Welcome to Sharp HealthCare - The Best Place to Work!

During your visit a drug screen, tuberculosis screen, history & physical exam, and immunizations will be completed and will take approximately 1 & 1/2 hours.

Please complete pages labeled 1-6. If you have any questions on any of the items in the paperwork, please feel free to give us a call or you may leave the question(s) blank and discuss it with us when you arrive for your appointment.

In the event that you are going to be late for your appointment, please call us in advance so we can make any arrangements needed and notify our clinical staff of the delay. If you are more than 15 minute late, your appointment is subject to rescheduling at a later date or time, which may result in a delay in your start date. It is recommended that you do not bring children to your appointment. Please make arrangements for child care.

TB Placement Date (if applicable):	Aug 12, 2020	**Time:**	1:10:00 PM
Physical Appointment Date:	Aug 12, 2020	**Time:**	1:10:00 PM

**** PLEASE ARRIVE TO PHYSICAL APPOINTMENT 10 MINUTES EARLY****

Appointment Location: Spectrum EOHD- 8695 Spectrum Ct Blvd, San Diego, CA 92123 - Office #: (858)499-5259

Be Sure to follow the instructions below and bring the items listed to your first appointment. Immunization records are critical to

Drug Screening Preparation (except Accumen Employees)

1. Drink no more than 6 to 8 ounces of fluid in the 2 hours preceding your appointment. Fasting is not required. Please eat and take prescribed medications.
2. A urine specimen will be collected for drug screen testing during this appointment. Please advise us as soon as possible if you are in need of an accommodation to participate in the testing process.

Please bring ALL of the following to your appointment:

1. Current photograph identification - current valid Driver's License, Passport or California ID.
2. Immunization Records or Titers
   a)If you work in a patient care area (even if you do not come in direct contact with patients) you are **required** to provide records of the following immunizations: Measles (Rubeola), Mumps, Rubella, Varicella and Tetanus Diphtheria /Pertussis (Tdap) and Influenza.
   b)Hepatitis-B vaccine is recommended but not required if you have direct contact with patients.
   c)It is important to bring records to your appointment in order to avoid any delay in the hiring process. If you can not provide records, you will be required to receive mandatory vaccines.
   *You may be able to access your records online, please check with your provider.
3. TB (tuberculosis) skin testing (also known as a PPD Test).
   a) If you have a history of negative TB Skin Test within the last 12 months, please bring a copy. You will be given a TB Skin Test and you will have it read at your 2nd appointment. TB Skin Testing is required for all New Employees and Volunteers.
   b) If you have a history of positive TB Skin Test, bring a copy of the positive TB Skin Test and a copy of your chest x-ray report (if x-ray was done within last 6 months).
4. Name and phone number of prescribing provider for any prescribed medications.
5. Glasses if you wear them.
6. Please do not bring children to your appointments. If there is a case where you need to bring your child(ren), please bring someone with you to supervise your child(ren) in the waiting room while you are completing your physical on the first and second appointment. If you have any questions on this, the secretary can help you.
7. If you are in need of an interpreter to assist with hearing loss, please let us know before you arrive.

Post Offer Drug Screen Frequently Asked Questions

WHY DOES SHARP HEALTHCARE CONDUCT DRUG SCREENING?

Sharp HealthCare follows the federal Drug-Free Workplace Act. All employees offered employment are required to complete a urine drug screen as part of the post offer employment process.

WHAT SUBSTANCES ARE TESTED FOR IN THE POST-OFFER URINE DRUG SCREEN?

The urine drug screen tests for the following substances:

- *Amphetamines*
- *Barbituates*
- *Benzodiazipines*
- *Cocaine*
- *Marijuana*
- *Methadone*
- *Opiates*
- *Phencyclidine*

CAN I STILL BE ELIGIBLE TO MOVE FORWARD WITH THE HIRING PROCESS IF I DO NOT PASS THE URINE DRUG SCREEN?

If you do not pass the urine drug screen, the post offer employment process will not move forward. Eligibility to reapply for a position at Sharp HealthCare will be restricted to one year from the date of notification of a failed urine drug screen.

DOES SHARP HEALTHCARE ALLOW RECREATIONAL MARIJUANA OR MEDICINAL MARIJUANA (MEDICAL CARD)?

No, Sharp HealthCare manages federal contracts and therefore is required to follow the federal regulations for a drug-free workplace. Marijuana is considered illegal by federal laws. We follow the federal law as a Drug-Free Workplace and marijuana usage, both recreational and medicinal, are not permitted, even if California has legalized it.

WHAT IF MY MEDICAL DOCTOR PRESCRIBES MARINOL (PRESCRIPTION THC)?

A prescription for Marinol that is filled at a U.S. Pharmacy and is verified by a Medical Doctor is permitted. A "medical marijuana card" is not a valid prescription and in violation of federal regulations.

WILL CANNABIDIOL (CBD) CAUSE A POSITIVE THC RESULT?

CBD will not cause a positive result. CBD does not contain THC.

Employee Wellness Screening:
As part of our journey to be the best place to work, Sharp offers complementary health screenings as part of your new hire screening process. This optional health screening will measure your blood sugar and cholesterol. Participation does not impact the new hire process or your start date.

A few things about the screening:
· It should take a few extra minutes to complete.
· It is completely confidential - the results will be confidential and not shared with human resources or managers
· Like all wellness activities at Sharp, participation is voluntary.
· As a thank you for taking the time to learn more about your health, you will receive a Sharp Best Health Lunch Bag!

EMPLOYEE OCCUPATIONAL HEALTH DEPARTMENT

PARKING PERMIT
FOR EOHD NEW HIRE CANDIDATE

DISPLAY ON FRONT DASHBOARD

VALID THROUGH: Aug 14, 2020

EMPLOYEE OCCUPATIONAL HEALTH DEPARTMENT
HEALTH HISTORY QUESTIONNAIRE

Name: Ferreiro, Maria Suzana

We require you to submit to a health examination to determine your capacity to work or volunteer safely without creating hazards for yourself or others. This examination is for the purpose of evaluating you for employment at Sharp HealthCare only, and is not designed to substitute treatment by your own physician or for any periodic examination that you may require.

Answers to specific questions will be considered only to the extent that they are medically related to your ability to safely perform the duties of your position, with or without an accommodation.

In answering the following questions, please mark the appropriate responses for each question or condition and write a response where indicated. If you cannot understand or respond to these questions, for any reason, please advise the secretary or other Employee Occupational Health Department staff person immediately.

Please answer the following questions about yourself.

Date of Birth:	Age:	Gender:
Home Number:		Cell Number:
Mailing Address:		
City:	State:	Zip Code:

Allergies (Please list all Medication, Food or Latex Allergies AND describe reaction)

Medications

Medical History

Please answer the following questions regarding your past and current medical history. Answers to specific questions will be considered only to the extent that they are medically related to your ability to safely perform the job for which you are applying or being considered.

	Yes	No	Date:
Vision Problems	☐	☐	
Color Blindness	☐	☐	
Injury to eye	☐	☐	
Cataract	☐	☐	
Glaucoma	☐	☐	
Do you wear Glasses/Contacts?	☐	☐	
If yes, check one; ☐ Near ☐ Distance Correction ☐ Both			
Loss of Hearing	☐	☐	
Use Hearing aid	☐	☐	
Ringing in ears	☐	☐	
Asthma	☐	☐	
Bronchitis/ Emphysema	☐	☐	
Pneumonia	☐	☐	
Shortness of Breath	☐	☐	
Chronic Cough	☐	☐	
Lung problems			
Tuberculosis	☐	☐	
High Blood Pressure	☐	☐	
Heart Murmur	☐	☐	
Heart Disease or Failure	☐	☐	
Heart Attack	☐	☐	
Blood Clots / Embolus	☐	☐	
Stroke	☐	☐	
Angina / (Chest Pain)	☐	☐	
Varicose Veins	☐	☐	
Leg Ulcers	☐	☐	
Swelling of Ankles	☐	☐	
Leg pain on walking	☐	☐	
Stomach/ Intestinal Problems	☐	☐	
GI Bleeding	☐	☐	
Hepatitis	☐	☐	
Hernia	☐	☐	
Cirrhosis or Liver Disease	☐	☐	
Frequent diarrhea	☐	☐	
Nausea/Vomiting	☐	☐	
Kidney Infection	☐	☐	
Bladder/Urinary Problems	☐	☐	
Disc Disease	☐	☐	
Joint Problems	☐	☐	
Osteoporosis	☐	☐	

	Yes	No	Date:
Arthritis	☐	☐	
Tendonitis	☐	☐	
Frequent back aches/pain	☐	☐	
Back Injury / Strain	☐	☐	
Head / Neck Injury	☐	☐	
Broken Bones	☐	☐	
Type:			
Dislocations	☐	☐	
Chiropractic Treatment	☐	☐	
Painful Feet	☐	☐	
Dermatitis/Eczema	☐	☐	
Psoriasis	☐	☐	
Sensitivity to chemicals	☐	☐	
Skin Problems	☐	☐	
Type:			
Seizures	☐	☐	
Sleep disorders	☐	☐	
Guillain-Barré	☐	☐	
Frequent Headaches	☐	☐	
Fainting Spells	☐	☐	
Loss of Conciousness	☐	☐	
Dizziness or vertigo	☐	☐	
Daytime Sleepiness	☐	☐	
Anxiety	☐	☐	
Hyperactive disorder	☐	☐	
Depression	☐	☐	
Bipolar disorder	☐	☐	
Post traumatic stress disorder	☐	☐	
Obsessive compulsive disorder	☐	☐	
Other Mental Health conditions	☐	☐	
If other, Please note;			
Hyperthyroid	☐	☐	
Hypothyroid	☐	☐	
Diabetes Type I	☐	☐	
Diabetes Type II	☐	☐	
Significant Weight Loss/Gain	☐	☐	
Loss of appetite	☐	☐	
Anemia	☐	☐	
Leukemia	☐	☐	
Blood Disorders	☐	☐	
Immune Disorders	☐	☐	
Cancer/Tumors	☐	☐	

Hospitalizations / Surgical / Motor Vehicle Accidents Causing Injury / Sports Injury History

Surgery or hospitalization for what condition	Year	Name & Location of Hospital	Treatment

Do you have any other medical condition that may affect your ability to perform the job you are applying for? ☐ Yes ☐ No
If yes; are you in need of an accomodation to perform the job?

Please carefully read and sign the following.

I hereby declare that, to the best of my knowledge and belief that the information given above is correctly recorded, complete and true.

Signature: Date:

For Clinical Use below this line

SHARP

EMPLOYEE OCCUPATIONAL HEALTH DEPARTMENT

Section 5199 Appendix B - Alternate Respirator Medical Evaluation Questionnaire for Filtering Facepiece Respirators used for Protection against Infectious Aerosols

To the Employer: Answers to questions in Section 1, and to question 6 in Section 2 of Part A, do not require a medical examination.

To the Employee: Complete only if providing direct patient care. Can you read and understand this? ☐ 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 or review your answers, and must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Part A- Section 1:

The following information must be provided by every employee who has been selected to use any type of respirator. (Please Print)

Name: Ferreiro, Maria Suzana Age: Sex: F

Job Title: ACCESS SVC REP-PT FOCUS Height: Weight:

Phone number where you can be reached (list others if applicable) :

The best time to contact you at this number:

Has your employer told you how to contact the health care professional who will review this questionnaire? ☐ Yes ☐ No

Check the type of respirator you will use (You can check more than one category)

☐ N, R or P disposable respirator such as an N95 TB mask (filter-mask, non-cartridge type only; **Such as an N95 Mask used in patient care areas).**

☐ Other type (ex., half- or full-facepiece type, PAPR, supplied-air, SCBA). Fill in type here: _____

☐ I do not know if my position will require an N95 Mask.

☐ I will not need to wear any type of respirator including an N95.

Have you ever worn a respirator? ☐ Yes ☐ No

If "yes", what type(s)?

Part A- Section 2:

Questions 1 through 6 below must be answered by every employee who has been selected to use any type of respirator. Please mark "yes" or "no" for each question.

1.	Have you ever had any of the following conditions? a. Allergic reactions that interfere with your breathing What did you react to?	☐ Yes	☐ No
	b. Claustrophobia (fear of closed-in places)	☐ Yes	☐ No
2.	Do you currently have any of the following symptoms of pulmonary or lung illness: a. Shortness of breath when walking fast on level ground or walking up a slight hill or incline?	☐ Yes	☐ No
	b. Have to stop for breath when walking at your own pace on level ground?	☐ Yes	☐ No
	c. Shortness of breath that interferes with your job?	☐ Yes	☐ No
	d. Coughing that produces phlegm (thick sputum)?	☐ Yes	☐ No
	e. Coughing up blood in the last month?	☐ Yes	☐ No
	f. Wheezing that interferes with your job?	☐ Yes	☐ No
	g. Chest pain when you breathe deeply?	☐ Yes	☐ No
	h. Any other symptoms that you think may be related to lung problems?	☐ Yes	☐ No
3.	Do you currently have 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 activity?	☐ Yes	☐ No
	c. Pain or tightness in your chest that interferes with your job?	☐ Yes	☐ No
	d. Any other symptoms that you think may be related to heart or circulation problems?	☐ Yes	☐ No
4.	Do you currently take any medications for any of the following problems: a. Breathing or lung problems?	☐ Yes	☐ No
	b. Heart troubles?	☐ Yes	☐ No
	c. Nose, throat or sinuses?	☐ Yes	☐ No
	d. Are your problems under control with these medications?	☐ Yes	☐ No
5.	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 box and go to question 6)	☐ Yes	☐ No
	a. Skin allergies or rashes?	☐ Yes	☐ No
	b. Anxiety?	☐ Yes	☐ No
	c. General weakness or fatigue?	☐ Yes	☐ No
	d. Any other problem that interferes with your use of a respirator?	☐ Yes	☐ No
6.	Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?	☐ Yes	☐ No

Signature: _____ Date: _____

SHARP

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge I have received the Sharp HealthCare Notice of Privacy Practices (3/03) as required by federal regulation 45CFR 164.520.

Signature: _____ Date: _____