



Wellforce Occupational Health Requirements

The Employee Health Services Department will help you complete the necessary health screening and clearance that you will require to begin your employment at Wellforce. In our efforts to protect our patients and to provide a safe and healthful workplace for all employees, new employees must obtain a health clearance from Employee Health before they can begin working. During this appointment, you will need to complete a health history form and review it with a health care provider. In addition, we will determine the status of your immunization requirements listed below. You may have already received some of these immunizations. If you have, please bring with you any written documentation of past immunizations that you may have had from your previous employer, primary care physician, school health office, immigration office or from some other official reference. We will help you obtain any additional requirements that you will need.

The following infection control requirements will need to be satisfied **before** you start work:

1. **TB SCREENING** You will need proof of a two-step TB skin test within the past six months. If you have not had this test, then it will be administered during that first visit to Employee Health. This test, called a PPD, will require a second visit to the Department in 48-72 hours to interpret the results. Therefore, your first appointment should be at least 2 days (48 hours) before you start work. Employees with a previously positive PPD test will need to provide documentation of their evaluation and/or treatment and a chest x-ray report. If no CXR report is available, we will arrange to have a CXR taken here.
2. **TETANUS AND DIPHTHERIA (Td) BOOSTER** You will need proof of a Td booster within the past 10 years. If you are unsure of your status, or cannot provide documentation, then we will provide you with an updated Td or Tdap booster.
3. **MEASLES, MUMPS AND RUBELLA (MMR)** vaccine(s) documentation. You need documentation of two MMR vaccinations or positive serologies, showing that you have immunity against these viruses.
4. **HEPATITIS B IMMUNIZATION AND EVIDENCE OF HBV ANTIBODY** If you have had the 3 vaccines series and/or have documentation of a HBV antibody response, please bring the documentation, including the dates. If you have not received the vaccine, you will need to obtain it, or sign a waiver that you decline vaccination. We offer the hepatitis B vaccination to all employees with direct patient care and to employees whose work could place them at risk of exposure.
5. **CHICKENPOX (VARICELLA)** If you know that you have had chickenpox, verbal acknowledgement will be sufficient. If you are not sure, then serology testing can determine whether you have had this infection in the past. If you have not had the disease, you will need two vaccines.
6. **RESPIRATORY QUESTIONNAIRE** Employees with direct patient contact may be required to have a respirator fit test here at the Hospital. If so, prior to fit testing, you must complete the enclosed questionnaire. Please bring this completed form to us with the above immunizations records.

When these infection control requirements are completed, you will be cleared to start work. Please call our office at (617) 636-5480 to schedule your appointment. Please call Outpatient Registration at 617-636-0084 to obtain a Medical Record Number.

Employee Health Services is located on the 6th floor of the Farnsworth Building at 800 Washington St., Boston, MA 02111. We look forward to meeting you.

PREPLACEMENT HISTORY

Today's Date: _____/_____/_____

Name _____

Maiden Name: _____

D.O.B. ____/____/____ Age: _____

Address: _____

City/State/Zip: _____

Birthplace: _____

Tel.: (Home) _____

Tel.: (Work) _____

Emergency Contact: _____

Relationship: _____ Phone: _____

Physician: _____ Phone _____

Occupational History: Yes No
Are you able to perform the essential functions of this position (job) without an accommodation? ____
If no, please explain: _____

Assistive devices used:
glasses/contact lenses ____
hearing aid _____
Prosthesis (type) _____

New Job Title: _____

Department: _____

As part of this job will you: Yes No

**** Work with ANIMALS? ____

Have patient contact? ____

Work with lab specimens? ____

Use protective clothing/equipment ____

Healthy Lifestyle: Yes No

Tobacco: Do you smoke? ____

How many cigarettes per day? ____

Have you smoked in the past? ____

How many years? _____and, how much? _____

If you have quit, how long has it been? _____

Do you smoke cigars or a pipe? _____

Alcohol: How many drinks containing alcohol do you usually have in one week? _____

Exercise: How many days per week do you engage in aerobic exercise or moderate physical activity? _____

Medical History:

List all allergies (include foods, medications, & chemicals) _____

Do you have a latex allergy? Yes ____ No ____

List all medications _____

List hospitalizations, include surgeries _____

PLEASE CIRCLE ALL THAT APPLY

Anemia

Arthritis

Asthma

Bleeding tendency

Cancer

CHICKENPOX (history of disease)

Chronic bronchitis/frequent cough

Colitis/crohn's disease

Diabetes

Depression/Mood Disorder

Eczema

Emphysema

Epilepsy/Seizure Disorder

Exposure to a hazardous substance

Heart Disease/chest pain

Heart murmur

High blood pressure

Kidney disease

Liver disease

Migraine headaches

Phlebitis

Pneumonia

Polio

Rashes

Strokes

Thyroid disease

Tuberculosis:

Positive skin test? YES___NO _____

Treated for disease? YES___NO _____

Ulcers

Additional Information:

_____ Other: _____

Have you consulted with a medical professional for any health conditions not covered by this form? If so, please explain _____

I certify that the information given by me is true and complete to the best of my knowledge. I understand that providing false information may be grounds for termination of employment.

Signature

Date

History Reviewed By:

Date