University of Maryland Medical Center Employee Health Services
Room T1R05, next to first floor Shock Trauma elevators (Mon - Fri 7 am – 4 pm, closed holidays)
Fax: 410-328-2610 Appointments 410-328-6151 Mgr Phone: 410-328-1788 Regina Hogan

RESIDENTS / FELLOWS

Welcome to University of Maryland Medical Center. Congratulations on becoming a resident or fellow. Prior to beginning work at the University of Maryland Medical Center (UMMC), you will need a pre-placement health evaluation.

Scheduling Your Pre Placement Health Evaluation

- You have the option of conducting a remote evaluation or an onsite evaluation within Employee Health. We strongly encourage you to select a remote evaluation. This is especially true if you live out of state. Remote evaluations do not require an appointment.
- A remote evaluation involves sending all of the required forms, immunization records and TB screening results to employee_health@umm.edu. An RN will review the documents and will respond. A 'Quest passport' for a urine drug screen (uds) and instruction for next steps will be sent back to you as long as the required information for the uds has been provided (see below).
- If you require an onsite evaluation, the **LATEST** the evaluation can be completed is **two weeks prior** to your start date. Please do not wait to schedule your onsite visit as these appointments fill up quickly. Please schedule your onsite appointment by calling **410-328-6151**. For onsite evaluations, plan about one hour in your schedule to complete the pre-placement evaluation process. The urine drug screen may take up to 3 hours if you are unable to immediately provide a specimen.
- Regardless of whether you are requesting an onsite appointment or a remote evaluation, we ask that you send us all of the "health evaluation components" as listed below prior to your appointment to employee_health@umm.edu based on the start date deadlines listed below. When sending the required documents, please indicate whether you are requesting an onsite appointment or a remote evaluation.

Resident/Fellow Start date	Deadline to submit paperwork to EHS
June 2024	4/1/24
July 2024	5/1/24
August 2024	6/1/24

- If you are currently actively employed by UMMC but changing programs, you do not require a pre placement health evaluation. If you are uncertain about this, please call Regina Hogan (EHS manager) at 410-328-1788 or Jennifer Myers (Pre placement coordinator) at 410-328-0715.

Health Evaluation Components

1. **You must bring or provide a picture ID** (driver's license or passport) or we will not be able to perform your evaluation
2. **Medical History Questionnaire:**
   Access forms from the GME Website: http://umm.edu/professionals/gme/prospective/credentialing-process. Print and complete forms, scan and send to employee_health@umm.edu.
   DO NOT (use Postal) MAIL to send THE COMPLETED FORMS TO YOUR RESIDENCY PROGRAM OR TO EMPLOYEE HEALTH.
   - If you have **ANY** current medical conditions or take any medication that may impact your ability to perform the essential duties of your job that would then necessitate requesting an accommodation, you *may* be required to provide medical documentation **(use on-line form titled: Treating Physician Pre-placement Medical Review form)** from your treating physician. If you have a question about this, please call Regina Hogan (EHS Manager) 410-328-1788 or Jennifer Myers 410-328-0715.
   - The documentation (Treating Physician Pre-placement Medical Review form) should include your diagnosis, treatment, medications, any restrictions to your physical activities or other restrictions. The note should further indicate whether your medical condition is under control and whether it would interfere with your ability to perform the duties of your residency program. The form is required to be completed in its entirety by your treating provider.

3. **Vaccination History:**

Measles, Mumps, Rubella, Varicella (chicken pox) and Hepatitis B

Please bring documentation of any vaccinations or lab results indicating you are immune.

- If you cannot show proof of vaccination history or immunity, you will require a blood draw to determine whether or not you are immune to measles, mumps, rubella, varicella and Hepatitis B.
- For Hepatitis B, in order to verify long term immunity, EHS requires both documentation of vaccination AND evidence of protective titers. If you have a protective hepatitis B antibody titer without evidence of vaccination, Immunize.org recommends the vaccination series. If you wish to decline vaccination, you may sign a declination form. (see on-line form)
- If you do NOT have immunity to measles, mumps, rubella, varicella, then **proof of two vaccine doses** are required for immunity. You will be required to receive the first vaccination in order to be medically cleared **to start work**.
- EHS will provide any of these required vaccinations free of charge.

4. **Tuberculosis Screening needs to occur within 90 days before start date:**

- UMMC requires either a 2- step TB skin test or a TB blood test.

OPTIONS:

- A current TB skin test placed (within 90 days of start), then 'read' in 48 – 72 hours and as long as it is negative, another one will be required 1-2 weeks later to be certain your baseline is negative. **OR**
- A current TB skin test placed (within 90 days of start) then 'read' in 48 – 72 hours and If you have had a TB skin test in the last 12 months, please send documentation of the result with other health information **OR**
- UMMC will accept a TB blood test that has been performed within 90 days prior to the start date and this will satisfy the 2-step TB requirement.

- If you have had a **positive** TB skin test in the past, please scan and send a copy of a chest x-ray report performed at the time of conversion or later along with the documentation of the positive TB test. Otherwise we will perform a repeat TB test and/or repeat chest x-ray. We will also ask you to complete the UMMC Positive TB Skin Test Symptom Based Questionnaire.

5. **Drug Screen:**

- **Onsite** urine drug screen: Please come to your appointment prepared to provide a urine specimen. This is usually a quick process (15 – 20 minutes). However, it may take up to 3 hours if you are unable to provide a specimen of sufficient quantity and temperature. The urine collection process will not be started after 1:00 pm. The urine drug collection may be scheduled separately from the pre-placement evaluation if there are time constraints. The urine drug collection process **may take up to three hours** to complete. **If you start the urine drug collection process and leave the collection site before providing a sufficient specimen and prior to the three hour time frame, the outcome of the collection will be deemed a "refusal to test" and the job offer will be rescinded.**

- **Remote** urine drug screen: We encourage all individuals to accept the opportunity to perform the **urine drug screen collection at a Quest site near your current residence or work location**. This collection can be done up to 2 weeks prior to the UMMC start date. This **must be requested** when sending the Medical History Questionnaire to employee_health@umm.edu. In order to arrange this, **UMMC EHS needs the resident's current location including zip code, last six SSN, phone number, sex assigned at birth and date of birth.** PLEASE NOTE: You may be required to stay at the collection site for up to three hours once the urine drug testing collection process begins. If you are **NOT** able to remain for three hours, do **NOT** start the collection, you should plan the collection for another day when you ARE able to remain for three hours if required. **If you start the urine drug collection process and leave the collection site before providing a sufficient specimen and prior to the three hour time frame, the outcome of the collection will be deemed a "refusal to test" and the job offer will be rescinded.**

- **Color Vision Screen**: Please fill out the Color Vision form by identifying the number in the circle in the designated space and tracing the lines where requested.

6. **COVID Vaccination Proof:**

- Please submit proof of COVID vaccination primary series and booster dose(s) to UMMC COVID website, if you have been vaccinated. Please go to this link **using Chrome** as the web browser.
  http://www.umms.org/vaxreporting
- After indicating you were vaccinated, entering dates, **please upload your proof card and then also send COVID vaccine proof to UMMC with your other vaccination records.**
- Please use your **EMPLOYEE ID number NOT your badge number.**
- Although UMMC no longer has a mandatory COVID vaccination policy, UMMC is still required to submit employee COVID vaccination information to the National Healthcare Safety Network (NHSN).

7. **Respiratory Fit Testing:**

- Respiratory medical clearance will be done by Employee Health and the questions are embedded in the health questionnaire. Respirator fit testing will be performed on site by the Safety Department Fit Test Center (P4H01) which is on the 4th floor of the Institute of Psychiatry and Human Behavior (IPHB) building in the main hospital. Schedule appointments using the QR code below, this link https://app.smartsheet.com/b/form/a87d05c667bf4a23bfbe889d88df06c1 or 410-328-5000.
- Men are required to be 'clean shaven' if being fit tested with a disposable mask, therefore you need to be 'clean shaven' for a respirator fit test appointment.
- If you cannot be fit tested (due to a religious reason, medical reason, unable to be clean shaven or another reason) you will be educated on the use of the Powered Air Purifying Respirator.

If you are unable to keep an appointment and need to reschedule please call 410-328-6151.

Please note that your **start date may be delayed** by failure to return/complete vaccination records, TB skin test results and Treating Physician Pre-placement Medical Review form if indicated. If required information is not received, the **Residency Director will be notified** that the employee has not completed employment clearance requirements. Medical Clearance by EHS is required for employee to be 'medically cleared' to start work and to be **paid.**

Revised 02/20/2024

UNIVERSITY of MARYLAND MEDICAL SYSTEM

Employee Health Services Registration Form

Please Print Clearly

Name: _____ Today's Date: _____

SS #: _____ Date of Birth: _____

Sex: ☐ Male ☐ Female

Street Address: _____

City: _____ Home Phone: _____

State: _____ Cell Phone: _____

Zip Code: _____ Email: _____

Job Title: _____ Work Phone: _____

Supervisor: _____ Department: _____

Recruiter: _____ Anticipated Start Date: _____

Have you been employee of the University of Maryland System, in the past? Yes ☐ No ☐

If so, please list other names used: _____

IN CASE OF EMERGENCY, NOTIFY:

Name: _____ Phone: _____

Address: _____

UNIVERSITY of MARYLAND MEDICAL SYSTEM

	UM Baltimore Washington Medical Center		UM Rehabilitation and Orthopedic Institute
	UM Capital Region Medical Center		UM Shore Regional Health
	UM Charles Regional Medical Center		UM St Joseph Medical Center
	UMMC Downtown Campus		UM Upper Chesapeake Health
	UMMC Midtown Campus		UM Corporate Shared Services

EMPLOYEE HEALTH SERVICES
Initial Employee Health Evaluation

Today's date: _____

Print Name – First, Middle, Last Name: _____ Date of Birth: _____

Telephone number (best contact number): _____ Best email address: _____

Job Title: _____ Job Code (If Known) _____

The purpose of this evaluation is to determine whether vaccinations are necessary to protect you and your patients, to clear you to use a respirator, and to determine whether you have any impairment that could affect your ability to perform the essential functions of the job that you have been offered. This is NOT meant to substitute for the comprehensive health assessments that your private doctor performs for your personal health.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Accommodations:
Do you have any medical conditions or take any medications that may impact your ability to perform the essential duties of your job that would then necessitate requesting an accommodation? Examples may include but are not limited to neurologic conditions such as seizure disorders, psychiatric disorders, immunosuppressive conditions/treatments, medications, musculoskeletal disorders, recent surgeries or injuries? Yes__ No__

If yes, please describe medical condition:

I have read the job description for which I have been offered conditional employment. I can perform the job tasks and essential duties of this job:

___ **Without reasonable accommodation**
___ **With reasonable accommodation**

If you require a reasonable accommodation, please indicate the specific accommodations that are needed and the reason why they are necessary.

_____
_____
_____

Are these accommodations: □ Permanent □ Temporary until: (provide end date)

Medical Provider documentation may be required.

Are you currently being treated or monitored for substance use disorder (including illegal drugs, use of legal drugs or alcohol)? If yes, list/describe substance, treatment program (name/location/frequency) and ongoing monitoring (e.g. repeat urine or blood tests):_____	Yes	No
Are you currently (or have you ever been) on a contract with your licensing board for a substance or alcohol use disorder? [If you are currently on a contract with your licensing board for substance or alcohol use, please provide a copy of the contract to Employee Health and Human Resources]	Yes	No
Do you have decreased ability in any of the following? (Check all that apply) □ To stay awake or maintain consciousness due to a medical condition □ Manage multiple tasks at one time □ Work rotating shifts if applicable	Yes	No

Latex and General Allergy Screening		
a. Have you ever been told by a medical professional that you have a latex allergy?	Yes	No
b. Have you ever had difficulty breathing, wheezing or swelling of the face, mouth, lips or throat after contact with latex?	Yes	No
c. After handling latex products, have you ever experienced any of the following?		
Difficulty breathing or wheezing	Yes	No
Runny, itchy nose or congestion	Yes	No
Itching eyes/increased tearing	Yes	No
Systemic hives/rash	Yes	No
Itching or hives on hands	Yes	No
Swelling of hands	Yes	No
Redness of hands	Yes	No
Chapping or cracking of hands	Yes	No
d. Do you have any additional allergies? If yes, please describe:	Yes	No
Will you be working in the hyperbaric chamber? □ Yes □ No If yes, Employee Health will provide an additional hyperbaric screening questionnaire to be completed. (Note that this question is only relevant for employees working at UMMC DTC who have been or will be assigned to work inside the hyperbaric chamber.)		

OSHA Respirator Medical Questionnaire – These questions are required by OSHA for individuals who may need to wear a respirator. Please see OSHA Respirator Standard, 1910.134 Appendix C OSHA Respirator Medical Evaluation for details.		
What is your height? _____ ft. _____ in. What is your weight? _____ lbs		
Have you ever worn a respirator? If 'yes' what type (s)? _____	Yes	No
Do you *currently* smoke tobacco, or have you smoked tobacco in the last month?	Yes	No
If you smoke, how often do you smoke and for how many years? _____ If you do not smoke, have you ever smoked? If you are a former smoker, when did you quit and how much did you smoke? _____	Yes	No

Have you *ever had* any of the following conditions?		
Seizures	Yes	No
Diabetes	Yes	No
Allergic reactions that interfere with your breathing	Yes	No
Claustrophobia (fear of closed- in places)	Yes	No
Trouble smelling odors	Yes	No

Have you *ever had* any of the following pulmonary or lung problems?		
Asbestosis	Yes	No
Asthma	Yes	No
Chronic bronchitis (i.e. on-going cough or phlegm over several months)	Yes	No
Emphysema	Yes	No
Pneumonia	Yes	No
Tuberculosis	Yes	No
Silicosis	Yes	No
Pneumothorax (collapsed lung)	Yes	No
Lung cancer	Yes	No
Broken ribs	Yes	No
Any chest injuries or surgeries	Yes	No
Any other lung problems you've been told about	Yes	No

Do you *currently* have any of the following symptoms of pulmonary or lung illness?		
Shortness of breath	Yes	No
Shortness of breath when walking fast on level ground or walking up a slight hill or incline	Yes	No
Shortness of breath when walking with other people at an ordinary pace on level ground	Yes	No
Have to stop for breath when walking at your own pace on a level ground	Yes	No
Shortness of breath when washing or dressing yourself	Yes	No
Shortness of breath that interferes with your job	Yes	No
Coughing that produces phlegm (thick sputum)	Yes	No
Coughing that wakes you early in the morning	Yes	No
Coughing that occurs mostly when you are lying down	Yes	No
Coughing up blood in the last month	Yes	No
Wheezing	Yes	No
Wheezing that interferes with your job	Yes	No
Chest pain when breathe deeply	Yes	No
Any other symptoms that you think may be related to lung problems	Yes	No
Have you *ever had* any of the following cardiovascular or heart problems?		
Heart attack	Yes	No
Stroke	Yes	No
Angina	Yes	No
Heart failure	Yes	No
Swelling in your legs or feet (not caused by walking)	Yes	No
Heart arrhythmia (heart beating irregularly)	Yes	No
High blood pressure	Yes	No
Any other heart problems that you've been told about	Yes	No
Have you *ever had* any of the following cardiovascular or heart symptoms?		

Frequent pain or tightness in your chest	Yes	No
Pain or tightness in your chest during physical activity	Yes	No
Pain or tightness in your chest that interferes with your job	Yes	No
In the past two years, have you noticed your heart skipping or missing a beat	Yes	No
Heartburn or indigestion that is not related to eating	Yes	No
Any other symptoms that you think may be related to heart or circulation problems	Yes	No

Do you *currently* take medication for any of the following problems?		
Breathing or lungs problems	Yes	No
Heart trouble	Yes	No
Blood pressure	Yes	No
Seizures	Yes	No
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 space and go to next question): ___ (check here if you've never used a respirator)		
Eye irritation	Yes	No
Skin allergies or rashes	Yes	No
Anxiety	Yes	No
General weakness or fatigue	Yes	No
Any other problem that interferes with your use of a respirator	Yes	No
Shortness of breath or difficulty breathing	Yes	No
Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? Yes No **If you select "yes", someone will contact you. If you select "no" and change your mind, please contact the Employee Health Services Dept that performed your evaluation and ask to speak with the individual who reviewed your questionnaire.** **Apart from patient care, describe any specific additional responsibilities you'll have that would require you to wear a respirator and the type of respirator you anticipate wearing** _____ _____ _____		

By signing this form, I am certifying that to the best of my knowledge I have provided answers truthfully and will provide a doctor's note and/or medical records, as requested, to determine if I am medically fit to perform this job if this is required. I also understand that if any abnormal findings are identified that may interfere with my work performance or the safety of patients or hospital employee learns this may be discussed with my supervisors and Human Resource personnel if necessary. Finally, if I misrepresented facts, or failed to disclose information, then Employee Health will inform Human Resources who will decide as to whether my job offer will be rescinded.
If I develop a new medical condition or experience changes in any previously reported medical condition(s) that would in any way impair or limit my ability to perform job duties or impact patient safety, after completion of the pre-placement health evaluation but before starting work, it is my responsibility to inform Employee Health Services of this information

Your signature_____ Date_____

To be completed by Employee Health Services

****

Color Vision Screening

□ Normal □ Abnormal □ How many missing: _____

Bloodborne Pathogen (BBP) Review - Counseled on actions to take if HCW has a BBP exposure _____

Outstanding issues:

RN/MA reviewing health questionnaire _____ Date _____

****

Physician or Licensed Health Care Professional Medical Clearance for Respirator Use:

□ Medically cleared to wear a respirator

□ Medical Clearance determination pending for the following reasons: _____

_____

□ Medically cleared with the following restrictions _____

_____

□ Not medically cleared for the following reason(s)_____

_____

Additional Comments:

Medical Provider Respirator medical Clearance_____Date:_____

	UM Baltimore Washington Medical Center		UM Rehabilitation and Orthopedic Institute
	UM Capital Region Medical Center		UM Shore Regional Health
	UM Charles Regional Medical Center		UM St Joseph Medical Center
	UMMC Downtown Campus		UM Upper Chesapeake Health
	UMMC Midtown Campus		UM Corporate Shared Services

REPORTABLE CONDITIONS AND OCCURRENCES FOR TEAM MEMBERS

In compliance with established policies governing Employee Health and Infection Prevention and in the best interest of other staff and patients, you are required to report the following conditions or exposures to Employee Health or to Infection Prevention at the time of hire or any time during your employment or affiliation with UMMC.

1. If you are suspected or diagnosed with any of the following infections during your employment or affiliation with UMMC (see below for notification points of contact)*:
    a. Hepatitis A
    b. Measles
    c. Mumps
    d. Rubella
    e. Chickenpox or Shingles (zoster)
    f. Tuberculosis
    g. Pertussis
    h. Bacterial (Neisseria) meningitis
    i. COVID-19
    j. Infectious diarrhea e.g., C. difficile, E.coli, Salmonella, Shigella, Campylobacter, Norovirus etc. or Salmonella infection even without diarrhea
    k. Mpox
    l. Other acute febrile rash illness that could be from a transmissible infection e.g., Hand foot and mouth disease
    m. Scabies
2. Infection with HIV, Hepatitis B or Hepatitis C only if as part of your job you perform procedures that are considered "exposure-prone" or SHEA** category III procedures*** and therefore pose a risk for transmission of bloodborne infection. This would include the following jobs: Surgeons or first assistants in the OR, emergency medicine physicians, OB/gyns & midwives, dentists and oral surgeons, or any other job category in which the healthcare worker is handling sharp instruments in small, confined spaces or in which visibility is difficult (see below for notification points of contact)*.
3. All bloodborne pathogen exposures (needlesticks, sharps, mucous membrane or non-intact skin exposure to patient's blood or body fluids containing visible blood or other potentially infectious material) should be reported to Employee Health via hospital pager (410-328-2337) enter 7845 and follow the prompts as soon as possible after the exposure.
4. All potential patient exposures to your blood should also be reported as soon as possible to Employee Health or Infection Prevention at 410-328-5757 (weekdays 8-5) or via Tigerconnect (24/7).

I understand that it is my responsibility to notify Employee Health or Infection Prevention of the above infections/circumstances. Failure to report any condition will result in appropriate corrective action.

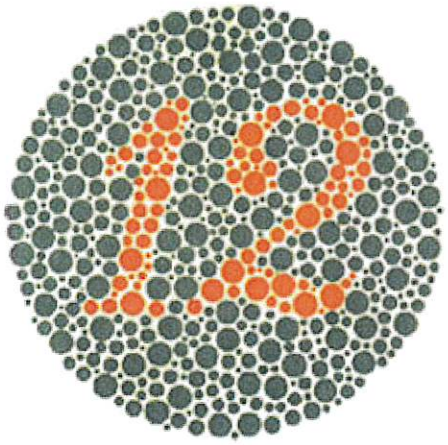
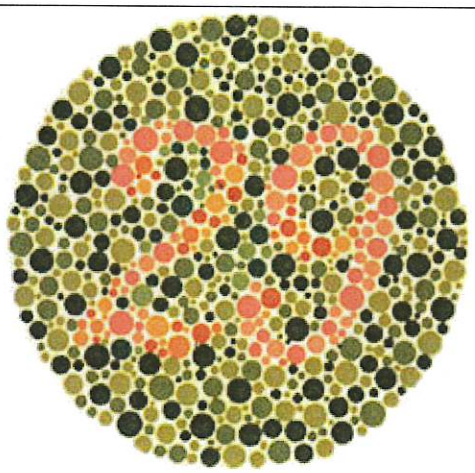
Printed Name:_____ Job Title:_____

Signature:_____ Date:_____

* Infection with any of these conditions should be reported to EHS: Regina Hogan, RN manager, or Elizabeth Nguyen, CRNP or Melissa Frisch, MD.

** See Henderson DK, Dembry L, Fishman NO, et al. SHEA guideline for management of healthcare workers who are infected with hepatitis B virus, hepatitis C virus, and/or human immunodeficiency virus. Infect Control Hosp Epidemiol 2010;31:203–232.

** *"Category III procedures are those procedures for which there is definite risk of bloodborne virus transmission or that have been classified previously as "exposure-prone". They include all surgical specialties, OB/gyn, oral surgery, (see SHEA guideline table 2 for full list/description).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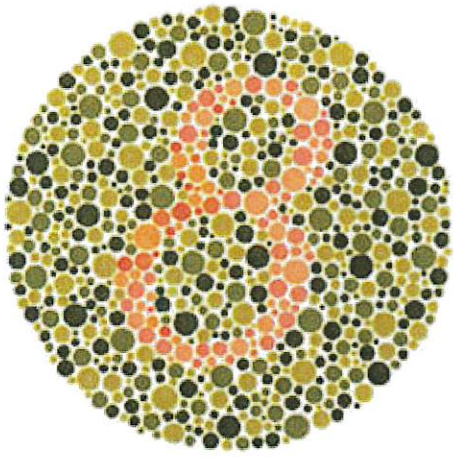	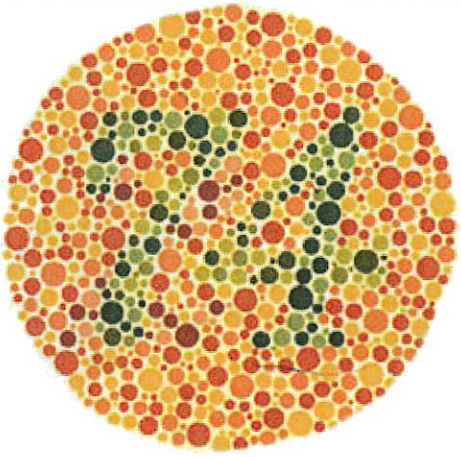
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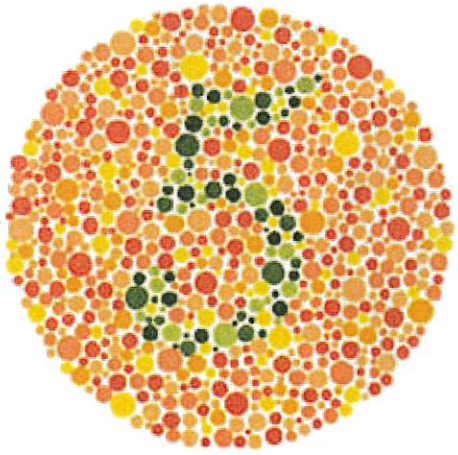	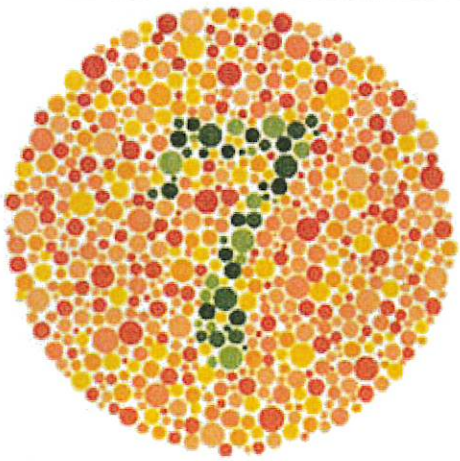
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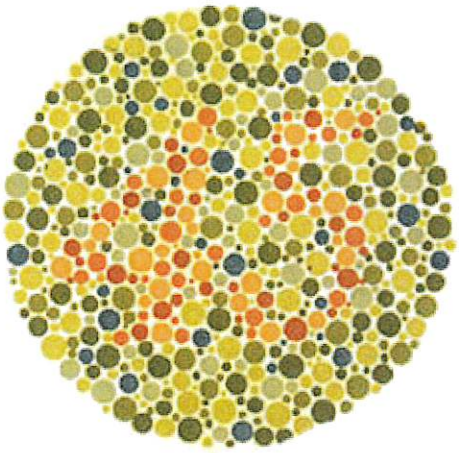
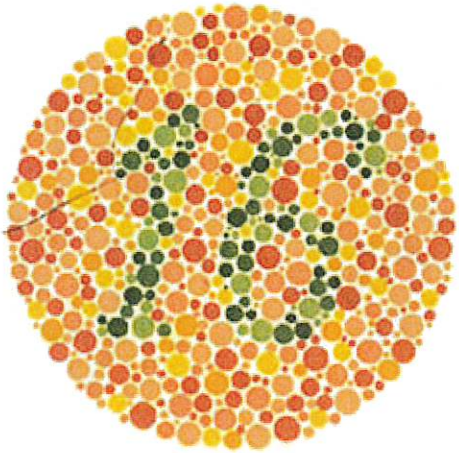
Employee Name:_____ Date:_____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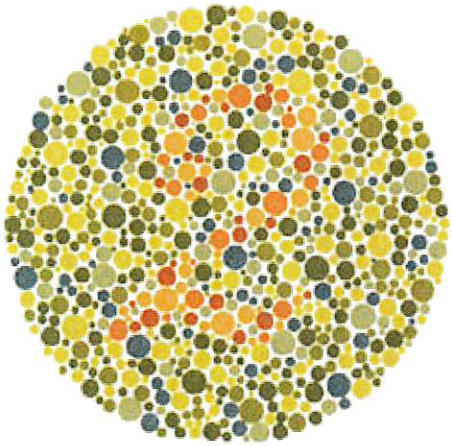	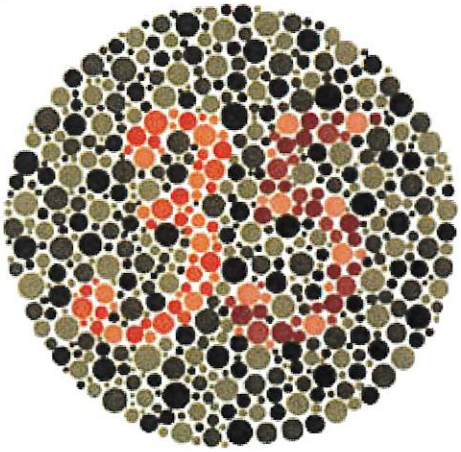
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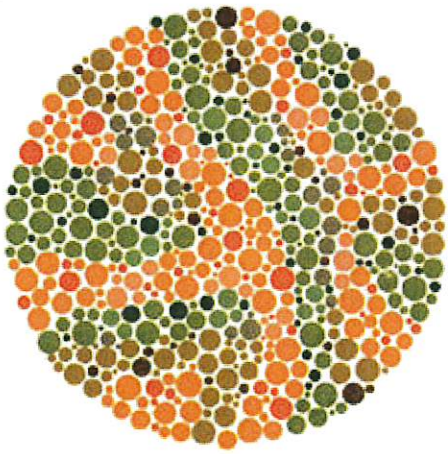	
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Employee Name:_____ Date:_____

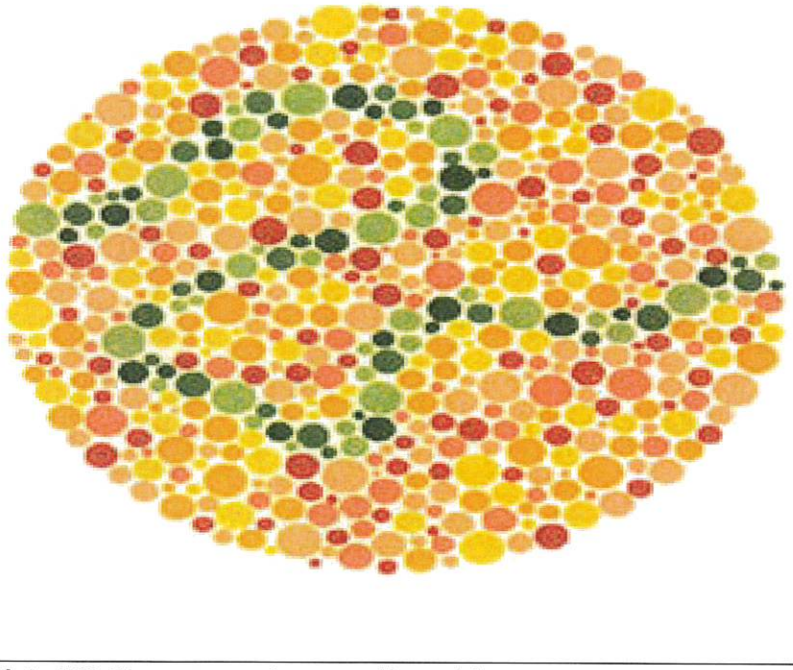

Plate #13 Please trace the green line with a pen.

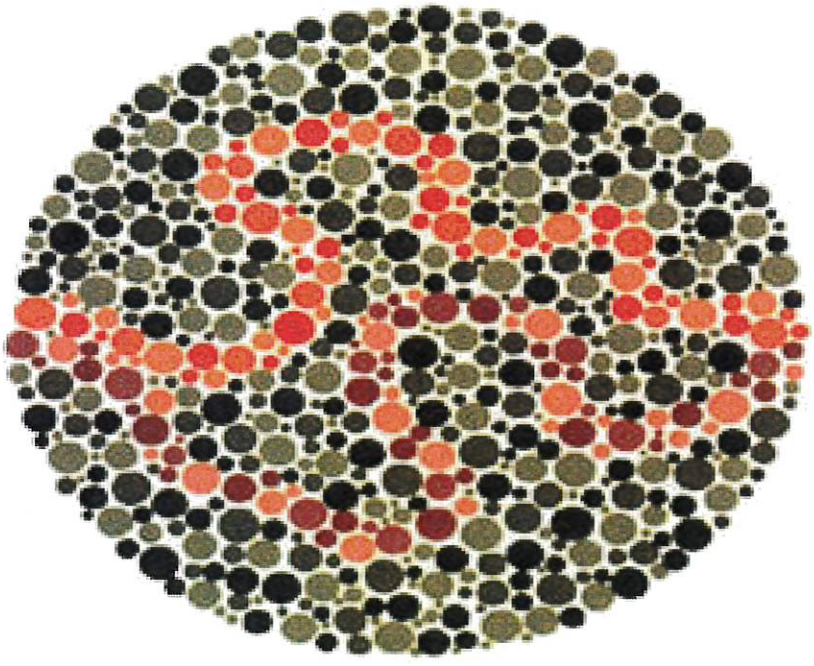

Plate #14 Please trace the red line AND the purple line with a pen.

Employee Name:_____ Date:_____

UNIVERSITY of MARYLAND MEDICAL CENTER

Indication: ☐ Latent TB - Annual ☐ New Hire/Volunteer ☐ TB Skin Test ☐ TB Blood Test

Employee Health Services: Tuberculosis Screening Form

Date	Printed Name	Signature
Email	Phone Number	Date of Birth
SSN for non-employee (Volunteers)/ Emp ID Number	Department	

Employer UMMC/UMMS: ☐ Employee ☐ Attending Physician ☐ New Hire ☐ Volunteer ☐ Other_____

1. Have you ever:
   a) Had active TB? Yes No
      - If yes, provide details regarding date and treatment protocol
   b) Taken medication for a TB exposure or positive TB test? Yes No
   c) Had BCG vaccination? Yes No
      (Provided in countries with prevalent TB disease)
   d) Had a positive reaction to a TB skin or blood test (latent TB)? Yes No
      - If yes to testing positive to TB did you have a CXR? Yes No
      - Date of CXR_____ Normal or Abnormal? (circle one)

      (New Hires & New Volunteers *ONLY*) 'Yes' answers in the section above requires confirmation documentation.

      Documentation Submitted? ☐ Yes. ☐ No.

2. Have you had:
   a) **An abnormal chest x-ray (such as fibrotic changes) **Yes No
      If so, when _____
   b) **Close contact/exposure to someone who has had infectious TB disease within the past two years. **Yes No
   c) Temporary or permanent residence (>1 month) in a country with high TB rate? Yes No
      (Any country other than the US, Canada, Australia, New Zealand, and those in Northern or Western Europe)
   d) **Are you currently or planning to be immunosuppressed? **Yes No
      Including HIV, organ transplant recipient, treatment with TNF-alpha blocker (e.g., infliximab, etanercept or other), chronic steroids (equivalent to ≥15 mg/day for ≥ 1 month) or other immunosuppressive medications
   e) Do you work in a lab and handle AFB specimens and/or mycobacterium tuberculosis cultures Yes No

3. Do you **CURRENTLY** have any of the following?

Persistent cough (lasting for > 3 weeks)	Yes	No
Coughing up blood	Yes	No
Night sweats	Yes	No
Unexplained weight loss	Yes	No
Unexplained tiredness	Yes	No
Persistent fever	Yes	No
Hoarseness	Yes	No

Please explain any 'yes' answers _____

***** Do Not Write Below This Line *** Employee Health Use Only *****

	New Hire	(Circle One)	#1	#2
	Exposure	(Circle One)	Baseline	8-10 Week Post Exposure

Date Given:	Time Given:	Lot #:	Exp. Date:	Intradermal Site (0.1 ml)	Administered by:	STIX
				LFA RFA		

Date Read:	Time Read:	Induration in mm	Health Provider Signature:	STIX

CRNP should follow up on all positives with review of CXR/Symptoms/History

POSITIVE RESULTS Go to... *Initial Attending's* – Elizabeth T. Nguyen CRNP ** *New Hires* – Evette Everett RN or Jennifer Myers RN ** *Current Employees* – Theresa Cappadona RN

Rev 10.18.22

UNIVERSITY of MARYLAND
MEDICAL SYSTEM

	UM Baltimore Washington Medical Center		UM Midtown Campus
	UM Capital Region Medical Center		UM Rehabilitation and Orthopaedic Institute
	UM Charles Regional Medical Center		UM Shore Regional Health
	UM Corporate Shared Services - Linthicum		UM St. Joseph Medical Center
X	UMMC Downtown Campus		UM Upper Chesapeake Health

Hepatitis B Information and Declination Form

Information:

The University of Maryland Medical System is offering recombinant Hepatitis B vaccine to all at-risk UMMS employees free of charge. Immunization against Hepatitis B can prevent acute Hepatitis B as well as reduce illness and death resulting from chronic active Hepatitis, cirrhosis, and liver cancer.

Hepatitis B is a viral infection caused by the Hepatitis B virus (HBV). One of the leading occupational hazards to healthcare workers is exposure to Hepatitis B. This risk comes from a significant exposure to blood and body fluids after a needle stick or mucous membrane exposure. The Hepatitis B vaccine is available to healthcare workers to prevent Hepatitis B infection. This is a genetically engineered vaccine and is free of any association with human blood or blood products. The vaccine series consists of two or three intramuscular injections given over a one to six-month period of time after which your blood is tested for immunity 4-6 weeks after the last dose is administered. In order to verify long term immunity, Employee Health requires both documentation of vaccination and evidence of protective titers (Immunize.org).

Declination:

I understand that I could acquire Hepatitis B Virus (HBV) infection due to my occupational risk of exposure to blood and other potentially infectious material. I have been given the opportunity to be vaccinated with the Hepatitis B Vaccine, at no charge to myself. I decline the **Hepatitis B vaccination** at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious blood disease. If in the future I continue to have the risk of occupational exposure to blood or other potentially infectious material and I want to be vaccinated, I can receive the Hepatitis B vaccine at no charge to me.

	I am confirming that I have already received an approved Hepatitis B vaccine series and **DO NOT desire further vaccination.**
	I have a positive titer without documentation of vaccination and **DO NOT** desire further vaccination
	I was vaccinated but never developed positive titer and **DO NOT** desire further vaccination
	I do not want the vaccine at this time, I **DO NOT** desire vaccination against Hepatitis B.
	I am willing to complete the vaccination series
	Other: Please list why

Signature	Printed Name
Department	Date
Employee ID Number	SSN for non-employee

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EMPLOYEE HEALTH SERVICES

Rubeola (Measles), Mumps, Rubella (German Measles) and Varicella (Chickenpox)

Statement of Understanding

UMMC requires employee's to provide evidence of immunity to Rubeola (Measles), Mumps, Rubella (German Measles) and Varicella (Chickenpox).

Measles and Rubella immunity is a requirement of the State of Maryland Health Department. In order to safeguard the health of employees and patients and prevent the spread of disease, UMMC is also requiring immunity to Mumps and Varicella. There have been some occurrences of Mumps outbreaks in the United States. There have been frequent occurrences of patients admitted to the hospital with Varicella (chickenpox) and Shingles.

Acceptable proof of immunity:

Measles – evidence of 2 vaccinations or blood test indicating sufficient antibody levels.

Mumps - evidence of 2 vaccinations or blood test indicating sufficient antibody levels.

Rubella - evidence of 1 vaccination or blood test indicating sufficient antibody levels.

Varicella - evidence of 2 vaccinations or blood test indicating sufficient antibody levels

If you are found to be <u>not</u> immune to any of these diseases prior to starting work, your start date may be delayed if you cannot accept vaccination.

If you have a medical contraindication or sincere religious objection to vaccination, you must communicate this to EHS and follow processes to submit documentation to decline vaccination.

_____ _____

Employee Print/ Sign Date

Revised 3/2/23

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Applicant Consent to Drug Testing

_____
Applicant/Employee Name (Print)

I understand that the urine drug test collection process **may take up to three hours** to complete and thus I understand that I might **need to remain in Employee Health Services for up to three hours** once the urine drug testing collection process begins.

I understand that if I am not able to remain in employee health services (or at the testing site) for up to three hours once my urine collection has started, then I should not start the urine collection process and I should make an appointment to schedule the urine collection for another day when I know that I can remain in the clinic for up to three hours.

I understand that if I do start the urine collection process and then **leave the testing site prior to providing an adequate specimen** and prior to the completion of the three hour time frame, then the outcome of my **collection will be deemed a "refusal to test" and my job offer will be rescinded.**

I understand that the University of Maryland has a Drug-Free Work Place Policy against the manufacture, use, possession, distribution or sale of illegal drugs and the abuse of legal drugs or alcohol by its employees on hospital property or while conducting business for the hospital. I further understand that the University of Maryland is committed to a drug-free workplace and has adopted a drug testing program as one method of implementing that policy. I also understand that in the event that I become an employee of the University of Maryland, I may be subject to reasonable cause testing in accordance with policy.

I hereby voluntarily consent to provide samples of my blood and/or urine to a laboratory designated by the University of Maryland to determine the presence or use of drugs, I understand that all screening tests for drugs will be subject to careful testing procedures. If the test result is positive, I can request a retest of the same sample, I understand that I must pay for the second test. I further understand that if my test indicates positive for illegal drugs, abuse of legal drugs as an applicant I will not be considered for employment, or as an employee, I may be subject to discipline including termination. I release and discharge the University of Maryland as well as the laboratory, officers, employees, agents and representatives from any claim or liability arising from such tests, including the testing process and procedures, analysis and disclosure of results.

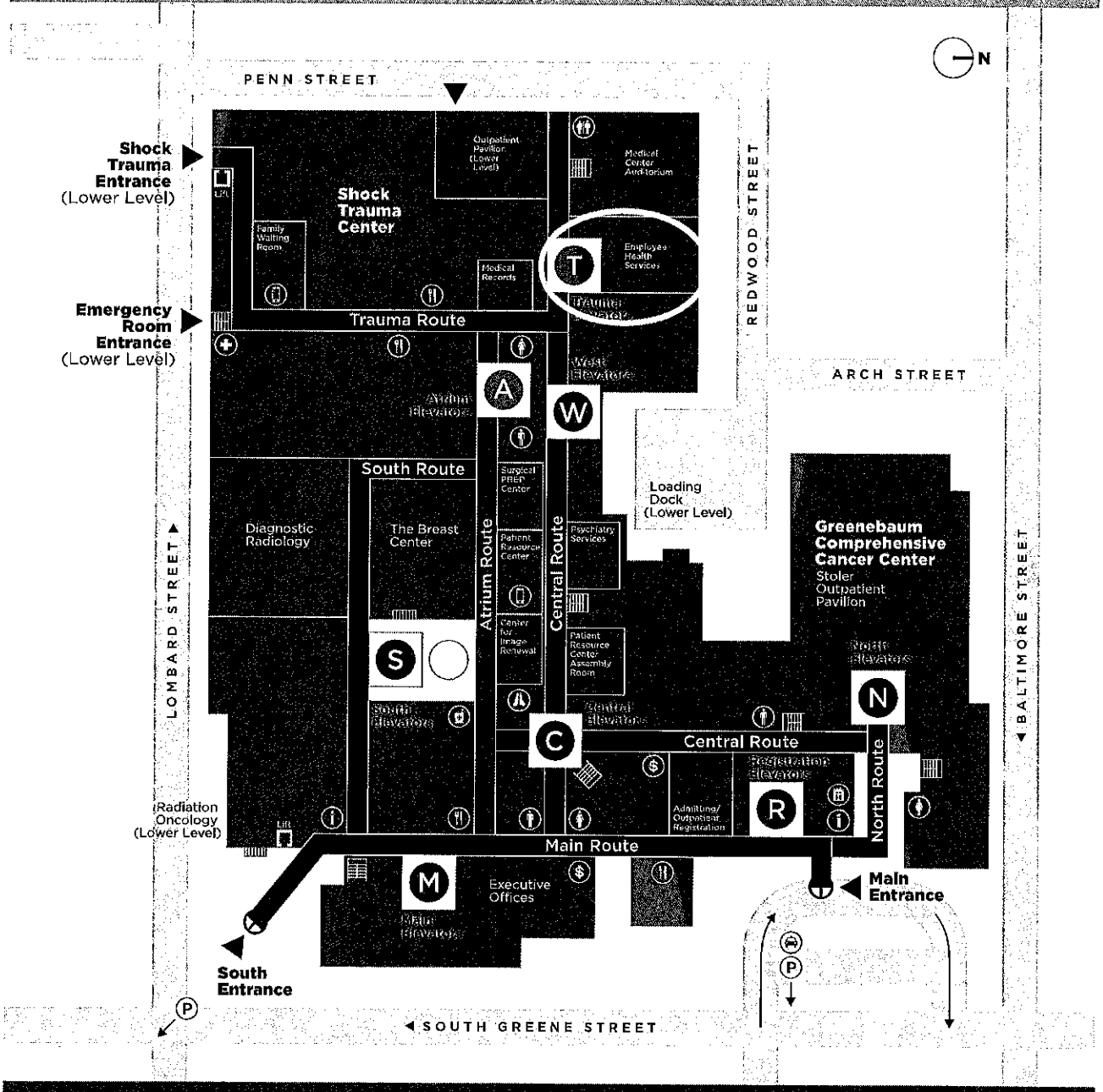
If you are licensed by a professional licensing board including, but not limited to, the Maryland Board of Nursing, Board of Physicians or Board of Pharmacy, and you have a positive urine drug screen result, your results may be reported to the licensing board as required by statute or regulation.

I voluntarily authorize the release of medical information concerning the results of my drug test(s) to company representatives (UMMS recruiting, hiring and onboarding vendor ["Vendor"]) who will use it to determine if I am in compliance with hospital work rules and policies on drug use. I also understand that I am entitled to a copy of this authorization. I understand that refusal by me to sign this consent will be cause for termination or ineligibility for employment.

_____ _____
Applicant/Employee Signature Date

Date

First Floor Map



SYMBOL KEY

- ATM
- Charging Station
- Chapel
- Food
- Gift Shop
- Information
- Emergency Services
- Men's Room
- Parking
- Pharmacy
- Restrooms
- Taxi
- Women's Room