Health at Work
Health for Our Employees
1313 Carolina Street, Suite 102 – Greensboro, NC 27401 – 336-832-3850

# Contract/Provider/Volunteer Post Offer Health History

## DEMOGRAPHICS

| | | | |
|---|---|---|---|
| **Have you ever staffed for any entity that is now a Cone Health entity?** | | | ☐ Yes ☐ No |
| **Last Name** | | **First Name** | |
| **Social Security #** | | **Date of Birth** | |
| **Gender Identity** | ☐ Male ☐ Female | | |
| **Job Title** | | **Specialty / Department** | |
| **Campus** | ☐ Alamance ☐ Women's<br>☐ Annie Penn ☐ System Wide<br>☐ Moses Cone<br>☐ Wesley Long ☐ Other | **Anticipated Start Date with Cone Health** | |
| **Mailing Address** | **STREET:**<br>**CITY:** **STATE:** **ZIP:** | | |
| **Email Address** | | **Daytime Phone** | **(  )** |
| **Name of Office Contact** | Joanna Washington | **Email of Office Contact** | Joanna.washington@ayalocums.com |
| **Emergency Contact Name** | | **Emergency Contact Phone** | **(  )** |

## HEALTH INFORMATION

| | |
|---|---|
| **Do you have any communicable disease?**<br>**(i.e. Hepatitis B, Hepatitis C, HIV)**<br>*Note: This information is used for the Health at Work Medical Director to make a determination as to the safety of providing care. For most providers, there is no contraindication for staffing. This information is never released to any other individual, unless required by law (i.e. Health Department).* | ☐ **No**<br>☐ **Yes (please list)** |
| **Do you have any medical conditions or limitations that would affect your ability to perform the essential functions of the job with or without accommodation?** | ☐ **No**<br>☐ **Yes (please explain)** |
| **Do you have allergies to vaccinations, medications, latex or other items that you may encounter while staffing at Cone Health?** | ☐ **No**<br>☐ **Yes (please list)** |

## ACKNOWLEGEMENT

I have been informed of the Health at Work requirements for Cone Health. I agree to provide all documentation or receive required vaccinations within 5 business days of notification. I understand my assignment may be interrupted if I am not in compliance.

**Signature: X**_____ **Date:** _____

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# *DRUG SCREEN CONSENT*

N.C. Controlled Substance Examination Regulation Act - Initial Notice to Employees/Applicants

In accordance with Cone Health policy, you have been selected for a controlled substance test for the purpose of post offer screening, post-accident screening or reasonable suspicion screening. In accordance with 13 NCAC 20.0401, this Notice explains your rights and responsibilities under the N.C. Controlled Substance Examination Regulation Act ("CSERA") (Chapter 95, Article 20 of the N.C. General Statutes) and the corresponding administrative rules (Title 13, Chapter 20 of the N.C. Administrative Code).

- You may refuse the drug screen test; however, if you refuse to submit to the test or try to avoid the test or affect the results of the test by any trick or device, you will not be hired or your employment may be terminated for current employees.
- Cone Health may collect samples from both applicants and current employees on-site.
- Cone Health may screen samples from applicants using an instant test.
- All screening of samples for current employees must be conducted by an approved laboratory.
- Any positive results will be confirmed by an approved lab using gas chromatography with mass spectrometry (GS/MS).
- Both applicants and current employees can request a "re-test" of any positive sample that has been confirmed by an approved laboratory. The re-test can be conducted by the same or another approved laboratory. All re-tests must be of the **same sample** and **must be paid for by the applicant** or current employee.
- Results of controlled substance examinations, medical histories and use of lawful prescription drugs must be kept confidential by the employer.
- You can file a complaint with the N.C. Department of Labor – Wage and Hour Bureau at (919) 807-2796 or 1-800-NC-LABOR if you believe procedural requirements of the CSERA were violated. The Department has no jurisdiction regarding an employer's requirement for controlled substance testing or its decisions regarding results of controlled substance testing.
  If you desire a retest, you must notify Health at Work in writing within 90 days of the date your sample was collected. You must specify to which approved laboratory the sample is to be sent. You will be responsible for payment of all reasonable expenses for chain of custody procedures, shipping and testing of the positive sample. If the results of the retest are negative, your expenses will be reimbursed by Cone Health.

I understand that as a condition of my employment or continued employment with Cone Health, I must abide by the terms of the Substance Abuse Policy and may be required to submit to such testing as a condition of employment with Cone Health. I understand disciplinary action, up to and including termination of employment may result if I refuse to consent to such testing, if I refuse to execute all forms of consent as are usually and reasonable attendant to such examinations, if I refuse to authorize release of testing results to Cone Health, if the results of the test establish a violation of the Substance Abuse Policy, or if I otherwise violate the policy.

**I acknowledge receipt of the above Notice of Rights. I hereby consent to the administration of the drug test and to the terms and conditions of the consent agreement.**

| **List all Medications (Prescription & Over the Counter) you have taken in the last 30 days (or write none).** | |
|---|---|
| **Were you hospitalized in the last 30 days?** ☐ **Yes** ☐ **No** | |
| **Candidate Signature:** | **Date:** |
| **Witness Signature:** | **Date:** |

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## *TB SCREENING QUESTINONAIRE*

| **TB SYMPTOM SCREENING** | **YES** | **NO** |
|---|---|---|
| **1.** Have you had a **productive cough or bloody sputum** for longer than 3 weeks that is **new or abnormal for you**? *(answer No if explained by condition like asthma, allergy, COPD)?* | ☐ | ☐ |
| **2.** Have you had **persistent fever** that has lasted for more than 1 month that you **cannot explain with illness** like flu, pneumonia, etc *(answer No if caused by an illness like flu, cold)?* | ☐ | ☐ |
| **3.** Have you had **heavy night sweating** leaving sheets and bedclothes wet in the last month that is **new or abnormal for you** *(answer No if caused by menopause, etc)?* | ☐ | ☐ |
| **4.** Have you had **unexplained weight loss or loss of appetite** in the last month? *(answer No if caused by dieting, exercise, known illness)* | ☐ | ☐ |
| **5.** Have you had **unexplained fatigue/tiredness** more than what is usual for you? | ☐ | ☐ |
| **TB EXPOSURE SCREENING** | **YES** | **NO** |
| **6.** Did you **travel** outside the United States in the last year? If Yes, **please list location and reason**: | ☐ | ☐ |
| **7.** Have you ever had a reaction to a TB Test (told not to take a TB test again)? **IF YES**: Please **describe as much as you know** : Year of Abnormal Test ☐ \| Last Chest X-Ray ☐ \| Health Dept Visit ☐ \| Medication Taken? ☐ | ☐ | ☐ |

**---------OFFICE USE ONLY BELOW---------**

**POST OFFER:**

☐ QFG Ordered ☐ QFG/TSpot Documented w/I 30 days ☐ Prev Positive, no s/s, no QFG indicated

**Clinician: P Boyd / L Draper / G Fountain / M Frazier / D Guzman / B Haddock / S Hampton / J Mann / K Nichols / S Nichols / E Pimentel / C Queen / B Roberts / T Robertson / B Trevino / J Walker**

**(SIGN IF NAME NOT LISTED ABOVE)** _____

## *Authorization for Release of Medical Information*

I authorize the Health at Work Department, a service provided by the Cone Health System, its physicians and other health care professionals involved in providing my care to obtain and release medical information obtained during this visit for purposes of treatment and health care operations. This includes results/outcomes for services as requested/required by my employer/third party affiliate as listed but not limited to:

- Post-offer testing including physicals limitations, immunizations
- Any/all diagnostic results
- Urine Drug Screen results, Lab results, Breath Alcohol Test results
- Results of any/all medical procedures, x-rays, MRI, Ultra Sounds, etc.
- Physical Capacity Profile testing and/or Return to Work evaluations

I understand this information will be provided only to my employer/third party affiliate, as identified below by Health at Work physicians and other health care professionals on a business need to know basis only. I agree to release and hold harmless, the Health at Work Department of Cone Health System, its physicians and other health care professionals from any/all responsibility that may result from procedures, examinations, tests, treatment, release of information and use of the NC Controlled Substance Reporting System as outlined by this authorization. I understand that this authorization will apply for the entirety of my employment/assignment at Cone Health. *Updated: 8/2017 1/2019*

| EMPLOYER/THIRD-PARTY AFFILIATE | Cone Health and Contracted Agencies |
|---|---|
| **Candidate Signature:** | **X** |

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## OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

This questionnaire was adapted from 29 CFR 1910-134 Appendix C – January 1998 and is required for all staff who wear respirators.

**SECTION 1- MANDATORY** (Please Print) ☐ **Check here if candidate needs help completing/reading this form**

| **Check the type of respirator(s) you will use**: | **Have you worn a respirator?** ○ Yes ○ No |
|---|---|
| ⊗ N-95 disposable respirator (filter mask, non-cartridge type only)<br>⊗Powered Air Purifying (PAPR/CAPR**)**<br>○Haz-Mat Powered Air Purifying Respirator (PAPR**)** | If Yes, what type? _____ |

**SECTION 2- MANDATORY** (Please Print)

| | YES | NO |
|---|---|---|
| **Do you currently smoke tobacco or have you smoked tobacco in the last month?** | | |
| **Have you *ever had* any of the following conditions?** *(Please circle any that apply to you)*<br>Seizures Diabetes (sugar disease) Allergic reactions that interfere with you breathing Claustrophobia (fear of closed-in places) | | |
| **HAW comments:** | | |
| **Have you *ever had* any of the following pulmonary or lung problems?** *(Please circle any that apply to you)*<br>Asbestosis Asthma Chronic Bronchitis Emphysema Pneumonia Tuberculosis<br>Pneumothorax (collapsed lung) Lung Cancer Broken Ribs Chest injuries or surgeries<br>Any other lung problem that you've been told about: | | |
| **HAW comments:** | | |
| **Do you *currently* have any of the following symptoms of pulmonary or lung illness?** *(Please circle any that apply to you)*<br>Shortness of breath Coughing Wheezing Chest Pain<br>Any other symptoms that you think may be related to lung problems: | | |
| **HAW comments:** | | |
| **Have you *ever had* any of the following cardiovascular or heart problems?** *(Please circle any that apply to you)*<br>Heart attack Stroke Angina/Chest Pain or Tightness Heart failure Heartburn High blood pressure<br>Heart arrhythmia (abnormal beating) Swelling in the legs or feet (not caused by walking)<br>Any other heart problem or circulation you've been told about: | | |
| **HAW comments:** | | |
| **Do you *currently* take medication for any of the following problems?** *(Please circle any that apply to you)*<br>Breathing or lung problems Heart trouble Blood pressure Seizures | | |
| **HAW comments:** | | |
| **If you've used a respirator, have you *ever had* any of the following related problems?** *(Please circle any that apply to you)*<br>Eye irritation Skin allergies or rashes Anxiety General weakness/fatigue<br>Any other problems that interferes with your use of a respirator: | | |
| **HAW comments:** | | |
| **Has your employer told you how to contact the Health at Work Nurse (the health care professional who will review this questionnaire)?** | | |
| **Would you like to talk to the health care professional who will review this questionnaire about your answers to the questionnaire?** | | |

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**SECTION 3- MANDATORY** (Please Print)

1. 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

2. Have you ever worked with any of the materials listed below?

| | YES | NO |
|---|---|---|
| Asbestos | | |
| Silica | | |
| Tungsten/Cobalt (e.g. grinding/welding material) | | |
| Beryllium | | |
| Aluminum | | |
| Coal (e.g. mining) | | |
| Iron | | |
| Tin | | |
| Hazardous amounts of dust | | |
| Any other hazardous exposures | | |

If yes to any above please describe: _____

3. Have you been in military services? ☐ Yes ☐ No
   **a.** If yes, were you exposed to biological or chemical agents(either in training or combat) ☐**Yes** ☐**No**

4. Have you ever worked on a HAZMAT team? ☐ Yes ☐ No

**EMPLOYEE / Candidate:**
*I have answered all questions accurately to the best of my ability to help determine my ability to wear a respirator. I understand that the respirator and proper fit is for my benefit to help protect me from potential hazard.*

| **Candidate Signature:** | **X** |
|---|---|

**OFFICE USE ONLY BELOW**

## Clinician reviewing medical evaluation:

Approved for Respirator Use: ☐ Yes (N-95 Fit Test/PAPR/CAPR) ☐ Yes (PAPR/CAPR only) ☐ No ☐ HAZMAT

**Clinician: P Boyd / L Draper / G Fountain / M Frazier / D Guzman / B Haddock / S Hampton / J Mann / K Nichols / S Nichols / E Pimentel / C Queen / B Roberts / T Robertson / B Trevino / J Walker**

**(SIGN IF NAME NOT LISTED ABOVE) _____**

## Fit Test Operator:

Respirator: ☐ 1860 Small 3M N95 ☐ 1870+ 3M N95 ☐ Halyard Reg ☐ Halyard Sm ☐ 8210 3M
☐ PAPR/CAPR Only ☐ FAILED (see comments below)
Overall Fit Factor for Quantitative: _____ (Pass is 100 or higher)

*I have instructed and demonstrated the proper use of the respirator(s) indicated above per Cone Health policy and OSHA guidelines; including how to put on, adjust and take off respirator(s) and methods to ensure an adequate fit.*

**Fit Test Operator Signature**: X Date:

*Fit Test Operator Comments - Optional:*