**Please bring these forms with you to your appointment. They do not go to the GME office.**

## PRE-EMPLOYMENT SCREENING AND IMMUNIZATION DOCUMENTATION

All incoming residents/fellows MUST schedule a medical clearance appointment with Occupational Medicine before being cleared to begin.

In order to protect the health of all residents/fellows, employees and patients, and in order to comply with CDC guidelines and immunization requirements mandated by state and federal agencies, all new residents/fellows must undergo Immunization/Tuberculosis screening performed by Employee Health Services (EHS) staff before beginning training, payroll or benefits.

**The following are required:**

1. Written documentation of vaccination with two doses of live vaccine MMR ( measles, mumps, rubella immunization) administered at least 28 days apart, or laboratory documentation of immunity via a positive antibody titer, or laboratory confirmation of disease
2. Written documentation of vaccination with two doses of varicella vaccine, or laboratory confirmation of disease
3. Written Documentation of a completed series of Hepatitis B vaccination **AND** positive Hepatitis B surface antibody titer. Persons who are determined to have anti-HBs titers less than 10 mIU/ml following the primary series will be offered a second 3-dose series. Non-responders will be tested for HBsAg.
4. Documentation of two PPD skin tests at least 2 weeks apart or Quantiferon TB Gold test within the past 12 months. If there is a history of positive PPD or a positive Quantiferon test, a chest x-ray report, if available, would be useful.
5. Documentation of adult Tdap.

**In order to facilitate the screening process:**

Please complete the required immunizations/TB skin tests and have your healthcare provider complete and sign the immunization documentation form included in this packet. Do not sign the form yourself. Complete the Patient questionnaire/Medical History screening form. Bring these documents to your appointment. Do not fax or mail them. Please bring your vaccination records and/or immunization titers to your appointment.

If the immunization/TB test records and antibody titers are not available, we will obtain blood for antibody titers and provide TB skin test/Chest x-ray at no charge to you, but this may delay your clearance. If needed, the required vaccinations will also be provided at no charge to you. Additionally, you may be required to return to EHS as scheduled for subsequent PPD skin testing, vaccinations and/or titers. The Graduate Medical Education (GME) will be notified that you are no longer fit for duty should you fail to meet these requirements.

It is prudent to schedule an appointment early. When you call, it is important that you identify yourself as a resident/fellow.

Our contact information:

Employee Health Service/Division of Occupational and Environmental Medicine
263 Farmington Avenue, Outpatient Pavilion, 2nd Floor East
Telephone: 860- 679-2893: Fax: 860-679-4587
Email for residents/fellows only: EHS-Residents@uchc.edu

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# IMMUNIZATION DOCUMENTATION FORM

First Name _____ Last Name _____ Date of Birth _____

| Employee | Resident | Student | Grad Student | Volunteer |
|---|---|---|---|---|
| Department: | Medical | Medical | MPH | Adult |
| _____ | Dental | Dental | PhD | Youth |
| Job Title: | Start Yr._____ | Start Yr._____ | **Post-Doctorate** | Summer |
| _____ | | | | |

**MMR TITERS ARE REQUIRED**

Date of Measles titer ____/____/____ Immune Not immune
Date of Mumps titer ____/____/____ Immune Not immune
Date of Rubella titer ____/____/____ Immune Not immune

**MMR VACCINATIONS**

1st vaccination ____/____/____
2nd vaccination ____/____/____

**VARICELLA TITER REQUIRED**

Date of Varicella titer ____/____/____ Immune Not immune
Verbal History of illness: (*circle*) YES NO

**VARICELLA VACCINATIONS**

1st vaccination ____/____/____
2nd vaccination ____/____/____

**Tetanus diphtheria (Td)**

Date of last booster dose ____/____/____

**Tetanus diphtheria accellular pertussis (Tdap)**

Date of vaccine ____/____/____

**TUBERCULOSIS: 2 TUBERCULIN SKIN TESTS WITHIN PAST 12 MONTHS REQUIRED**

Type PPD 1st ____/____/____
Result (*circle*) Positive ( mm) Negative
***If positive PPD, Chest x-ray must be within 12 months.***
**Chest x-ray** date ____/____/____
Results (*circle*) Negative Positive
**BCG** History: (*circle*) YES NO

PPD 2nd ____/____/____
Positive ( mm) Negative

Quantiferon TB Gold -Date ____/____/____
Results _____

**HEPATITIS B VACCINATIONS** Titer Post Vaccination Required (Not required for Volunteers)

Naturally Immune? (*circle*) Yes No
1st Dose ____/____/____
2nd Dose ____/____/____
3rd Dose ____/____/____
Titer Date ____/____/____
Titer Result (*circle*) Positive Negative

Previously vaccinated (*circle*) Yes No Unknown
4th Dose ____/____/____
5th Dose ____/____/____
6th Dose ____/____/____
Titer Date ____/____/____
Titer Result (*circle*) Positive Negative

The documentation above was completed by:

_____ _____ _____
Name of Health Care Provider (*print*) Telephone Number Address

_____ _____
Signature of Health Care Provider Date/Time

***PLEASE BRING COMPLETED FORM WITH YOU TO YOUR APPOINTMENT, OR SEND OR FAX TO: UCONN HEALTH CENTER, SECTION OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE, MEDICAL RECORDS, 263 FARMINGTON AVENUE, FARMINGTON, CT 06030-6210***
***Fax#*** 860-679-4587 ***Telephone#*** 860-679-2893

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IMMUNIZATION CONSENT / DECLINATION

**Type of Vaccine**: (circle) **MMR Varicella Tdap Td**

***CONSENT***

I have read or have had explained to me the information on the Vaccine Information Sheet. I have had a chance to ask questions which were answered to my satisfaction. I understand that due to my occupational exposure, whether by employment, residency, clerkship or volunteering, I may be at risk of acquiring infection. I believe I understand the benefits and risks of the vaccine and request that the vaccine checked above be given to me or to the person named below for whom I am authorized to make this request.

_____ _____ _____

Patient or Legal Guardian Signature | Relationship | Date/Time

**Type of Vaccine: MMR ( 0.5ml subcutaneous)**

#1 Date/Time_____ Manufacturer: _____ Lot# _____ Exp_____ Site _____

Provider _____ VIS Edition Date_____

#2 Date/Time_____ Manufacturer: _____ Lot#_____ Exp_____ Site _____

Provider _____ VIS Edition Date_____

**Type of Vaccine: Tdap / Td (0.5ml intramuscular)**

Date/Time_____ Manufacturer: _____ Lot#_____ Exp_____ Site _____

Provider _____ VIS Edition Date_____

**Type of Vaccine: Varicella ( 0.5ml subcutaneous)**

#1 Date/Time_____ Manufacturer: _____ Lot#_____ Exp_____ Site _____

Provider _____ VIS Edition Date_____

#2 Date/Time_____ Manufacturer: _____ Lot#_____ Exp_____ Site _____

Provider _____ VIS Edition Date_____

***DECLINATION***

I understand the information provided and explained to me on the vaccine. I understand that due to my employment, residency, clerkship or volunteering, I may be at risk of acquiring infection. I have been given the opportunity to be vaccinated with the vaccine. However, I decline vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring a serious disease. If in the future I continue to have exposure to this infectious disease and want to be vaccinated, I can receive the vaccine at that time.

**Type of Vaccine:** *(circle)* **MMR Varicella Tdap Td**

_____ _____ _____

Patient or Legal Guardian Signature | Relationship | Date/Time

Reason for Declination:_____

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## HEALTH QUESTIONNAIRE

Have you ever had back pain or injury which disrupted your usual activities ☐ No ☐ Yes If yes, please describe all episodes which resulted in absence from work or school (include dates):

Do you have any other medical condition not identified above? Please describe and give dates:

Please list current medications:

Do you have a current medical condition that may require workplace accommodations? ☐ No ☐ Yes If yes, please describe

Have you ever received disability benefits? ☐ No ☐ Yes
If yes, explain

Have you ever received an impairment rating and/or disability rating? ☐ No ☐ Yes

If yes, explain

Do you have any work limitations? ☐ No ☐ Yes If yes, explain

Have you ever been hospitalized? ☐ Yes ☐No

Please list any hospitalizations and/or surgeries for major medical illnesses, injury, or procedures:

### ALLERGY HISTORY

Please list any medication allergies

Please list any allergies to animals

Please list any allergies or sensitivities to chemicals, odors, fragrances, or environmental and/or indoor air allergens

Are you allergic to protective gloves or Latex (glove dermatitis) ☐ No ☐ Yes

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# HEALTH QUESTIONNAIRE

## TOBACCO/ALCOHOL

Do you use tobacco? ☐No, never ☐No, but I did in the past ☐Yes, currently

If you ever used tobacco, what did you use? ☐ Cigarettes ☐ Pipe or Cigars ☐Chewing

How old were you when you started to use tobacco? _____

How old were you when you stopped? _____

How much, on average, did you smoke when you were smoking?

_____packs cigarettes/day or _____ cigars/pipes per week

Do you drink alcohol? ☐ No ☐ Yes If yes, how many drinks do you average per day? _____

## HEALTH MAINTENANCE

Do you currently have a primary care physician? ☐ No ☐ Yes

If yes, name_____

Do you exercise regularly? ☐ No ☐ Yes If yes please describe_____

Do you have routine medical exams? ☐ Yes ☐ No

Have you completed a Hepatitis B vaccine series? ☐ Yes ☐ No

Do you receive the influenza vaccine annually? ☐ Yes ☐ No

Do you wear a seatbelt in a car? ☐ Yes ☐ No

## SCREENING EXAMS

What year was your last complete physical exam? _____

What year was your last vision (eye) exam? _____

What year was your last dental cleaning? _____

For women only, what year was your last cervical cancer screening (Pap smear)? _____

For women only, what year, if any, was your last mammogram? _____

What year was your last cholesterol screening test? _____

What year, if any, was your last colon cancer screening? _____

**********

I understand that the purpose of this exam is to screen for medical and physical conditions, assess whether substantial risks to me and/or to others may exist as these relate to the performance of essential job functions and, if so, recommend reasonable workplace accommodations.

I understand that the details of the exam remain confidential within the medical record, but the employer may be advised regarding the need for accommodation and specific accommodations may be recommended.

I understand that the ability to accommodate medical conditions and final employment decisions are determined by the employer.

I certify to the best of my knowledge that the above information is complete and true.

I understand that this evaluation (history review and physical exam) is related to my job and does not replace routine health care and physical examinations by my own doctor.

Patient Signature: _____ Date _____ Time_____

Reviewed By: _____ Date _____ Time_____

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# HEALTH QUESTIONNAIRE

Name _____

Home Address: _____

Home Telephone #: _____ ___ Cell Telephone #: _____

Employer_____ _____ Job Title: _____ Department: _____ Ext: _____

Describe Duties: _____

To your knowledge, which of the categories below best describes the physical demands of your new job?

- ☐ Mostly sitting
- ☐ Mostly sitting with occasional strenuous physical activity
- ☐ Mostly moderately physically active (at least 2 hours per day)
- ☐ Mostly strenuous activity, ie., lifting and carrying more than 10 pounds frequently during the work day.

Do you have any personal health problems that might be affected by work or workplace exposures? ☐ No ☐ Yes

If yes, please explain_____

_____

**WORK AND EXPOSURE HISTORY**: Briefly describe previous jobs, titles, duties and dates:

| Start Date | End Date | Employer | Job Title/Duties | Exposure |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

Have you ever lost more than one week of work-time or changed your job because of an illness or injury (either work or non-work related)? ☐ No ☐ Yes

If yes, please describe:_____ _____ _____

_____ _____ _____ _____ _____

Have you worked in an environment that was sufficiently noisy that hearing testing or hearing protection was recommended?

☐ No ☐ Yes Please describe_____

Have you spent time in an environment where you needed to receive treatment for exposure to chemicals or other environmental agents (e.g. mold, pepper spray, lead, isocyanates, tuberculosis,) ? ☐ No ☐ Yes If yes, please describe:

_____ _____

Are you are exposed to any other hazards at home or doing hobbies or current part-time jobs? ☐ No ☐ Yes

Please List: _____

Have you ever changed your residence or home because of health problems? ☐ No ☐ Yes If yes, please describe:

_____

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# HEALTH QUESTIONNAIRE

Do you live near an industrial plant or hazardous waste site? ☐ No ☐ Yes If yes, please describe:

_____ _____

**MEDICAL HISTORY** – Check if you have or have had any of the following and give the year.

| Illness | Yes | Illness | Yes | Illness | Yes |
|---|---|---|---|---|---|
| Dizziness, loss of consciousness, or fainting | | Sinus problems, nasal congestion, persistent or recurrent cough | | Ear Infection, ruptured ear drum, hearing loss or hearing deficit | |
| Heart problems, irregular heartbeats, skipped beats, palpitations | | Throat or voice problems, difficulties swallowing, thyroid disease | | Epilepsy or seizures | |
| Angina, heart attack, congestive heart failure, enlarged heart, or heart murmur | | Varicose veins, leg swelling, or leg sores | | Neurological disorder, difficulties with balance, coordination, speech, memory or use of limbs | |
| High blood pressure or elevated cholesterol levels | | Hernia | | Head Injuries, migraines, frequent headaches | |
| Chest tightness, chest pain, shortness of breath | | Weight change (increase or loss without trying) | | Elbow, wrist or hand problems | |
| Diabetes, high blood sugar, or low blood sugar | | Anemia, blood clots ,or other blood disorder | | Carpal tunnel syndrome, tingling or numbness in hands | |
| Cancer or immunodeficiency | | Pinched nerve or disc problem | | Bursitis/ tendonitis | |
| Recurrent bronchitis, emphysema, pneumonia, or other lung disease | | Sleep apnea , difficulties sleeping, or other sleep disorder | | Recurrent neck problems – strain, sprain, whiplash, stiffness | |
| Asthma, breathing problems, or wheezing | | Vision problems | | Shoulder problems/injury such as rotator cuff injury | |
| Tuberculosis | | Absent spleen | | Tendonitis/repetitive strain Injury | |
| Skin rashes; psoriasis, eczema, other skin sensitivity | | Urinary or kidney problems | | Hip, knee, ankle or foot problems | |
| Anxiety, depression that interferes with function, overwhelming stress, mood disorder, phobias or fears | | Mental health condition that may interfere with concentration or interpersonal relationships | | Recurrent back problems – sprain, strain, injury, stiffness | |
| Liver problems, hepatitis, cirrhosis, or pancreas problems | | Gastrointestinal Disease – GERD, ulcers, bowel disease, irritable bowel syndrome, blood in stools | | Arthritis, Lyme Disease, or other joint problems | |
| Weakness or chronic fatigue | | Multiple chemical sensitivities, or sensitivities to odors or fragrances | | Chronic pain, fibromyalgia, myofascial pain disorder, or muscle problems | |
| Connective tissue disorder such as Lupus, Sarcoidosis, Sjogren's Syndrome | | Alcoholism or drug addiction | | Difficulties standing, walking, climbing, using stairs | |

Please comment on the above conditions:

_____ _____ _____

_____ _____

_____ _____