Colleague Health Services
1500 Forest Glen Road
Silver Spring, MD 20910
301-754-7481 (telephone)
301-754-7482 (fax)

Colleague Health Services
19801 Observation Drive
Germantown, MD 20876
301-754-7481 (telephone)
301-557-1310 (fax)

Pre-Employment Appointment Instructions

PLEASE READ INSTRUCTIONS CAREFULLY

Candidates who fail to arrive on-time and/or who do not come with COMPLETED PAPERWORK, will be asked to reschedule. This may result in a delay of employment. If you have questions, call Colleague Health Services (CHS) at 301-754-7481.

- **If you cannot make a scheduled appointment, please cancel your appointment 24 hours prior to your scheduled time and reschedule your appointment on-line with the DaySmart Appointments system.**
- **Plan to arrive at your appointment location at least 30 minutes prior to your scheduled time. Allow time for parking and obtaining a visitor badge.** The visitor information desk in the main lobby will provide the visitor badge and can give information about how to get to Colleague Health Services (CHS). Allow 1-2 hours to complete your appointment.
- Dress appropriately in casual business attire. Your ID badge photograph will be taken.
- Do not bring children to your appointment, you will not be seen and will need to reschedule.
- Cell phone use is not allowed in CHS.
- Note that you may be required to make multiple visits to CHS prior to your start date. Plan accordingly.
- CHS cannot clear candidates for hire until all pre-employment screening requirements are met. Therefore, it is important to carefully and promptly follow the instructions given to you at your appointment.

Bring the following to your appointment:

1. **Completed Pre-Employment Health Questionnaire forms** (from confirmation email) *(complete form before appointment)*
2. **OSHA Respiratory Medical Evaluation Form (this is part of the packet)** *(complete form before appointment)*
3. **Valid US Government issued Photo ID**
4. **Health Records** **(if available):**

- ☐ **Measles, Mumps, and Rubella (MMR)** **Vaccination and/or Blood Tests for Immunity**
- ☐ **Varicella (Chicken Pox)** **Vaccination and/or Blood Tests for Immunity**
- ☐ **Hepatitis B** **Vaccination and/or Blood Tests for Immunity**
- ☐ Tetanus, Diphtheria, and Pertussis (Tdap) or Tetanus and Diphtheria (Td) Vaccination
- ☐ Covid 19 vaccination
- ☐ Influenza (flu) Vaccination (current season)
- ☐ TB Screening Records
  - If history of negative TB screen:
    - skin tests done within the past year
    - IGRA (Q-Gold or T-SPOT) blood tests within the past year
  - If history of positive TB screen
    - last skin test
    - chest x-ray report
    - if treated, treatment record
    - health department TB clearance card or other TB clearance paperwork

5. Special Instructions:

- **No gum and do not eat or drink anything other than water at least 15 minutes prior to your appointment.**
- **Candidates with beards are asked to be clean-shaven to complete N95 mask fitting.**
- **Per Hospital policy, all cosmetic products including make-up and lotion must be fragrance free. Also please do not wear perfume, cologne, or aftershave as it may cause adverse physiological symptoms for others in the work environment. You may not be seen and asked to reschedule.**
- **If you receive a TB Skin test at your appointment, you will be required to come back in 48 – 72 hours to have your arm evaluated. Please note a second TB Skin test if needed will be due in 1 – 3 weeks from the reading of the first skin test.**
- **Follow up appointments for the Holy Cross Germantown Hospital are by appointment only.**
- **The office is closed on the 2nd Friday of every month at 1130.**
- **CHS will not be able to accept emailed documents of medical records so please print out documents needed from the list above and bring them with you to your appointment.**

Pre-Employment Questionnaire and Assessment

(Please, note that all information shared with Colleague Health Services is confidential and cannot be shared without your signed consent)

PRE-EMPLOYMENT APPOINTMENT INFORMATION:

- Complete this paperwork prior to your appointment.
- Bring a government-issued ID with you.
- Bring medical documentation (if available)- *MMR (measles, mumps, rubella) vaccination and/or titers, varicella vaccination and/or titer, hepatitis B vaccination and/or titer, Tdap vaccination, current influenza (flu) vaccination, tuberculosis (TB) screen, chest x-ray, health department clearance.*
- Do not eat, drink, or chew gum for at least 15 minutes prior to your appointment.
- Arrive clean-shaven.

Name			**SSN**
Date of Birth	**Age**	**Department**	**Job Title**

Company/Location

◯ Holy Cross Hospital, Silver Spring
◯ Holy Cross Health Corporate
◯ Trinity Health
◯ Holy Cross Germantown Hospital
◯ Holy Cross Health Network
◯ Other _____

Supervisor	**Recruiter**
Home Address	

City	**State**	**Zip**
Contact Phone Number and best time to reach you	**Personal Email Address**	
Emergency Contact Name and Phone Number		**Relation**

Where were you born? _____

If born outside of the United States, Have you ever received the BCG (TB) Vaccine? ◯ Yes ◯ No

Have you ever tested positive for tuberculosis (TB) e.g. TB skin test or TB Blood Test (QuantiFERON or T-Spot)? ◯ yes ◯ no

If Yes When (Month/Year) _____

Have you ever been diagnoses with active TB **?** ◯ yes ◯ no

If Yes, when _____ What was prescribed and for how long? _____

Have you ever been treated for latent TB infection (LTBI) **?** ◯ yes ◯ no

If Yes, when _____ What was prescribed and for how long? _____

Do you have permanent or temporary residence (greater than 29 days) in a country with a high TB rate. (Any country other than USA, Canada, Australia, New Zealand, Northern and Western Europe)? ◯ yes ◯ no

Note: *If you have ever had a positive tuberculosis (TB) skin or blood test, even if you have no signs or symptoms, you may benefit from prophylactic medication; and are encouraged to speak with your primary health provider or the health department.*

Have you ever needed a chest x-ray to screen for tuberculosis (TB)? ◯ Yes ◯ No

Do any of these apply to you? *(check all that apply)* ◯ weakened immune system (including HIV, organ transplant) ◯ diabetes ◯ other lung problems ◯ take medications to suppress the immune system (including use of a TNF-alpha antagonist, chronic steroids (equivalent prednisone equal or ? 15 mg/d for equal to or > a month or other immunosuppressives including chemotherapy?

Have you had any possible tuberculosis (TB) exposures within the past year? ◯ yes *(check all that apply)* ◯ no

◯ household member with active TB ◯ work exposure ◯ travel to area where more TB cases may occur

Are you experiencing any of the following? ◯ yes *(check all that apply)* ◯ no

◯ persistent cough (greater than 3 weeks) ◯ chest pain ◯ unusual weakness or fatigue ◯ unusual night sweats ◯ coughing up blood ◯ unexplained weight loss/poor appetite ◯ fever/chills

(colleague must immediately report any of the above signs/symptoms to Colleague Health Services)

Risk Factors for the Development of TB

Generally, persons at high risk for developing TB disease fall into two categories:

- Persons who have been recently infected with TB bacteria.
  - Close contacts of infectious TB.
  - Persons who have immigrated from areas of the world with high rates of TB (any country other than USA, Canada, Australia, New Zealand, Northern and Western Europe).
  - Groups with high rates of TB transmissions, e.g., homeless, IVDA, HIV.
  - Persons who work or reside with people at high risk of TB, e.g., hospitals, homeless shelters, correctional facilities, nursing homes and residential homes for those with HIV.
- Persons with medical conditions that weaken the immune system, e.g., HIV, substance abuse, diabetes, severe kidney disease, organ transplants.

Infection Control

If a patient has symptoms of TB disease, Airborne Precautions should be instituted:

- Patients with a cough should wear a surgical or procedure mask.
- Place patient in negative pressure room ASAP.
- Healthcare personnel show wear a fit tested respirator (N95 or PAPR) while caring for the symptomatic patient to prevent inhalation of airborne bacteria.

If you develop symptoms of TB disease:

- Put on mask if coughing or other symptoms are present.
- Notify your primary care provider and Colleague Health Services ASAP.
- Do not report to work until cleared by Colleague Health Services.

I (print name) _____attest that this information is accurate and complete, and I have read and understand Risk Factors for Development of TB and Infection Control sections above.

Signature: _____

What is your height? _____feet _____inches	**What is your weight?** _____pounds

ALLERGIES: List all and describe reaction. Please answer each line individually, if no allergy, write 'None' on each line.	
Medications	
Vaccines	
Latex	
Food	
Animals	
Environment	
Other	

List any medications used currently or within the last 6 months, including birth control pills, herbal remedies, or over-the-counter (OTC) medications

_____

_____

Are you currently engaged in the unlawful or un-prescribed use of any drug or controlled substance? *(including, but not limited to amphetamines, marijuana, cocaine, crack, heroin, PCP, barbiturates, tranquilizers, sleeping pills, or methadone)*

◯ Yes ◯ No If yes, explain:

MEDICAL/EXPOSURE/SOCIAL HISTORY- currently or in the past		**If Yes, Describe**
Alcohol Use	◯ Yes ◯ No	# drinks/day _____ # days/week _____
Auditory or Hearing Problems (hearing aids, other)	◯ Yes ◯ No	
Bladder of Kidney Problems	◯ Yes ◯ No	
Blood Disorders (anemia, bleeding disorder, other)	◯ Yes ◯ No	
Bone or Joint Problems (disc trouble**,** back strain/injury, neck strain/injury, arthritis, knee problems, hand problems, leg cramps, wrist problems/carpal tunnel syndrome, shoulder problems, other)	◯ Yes ◯ No	
Communicable Diseases (tuberculosis (TB), hepatitis, herpes, measles, mumps, rubella, varicella (chicken pox), other)	◯ Yes ◯ No	
Endocrine Disorders (diabetes, thyroid problems, other)	◯ Yes ◯ No	
Eye Problems (other than corrective lenses) (cataracts, glaucoma, vision changes, other)	◯ Yes ◯ No	
Environment/Activity (excessive heat/cold, heavy lifting, frequent bending, excessive noise, other stressful environments/activities)	◯ Yes ◯ No	
Exposure (lead, ethylene oxide, toluene, formaldehyde, radiation, laser light, cytotoxic/chemotherapeutic drugs, primate animals, asbestos, other)	◯ Yes ◯ No	
Fatigue	◯ Yes ◯ No	
Heart or Circulatory Problems (blood clots, chest pain, heart attack, high blood pressure, low blood pressure, murmur, palpitations, irregular heartbeat, varicose veins, other)	◯ Yes ◯ No	
Hernia (inguinal, umbilical, other)	◯ Yes ◯ No	
Immune Disorders (weakened immune system, autoimmune disorder, other)	◯ Yes ◯ No	
Liver Disease	◯ Yes ◯ No	
Lung or Respiratory Problems (shortness of breath, asthma, COPD, emphysema, nose/throat problems, other)	◯ Yes ◯ No	
Mental Health or Psychiatric Conditions (alcohol or drug addiction, depression, anxiety/excessive worry, PTSD, schizophrenia, suicide attempt, other)	◯ Yes ◯ No	
Neurological Problems (disabling headaches, migraines, convulsions/seizures, head injury, stroke, weakness, other)	◯ Yes ◯ No	
Rheumatic Fever	◯ Yes ◯ No	
Skin Problems	◯ Yes ◯ No	
Do you smoke, including e-cigarettes?	◯ Yes ◯ No	# packs/day _____ # years _____
Stomach or Intestinal Problems (abdominal pain, other)	◯ Yes ◯ No	
Tumor or Cancer	◯ Yes ◯ No	

Please List Other Medical Conditions Not Listed Above: ◯ No other medical conditions

_____

_____

_____

List hospitalizations and surgical operations (include dates): ◯ No hospitalizations or surgical operations

_____

_____

_____

LIST PREVIOUS WORKERS' COMPENSATION CLAIMS/WORK INJURIES, INCLUDING BLOOD OR BODY FLUID EXPOSURE: ◯ None

_____

_____

OCCUPATIONAL HEALTH HISTORY AND PHYSICAL JOB REQUIREMENTS:

Have you reviewed the physical requirements of your job position?	◯ Yes ◯ No	
To your knowledge is there any reason you cannot physically or mentally perform the essential duties of your job assignment with Holy Cross Hospital? **This includes, but is not limited to the following listed below:**	◯ Yes ◯ No	
Lifting Restrictions	◯ Yes ◯ No	If Yes, Explain:
Standing Restrictions	◯ Yes ◯ No	If Yes, Explain:
Bending / Stretching / Twisting Restrictions	◯ Yes ◯ No	If Yes, Explain:
Hand / Wrist Restrictions	◯ Yes ◯ No	If Yes, Explain:

HEPATITIS B IMMUNIZATION STATUS

I understand that Hepatitis B infection is one of the leading occupational hazards of health care workers from significant exposure to blood and bodily fluids.

I understand that the vaccine consists of three (3) intramuscular injections of vaccine given in the deltoid muscle (upper arm). Dose two is given one month after the first dose, dose three is given six months after the first dose. Two months after last dose a titer is ordered.

I understand that over 90% of persons who have taken three doses of the vaccine, will become immune to the disease and will be protected against Hepatitis B infection should significant exposure such as a needle stick or mucus membrane exposure occur. The vaccine is generally not protective until after all three doses have been taken, however, the vaccine is an integral part of the post-exposure follow up for non-immune health care workers.

I have had the opportunity to read information about Hepatitis B Vaccine and to ask questions about the risks and benefits of the vaccine.

I understand that Holy Cross Health provides Hepatitis B Vaccine to eligible employees through the Colleague Health Services at no cost to the employee.

Please check one of the following statements:

◯ I have completed the Hepatitis B Vaccine series
◯ I intend to make an appointment with Colleague Health Services to begin the series
◯ I have started, but not completed the series, and intend to complete the series as scheduled
◯ I have been advised not to take the vaccine at this time because _____
◯ I am not sure if I have ever been vaccinated
◯ I do not want to be immunized against Hepatitis B at this time

Candidate Signature _____ **Date** _____

SEASONAL INFLUENZA (FLU) VACCINATION REQUIREMENT

I understand that, because I will be working in a health care environment, annual vaccination for seasonal influenza is mandatory for my protection and for the protection of the patients and community we serve.

I understand that receiving the seasonal influenza (flu) vaccine is a condition of employment.

Candidate Signature _____ **Date** _____

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION AND CONSENT TO SEND URINE

I authorize Holy Cross Health, its agents, and Colleague Health Services to perform a pre-employment assessment and diagnostic tests necessary to determine my ability to perform the duties of this job.

I authorize my doctor's office and facilities, where I have received medical treatment in the past to release medical information to Holy Cross Colleague Health Services. I understand Colleague Health Services may disclose any and all information regarding any work-related injury, for the purpose of OSHA, infection control, employee health reporting, and workers' compensation insurance claims. Disclosure method could be verbal, hard copy, or facsimile.

I hereby certify that the above answers are complete and true. I understand this pre-employment assessment does not take the place of a complete physical exam and that I am advised to see my personal physician for my health needs. I agree to notify Holy Cross Colleague Health Services of any changes in the condition of my health that would affect my abilities to perform my job.

I give consent for pre-employment urine drug testing and understand that a positive urine drug screen can result in automatic retraction of any job offer.

Candidate Signature _____ **Date** _____

OSHA Respiratory Medical Evaluation Questionnaire

Can you read? ◯ Yes ◯ No

Gender: ◯ Male ◯ Female

Have you been in the military? ◯ Yes ◯ No **If yes, were you exposed to biological/chemical agents?** ◯ Yes ◯ No

Have you worn a respirator (including N95 mask, PAPR, SCBA, Elastomeric)? ◯ Yes ◯ No

If yes, what type?

◯ N,R,P = Disposable (filter-mask, non-cartridge only)

◯ OTHER = for example half/full face-piece, supplied air, powered-air purifying (PAPR), self-contained breathing apparatus (SCBA)

Check the type of respirator you will use: ◯ N95 ◯ PAPR ◯ Elastomeric Half Face Piece

1. **Do you currently smoke tobacco, or have you smoked tobacco in the last month?** ◯ Yes ◯ No
2. **Have you ever had the following conditions?**
   - a. Seizures ◯ Yes ◯ No
   - b. Diabetes (sugar disease) ◯ Yes ◯ No
   - c. Allergic reactions that interfere with your breathing ◯ Yes ◯ No
   - d. Claustrophobia (fear of closed-in places) ◯ Yes ◯ No
   - e. Trouble smelling odors ◯ Yes ◯ No
3. **Have you ever had any of the following pulmonary or lung problems?**
   - **a.** Asbestosis ◯ Yes ◯ No
   - b. Asthma ◯ Yes ◯ No
   - c. Chronic bronchitis ◯ Yes ◯ No
   - d. Emphysema ◯ Yes ◯ No
   - e. Pneumonia ◯ Yes ◯ No
   - f. Tuberculosis ◯ Yes ◯ No
   - g. Silicosis ◯ Yes ◯ No
   - h. Pneumothorax (collapsed lung) ◯ Yes ◯ No
   - i. Lung cancer ◯ Yes ◯ No
   - j. Broken ribs ◯ Yes ◯ No
   - k. Any chest injuries or surgeries ◯ Yes ◯ No
   - l. Any other lung problem that you have been told about ◯ Yes ◯ No

4. Do you currently have any of the symptoms of pulmonary or lung illness?

a. Shortness of breath ◯ Yes ◯ No
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline ◯ Yes ◯ No
c. Shortness of breath when walking with other people at an ordinary place on level ground ◯ Yes ◯ No
d. Have to stop for breath when walking at your own pace on level ground ◯ Yes ◯ No
e. Shortness of breath when washing or dressing yourself ◯ Yes ◯ No
f. Shortness of breath that interferes with your job ◯ Yes ◯ No
g. Coughing that produces phlegm (thick sputum) ◯ Yes ◯ No
h. Coughing that wakes you early in the morning ◯ Yes ◯ No
i. Coughing that occurs mostly when you are lying down ◯ Yes ◯ No
j. Cough up blood in the last month ◯ Yes ◯ No
k. Wheezing ◯ Yes ◯ No
l. Wheezing that interferes with your job ◯ Yes ◯ No
m. Chest pain when you breathe deeply ◯ Yes ◯ No
n. Any other symptoms that you think may be related to lung problems ◯ Yes ◯ No

5. Have you ever had any of the following cardiovascular or heart problems?

a. Heart attack ◯ Yes ◯ No
b. Stroke ◯ Yes ◯ No
c. Angina ◯ Yes ◯ No
d. Heart failure ◯ Yes ◯ No
e. Swelling in your legs or feet (not caused by walking) ◯ Yes ◯ No
f. Heart arrhythmia (heart beating irregularly) ◯ Yes ◯ No
g. High blood pressure ◯ Yes ◯ No
h. Any other heart problem that you've been told about ◯ Yes ◯ No

6. Have you ever had 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 physical activity ◯ Yes ◯ No
c. Pain or tightness in your chest that interferes with your job ◯ Yes ◯ No
d. In the past two years, have you noticed your heart skipping or missing a beat ◯ Yes ◯ No
e. Heartburn or indigestion that is not related to eating ◯ Yes ◯ No
f. Any other symptoms that you think may be related to heart or circulation problems ◯ Yes ◯ No

7. Do you currently take medication for any of the following problems?

a. Breathing or lung problems ◯ Yes ◯ No
b. Heart trouble ◯ Yes ◯ No
c. Blood pressure ◯ Yes ◯ No
d. Seizures ◯ Yes ◯ No

8. If you have used a respirator, have you ever had any of the following problems?

a. Eye irritation ◯ Yes ◯ No
b. Skin allergies or rashes ◯ Yes ◯ No
c. Anxiety ◯ Yes ◯ No
d. General weakness or fatigue ◯ Yes ◯ No
e. Any other problem that interferes with your use of a respirator ◯ Yes ◯ No

9. Do you have any questions for the health care professional (HCP) reviewing your answers? ◯ Yes ◯ No

10. Have you ever lost vision in either eye (temporarily or permanently) ◯ Yes ◯ No

11. Do you currently have any of the following vision problems?

a. Wear contact lenses ◯ Yes ◯ No
b. Wear glasses ◯ Yes ◯ No
c. Color blind ◯ Yes ◯ No
d. Any other eye or vision problems ◯ Yes ◯ No

12. Have you ever had an injury to your ears, including a broken ear drum? ◯ Yes ◯ No

13. Do you currently have any of the following hearing problems?

a. Difficulty hearing ◯ Yes ◯ No
b. Wear a hearing aid ◯ Yes ◯ No
c. Any other hearing or ear problem ◯ Yes ◯ No

14. Have you ever had a back injury? ◯ Yes ◯ No

15. Do you currently have any of the following musculoskeletal problems?

a. Weakness in any of your arms, hands, legs, or feet ◯ Yes ◯ No
b. Back pain ◯ Yes ◯ No
c. Difficulty fully moving your arms and legs ◯ Yes ◯ No
d. Pain or stiffness when you lean forward or backward at the waist ◯ Yes ◯ No
e. Difficulty fully moving your head up or down ◯ Yes ◯ No
f. Difficulty fully moving your head side to side ◯ Yes ◯ No
g. Difficulty bending at the knees ◯ Yes ◯ No
h. Difficulty squatting to the ground ◯ Yes ◯ No
i. Climbing a flight of stairs or a ladder carrying more than 25lbs ◯ Yes ◯ No
j. Any other muscle/skeletal problem that interferes with using a respirator ◯ Yes ◯ No

Are you taking medications, including medications for breathing and lung problems, blood pressure, and seizures? ◯ Yes ◯ No

If yes, please list any medications not listed on page 2 of this document:

_____

Appendix D to OSHA Respirator Standard 1910.134
Mandatory Information for Employees Using Respirators when Note Required Under the OSHA Standard

Respirators are an effective method of protection against designated hazards when properly selected and worn. Respirator use is encouraged, even when exposures are below the exposure limit, to provide an additional level of comfort and protection for workers. However, if a respirator is used improperly or not kept clean, the respirator itself can become a hazard to the worker. Sometimes, workers may wear respirators to avoid exposures to hazards, even if the amount of hazardous substance does not exceed the limits set by OSHA standards. If your employer provides respirators for your voluntary use, or if you provide your own respirator, you need to take certain precautions to be sure that the respirator itself does not present a hazard.

You should do the following:

1. Read and heed all instructions provided by the manufacturer on use, maintenance, cleaning and care, and warnings regarding the respirator's limitations.
2. Choose respirators certified for use to protect against the contaminant of concern. NIOSH, the National Institute for Occupational Safety and Health or the U.S. Department of Health and Human Services, certifies respirators. A label or statement of certification should appear on the respirator or respirator packaging. It will tell you what the respirator is designed for and how much it will protect you.
3. Do not wear your respirator into atmospheres containing contaminants for which your respirator is not designed to protect against. For example, a respirator designed to filter dust particles will not protect you against gases, vapors, or very small solid particles of fumes or smoke.
4. Keep track of your respirator so that you do not mistakenly use someone else's respirator.

INITIAL HERE- after you read and understand the information contained in Appendix D of the OSHA Respiratory Protection Standard

I have reviewed and completed this paperwork to the best of my ability; and understand that I may request help and/or clarification from Colleague Health Services.

Candidate Signature _____ Date _____

↓ ***Pre-Employment Questionnaire and Assessment (CHS Staff only)*** ↓

Respiratory Mask – Fit Testing

Potential use limitations

◯ N/A ◯ beard ◯ glasses ◯ facial type ◯ Other _____

OSHA Respiratory Medical Evaluation Questionnaire ◯ N/A ◯ No ◯ Yes

If yes, CHS Licensed Staff _____ Date _____

Referred to Health Care Provider for medical examination ◯ N/A ◯ No ◯ Yes

If yes, Health Care Provider _____ Date _____

SIZE	Fluid Shield	Fluid Shield with safety seal	3M 1870+	MOLDEX	Elastomeric or special	Other Respiratory Clearance PAPR/SCBA/Full Face Piece		
REGULAR			ONESIZE	Large 1513		**YES**	**NO**	**N/A**
MEDIUM	N/A	N/A		1512				
SMALL				1511				

Comments (including alternate product recommendations)
Sweet ◯ Bitter ◯ 10 spray ◯ 20 spray ◯ 30 spray ◯ Number of Masks used _____

Candidate given badge card to identify mask type and size:
◯ Yes ◯ No ◯ N/A

Blood Pressure /	**Ishihara Screen** ◯ Pass ◯ Fail	
Height (feet/inches)	**Weight (pounds)**	**BMI**

CHS Licensed Staff Signature _____

Date _____ Time _____