4.	Unusual fatigue	☐	☐
5.	Anorexia (loss of appetite) for more than two months	☐	☐
6.	Hemoptysis (coughing up blood)	☐	☐
7.	Persistent temperature elevations over the past few months	☐	☐
8.	History of active TB within the past year or recently diagnosed TB and no subsequent disease inactivity	☐	☐
9.	Exposure to person with active TB in the past 2 years without personal protection equipment	☐	☐
10.	Abnormal chest x-ray (upper lobe infiltrates, cavitation, other infiltrates - if no other cause)	☐	☐
11.	History BCG vaccination (vaccine against TB)	☐	☐
12.	History of positive Quantiferon Gold or T-Spot (blood test confirming TB)	☐	☐
13.	Current use of immunosuppressive medications	☐	☐
14.	Have you ever had past 3-9 months of INH antibiotic therapy for TB **(If Yes- please send in record of INH treatment completion)**	☐	☐

***Please explain YES answers:**

Paper copies of this document may not be current and should be verified before use. The current version of this document can be found at: http://jeffersonhc.sharepoint.com/EmployeeHealthTeam/Documents/Forms1/TBMedicalScreeningQuestionaire

Washington State Department of Health
DOH 343-144 March 2019

Adult Tuberculosis Risk Assessment

- Use this tool to identify asymptomatic **adults** for latent TB infection (LTBI) testing.
- **Do not repeat testing** unless there are new **risk factors** since last test.
- Do not treat for LTBI until active TB disease has been excluded:
  For patients with TB symptoms or an abnormal chest x-ray consistent with active TB disease, further evaluation may be needed such as: sputum AFB smears, cultures and nucleic acid amplification testing. A negative tuberculin skin test or interferon gamma release assay does not rule out active TB disease.

LTBI testing is recommended if any of the three boxes below are checked.

☐ **Born, live, or travel in a country with an elevated TB rate for at least one month.**

- The duration of at least one consecutive month to trigger testing is intended to identify travel most likely to involve TB exposure.
- Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe.
- If resources require prioritization within this group, **prioritize** patients with at least one medical risk for progression (see Adult TB Risk Assessment User Guide for this list).
- Interferon Gamma Release Assay is preferred over Tuberculin Skin Test for non-U.S.-born persons ≥ 2 years old.

☐ **Immunosuppression**, current or planned.

HIV infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication.

☐ **Close contact** to someone with infectious TB disease during lifetime.

Treat for LTBI, if LTBI test result is positive and active TB disease is ruled out.

☐ None; no TB testing is indicated at this time.

Provider: _____

Assessment Date: _____

Patient Name: _____

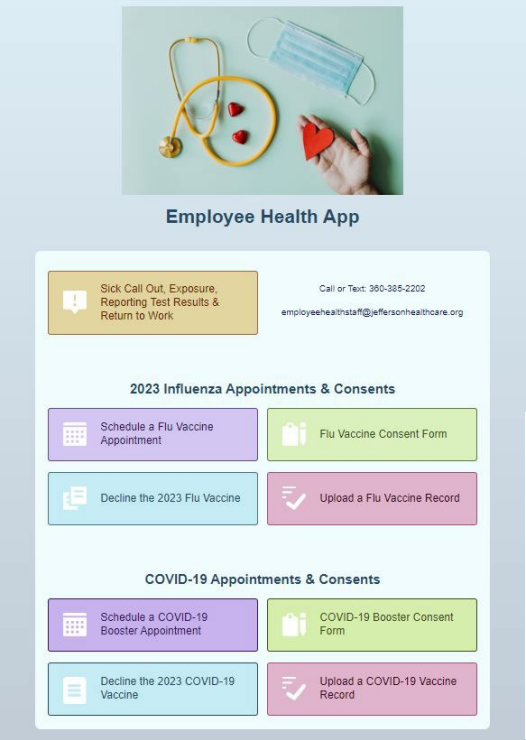
Date of Birth: _____

(Place sticker here if applicable)

See the Adult TB Risk Assessment User Guide (pages 2-3) for more information about using this tool.

Jefferson Healthcare

EMPLOYEE HEALTH APP



What is the Employee Health App?

The Employee Health App is a reporting tool that allows Employee Health to track staff illness, exposures, non-illness call-outs, COVID-19 test results, and returning to work all while keeping coworkers, patients, and families safe.

When should I use the Employee Health App?

- If you are calling out from work or having symptoms of illness.
- If you have tested positive for or been exposed to COVID-19 or other contagious illness.
- A negative COVID-19 antigen test does not automatically clear you to return you to work.

How do I report through the Employee Health App?

- Use the above QR code with your phone. You will have the option of putting the app on your home screen for future use.
- Access it by going to the JH website, click For Employees at the bottom right of the page or on the Jefferson Healthcare Intranet webpage.
- After report submission, you will immediately receive guidance based on your answers, and Employee Health will follow up with you if indicated.

How do I report a Bloodborne Pathogen Exposure or Work Injury?

1. Immediately report the incident to the House Supervisor or Clinic Manager. Go to the Employee Health Department Sharepoint page and print out the Bloodborne Pathogen Exposure or Work Injury packet single-sided for the instructions.
2. For a Bloodborne Pathogen Exposure, please be sure the House Supervisor or Clinic Manager has the Source Patient information and follows up **before** the patient leaves the facility.
3. Notify Employee Health via email at employeehealthstaff@jeffersonhealthcare.org

Jefferson Healthcare

What do I do with these fillable documents?

1. Completely fill out the forms.
2. Download the completed forms to your computer.
3. Email them to cschaff@jeffersonhealthcare.org and apankau@jeffersonhealthcare.org
4. **OR** print them out and bring them with you to your Employee Health new hire appointment.

Thank you,

Jefferson Healthcare Employee Health Team