

MCG Health Occupational Health Services

Post-Hire Physical Guidance Package



Welcome to MCG's Occupational Health Services. As a new employee it can often be a frightening transition. We have designed this packet to assist you with your process in a smooth and helpful manner. Please feel free to call our office for any questions you may have or simply ask the questions when you bring your paperwork back to the office for your initial visit with us.

We hope you find this information helpful and insightful in the first steps of your post-hire process with our department. Once again, welcome to MCG Health.

All new/returning candidates are required to undergo several different processes during the post-hire physical. Please make sure to read this completely and adhere to the requested process flow:

- Candidates may be asked to provide a urine sample for testing following strong chain-of-custody protocol. Make sure you do not drink large amounts of water prior to arriving and be sure to have a photo ID available.
- Candidates are required to have a TST/PPD placed for tuberculin testing. If you had a past positive reaction, then a copy of your most current chest X-ray will be accepted.
- Blood will be drawn to check on the status of several childhood immunization levels prior to starting work. If titer levels are below acceptable limits, the Medical Director may offer updates on your vaccinations after your employment begins.
- Most of our candidates are required to undergo an N-95 mask fitting session, therefore, when answering the questionnaire, be honest and forthright regarding any medical condition/s you may have.
- Most of our candidates will have another appointment set to return to the clinic to be examined by our Medical Director. Please make sure your schedule allows for this post-hire examination date.
- A second TST/PPD may be completed on some candidates if they cannot provide a copy of one that is less than one year old placed by another facility. If you have this, please bring a copy with you.

Section 1: Occupational Health History & Respirator Fit Form

Complete this form in its entirety. The top section directly requests your private information in which we populate our data base to form your individual medical record. Please complete this section completely.

The next section is detailed to your complete medical history/status. We ask that you please indicate any illness/conditions for which you have been diagnosed or treated for in the past or present by placing a checkmark in the appropriate box. Utilize the area at the bottom to make comments, and list any medication you may be taking as well. Some questions deal with your childhood immunization status. We ask that you check yes to the ones you can recall. We do not expect you to remember the year/s they were administered.

The bottom left section of the questionnaire is used to assist in determining whether or not you may wear a mask/respirator.

Healthcare workers with a history of cardiac and/or pulmonary problems are required to have further follow up with their physician for written approval to wear a respirator. The OHS Medical Director will determine if further information or follow up is needed prior to being fit-tested. These services must be completed by your treating doctor or your current Primary Care Provider.

Section 2: Hepatitis B Vaccination Form

Hepatitis B is a blood borne pathogen that can attack the liver if a person becomes infected. Part of our post-hire process is to verify you have had the series of 3 vaccinations administered at any time in your life and were told you had positive immunity. If you are unsure of this, you may sign the acceptance, as lab work will be completed to verify your immunity status.

However, if you are certain that you have completed the series you may sign the declination/refusal at the bottom of the page. Again, your labs will be drawn to verify this information.

Employee Signature

Date

My signature is required to validate I have read and understand the information given. I will be allowed to ask questions upon my physical with OHS by a nurse or the Medical Director.

MCG Health Occupational Health Services

New Employee Occupational Health History

LABEL

Personal Information			
Name:		Date of Birth:	
Race:	Sex:	Social Security#:	Marital Status:
Address:		City:	State:
Telephone:		Department Name & extension:	

Check the boxes for YES answers only. PAST = Past Medical History. NOW = Current medical problems.

Do you have or have you had:	Past	Now	Do you have or have you had:	Past	Now	Do you have or have you had:	Past	Now
Skin Rashes or infections			Back or neck problems/pain			Arm or leg numbness		
Hives			Disc problems			Dizziness, fainting spells		
Reaction to soap/detergents			History of falling			Frequent/severe headaches		
Vision and Hearing:	Past	Now	Sacroiliac pain/problems			Seizures, convulsions		
Glasses for reading?			Missed work r/t back pain			Multiple sclerosis		
Glasses for distance vision			Shoulder or arm pain/problems			Nerve damage		
Wear contact lenses			Leg or knee pain/problems			Nerve surgery		
Are you color blind?			Swollen joints			Cirrhosis, Jaundice, Hepatitis		
Any other visual problems?			Arthritis or gout			Stomach pain or ulcers		
Any work with lasers?			Bursitis or tendonitis			Hernia repair		
Any difficulty hearing?			Trouble walking or standing			Abdominal surgery		
Use hearing aides?			Trouble with sitting			Other intestinal problems		
Have you ever had:	Past	Now	Have you had surgery on:	Date		Excessive weight loss/gain *		
Chest pain *			Back or neck			Anemia		
High blood pressure			Shoulder, elbow, wrist, hand			Night sweats		
Shortness of breath *			Knee, ankle, or foot			Diabetes		
Swelling of the ankles	Past	Now	Facial or Dental *			Thyroid trouble or goiter		
Heart murmur			Other:			Kidney trouble		
Palpitations			Do you have weakness of:	Past	Now	Have you had the following:	Date:	
Heart surgeries			Arm, wrist or hand			Chicken Pox		
Do you have or had:	Past	Now	Leg, knee, ankle, or foot			Shingles		
Allergies			Previous jobs involving:	Past	Now	Red Measles (Rubeola)		
Chronic cough			Highly repetitive motions			German Measles (Rubella)		
Asthma, bronchitis			Power/vibration tools			Mumps		
Bloody Sputum			Work exposure to:	Past	Now	Vaccination History:	Date:	
Tuberculosis (TB): No Yes Treated			dust/fumes			MMR		
BCG Vaccine (date):			Chemicals			DPT/Td/Tdap		
Have you ever used:	Past	Now	Any difficulty working due to:	Past	Now	Polio		
Respirator or industrial mask			Stress, anxiety, or depression			Hepatitis B		
N95 Particulate Mask *			Do you or have you ever:	Past	Now	Influenza		
Ever experience sense of claustrophobia with a mask? *			Smoked cigarettes*			Other:		
			Other tobacco products*			Other:		
List known allergies:								
Pre-Placement Latex Allergy History								
Are you allergic to rubber, latex or powder in gloves?							Yes	No
Do your lips swell or itch after you blow up a balloon?							Yes	No
Do you have reactions (swelling, itching, trouble breathing/swallowing during dental procedures)?							Yes	No
Have you had eczema or rashes on your hands?							Yes	No
Have you had rashes, hives or other reactions to wearing gloves or to powder in gloves?							Yes	No
Are you allergic to any fruits or vegetables? List:							Yes	No
Please comment on positive responses above and list any other health issues not listed above:						List all medications taken regularly:		

Signature:

Date:

**MCG Health
Occupational Health Services
Hepatitis B Vaccination Consent/Waiver**

LABEL

Name: _____ SS#: _____ DOB: _____

A. Consent for Hepatitis B Vaccine

I, _____ consent to be immunized against hepatitis B. I acknowledge the following.

1. I have been informed that I am at risk of acquiring hepatitis B because of the nature of my professional responsibilities.
2. I have read the information sheet that lists the indications, benefits, and presently known side effects of hepatitis B vaccine, have had an opportunity to ask questions, and have had them answered to my satisfaction.
3. I must receive three (3) doses of vaccine over a period of six (6) months to confer optimal immunity.
4. I understand, however, as with all medical treatment, there is no guarantee that I will become immune or that I will not experience an adverse reaction to the vaccine.
5. In the event that I should terminate my employment at MCG Health Inc. prior to receiving all three (3) doses of the Hepatitis B Vaccinations, I understand it will be my own responsibility to complete the series at my own expense.

Are you currently pregnant or breast feeding? Yes _____ No _____ NA _____.

Employee Signature

Department

Date

B. Previous Immunization with Hepatitis B Vaccine

I, _____, have previously completed a three-dose series of the Hepatitis B Vaccine at _____ Date _____.

Employee Signature

Department

Date

C. Refusal to Receive Hepatitis B Vaccine

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.

Employee Signature

Department

Date