University of Maryland Medical Center
Employee Health Services
Room T1R05, next to first floor Shock Trauma elevators
Phone: (410) 328-0958 Fax: (410) 328-2610 Appointments (410) 328-6151

RESIDENTS/ FELLOWS

Prior to beginning work at the University of Maryland Medical Center (UMMC), you will need to schedule an appointment to be seen by Employee Health Service (EHS) for a pre-placement evaluation. **You must bring a picture ID** (driver's license or passport) or we will not be able to perform your evaluation. Please bring a copy of your vaccination record and TB skin test**.**

Plan about one hour in your schedule to complete the pre-placement evaluation process. The urine drug screen may take up to 3 hours longer if you are unable to provide a specimen.

1. **Medical History Questionnaire:** Complete (on-line)forms and bring them with you to your scheduled appointment. You will be instructed on how to access these forms online for convenience. **DO NOT MAIL THE COMPLETED FORMS TO YOUR RESIDENCY PROGRAM OR TO EMPLOYEE HEALTH**. Hand carry the forms with you to your appointment.
   - If you have **ANY** current medical conditions, which require ongoing treatment, you will be required to provide a note (**documentation , use on-line form titled: Treating Physician Pre-placement Medical Review form)** from your treating physician.
   - This note (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 state that your medical condition is under control and will not interfere with your ability to perform the duties of your residency program in an ongoing, safe and reliable manner. Bring this documentation with you to your appointment.

2. **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, we will draw your blood to determine whether or not you are immune to measles, mumps, rubella, varicella and Hepatitis B. If you have already received the Hepatitis B vaccination series or wish to decline, you may sign a declination form. (see on-line form)
   - If titers indicate that you are **not immune** to any of the above mentioned (you will **not** be cleared to work), you will be notified and instructed to return to EHS to be vaccinated.

3. **Tuberculosis Skin Testing:**
   - UMMC requires a 2- step TB skin test.
     OPTIONS:
     - This means we place one TB skin test and as long as it is negative, we place another one 1-2 weeks later to be certain your baseline is negative. OR
     - If you have had a TB skin test in the last 12 months, please **bring a copy** of the result. **Then you will only need to receive 1 TB skin test.** OR
     - Bring copy of 2 PPD's. (PPD documentation within 1 year *and* within 3 months of start date).
   - The TB skin test needs to be read or interpreted 48-72 hours after it was administered. You may return to Employee Health or have any RN or MD (but not yourself) document the result as long as there is no redness or induration. Any redness or induration **must** be read by UMMC EHS. Documentation can be hand carried or faxed to Employee Health (410-328-2610) or scanned and sent to rhogan@umm.edu.
   - If you have had a positive TB skin test in the past, please bring a copy of a chest x-ray report performed in the past 12 months. Otherwise we will repeat the chest x-ray. Also, complete the UMMC Positive TB Skin Test Questionnaire.
   - For your convenience, we are open Mon. – Fri. from 7am -4pm (except holidays).

4. **Drug Screen:**
   A urine drug screen will be obtained. 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 2:00 pm. The urine drug collection may be scheduled separately from the pre-placement evaluation if there are time constraints.

5. **Respiratory Fit Testing**
   Respiratory medical clearance and fit testing will be performed.

If you are unable to keep an appointment and need to reschedule please call 410-328-6151.
Please note that your **start date will be delayed** by failure to return/complete vaccination records, T.B. skin test results and Treating Physician Pre-placement Medical Review form if indicated.

Revised 01/17/2012

UNIVERSITY OF MARYLAND MEDICAL CENTER
UNIVERSITY OF MARYLAND MEDICAL SYSTEM

Employee Health Services Registration Form

Please Print Clearly

Name: _____ Today's Date: _____

SS #: _____ Date of Birth: _____

Sex: ☐ Male ☐ Female Race: _____

Street Address: _____

City: _____ Home Phone: _____

State: _____ Cell Phone: _____

Zip Code: _____ Email: _____

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

If so, please list other names used: _____

Job Title: _____ Work Phone: _____

Supervisor: _____ Department _____

Recruiter: _____ Anticipated Start Date: _____

IN CASE OF EMERGENCY, NOTIFY:

Name: _____ Phone: _____

Address: _____

Revised 5/08

University of Maryland Medical Center Today's date:
Initial Residents/ Fellows Employee Health Evaluation

Printed name – first name, middle name, last name:	Date of birth:

The purpose of this evaluation is to screen you for communicable diseases, determine vaccinations to protect you and your patients, to clear you to use a respirator, to screen you for latex allergy, and to determine whether you have any physical, mental or emotional impairment that could affect your ability to perform 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.

Employment Information --- All employee

Type of job you have been offered: Job code (if known):

Can you perform the essential functions of your job? □ Yes □ No □ Uncertain

Do you have any CURRENT disability requiring restricted physical activity? □ Yes □ No

If yes, will you require a job modification for a disability? □ Yes □ No □ Uncertain

If yes, state restrictions:

Are these restrictions:
□ Permanent □ Temporary until: (provide date)

Past Work/Exposure History--- All employees

Mark an "X" in the box next to ALL items you might have been exposed to in your past work:

□ Asbestos/silica	□ Pesticides	□ Lead/mercury/cadmium	□ Loud noise (above 85 decibels)
□ Dusts	□ Laboratory animals	□ Benzene	□ Solvents/degreasers
□ Formaldehyde	□ Epoxy resins	□ Hazardous wastes	□ Cytotoxic agents (e.g. chemo)
□ Welding	□ Blood or fluid exposures (HIV, Hep B, Hep C)	□ Plastics	□ Lasers
□ Latex Products	□ Vibration	□ Paints/isocyanates	□ Other chemicals (list):
□ Grease and oil	□ Ethylene oxide/other gases	□ Glutaraldehyde	_____

If you have been exposed to any of the above, provide further details, including the year, the amount of exposure and medical treatment: _____

Vaccines --- To be completed by all employees who work within the hospital, and by others who might work in patient care areas

UNK=Unknown

a. Have you ever received 3 doses of hepatitis B vaccine? If 'yes', what year?	Yes	No	UNK
Did you have a post-series antibody titer to determine immunity?	Yes	No	UNK
If 'yes', were you then considered immune?	Yes	No	UNK
b. Have you had serologic evidence of immunity to varicella?	Yes	No	UNK
Have you ever received 2 doses of varicella (chickenpox) vaccine?	Yes	No	UNK
c. Have you ever received 2 doses of live measles vaccine?*	Yes	No	UNK
d. Have you received at least 2 doses of mumps vaccine?*	Yes	No	UNK
e. At least 1 dose of rubella vaccine?*	Yes	No	UNK
f. Was your last tetanus shot within the past 10 years? If 'yes', what year?	Yes	No	UNK
g. When was your last TB skin test:			
h. What was the result?			
i. Do you have documentation	Yes	No	UNK

*Usually given as 2 doses. Documentation is required by Maryland state regulation. If not available, blood must be drawn for titers

Employee name: _____

Work Injuries --- All employees

Have you ever had an illness or injury that was related to your job?	Yes	No	
If 'yes': What was the injury or illness: Where did it happen (location): What was the date of the injury: Did you miss work? If 'yes', for how long? _____ Do you have any ongoing restrictions to your activity? If 'yes', describe restrictions:	 Yes Yes	 No No	

Latex Allergy Screening --- All employees

a. Have you ever been told by a medical professional that you have a latex allergy?	Yes	No	
b. Have you ever had an anaphylactic reaction to a latex product?	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. Are you allergic to: Check all that apply □ Bananas □ Avocado □ Kiwi □ Other foods (list):			

Current Health Status --- All employees

General Health and Function		
How would you rate your general health? Poor Fair Good Excellent		
How often do you engage in brisk physical activity that lasts at least 30 minutes? Not at all Rarely 2-3 times/week ≥ 3 times/week		
Do you smoke? If 'yes' what do you smoke? Cigarettes Cigars Pipe How many/often per day? _____ For how many years? _____ If 'no' have you ever smoked? _____ For how many years? _____ When did you quit? _____	Yes	No
Do you drink beer, wine, or hard liquor? Average less than 1 drink per day? Average 2 or more drinks per day?	Yes Yes Yes	No No No
Do you now or have you ever used illegal drugs?	Yes	No
Are you now using prescription pain killers?	Yes	No
Are you currently being treated or monitored (e.g. by a licensing board) for substance abuse (including illegal drugs, use of a legal drug that has not been prescribed for you, or alcohol)? If yes, list/describe substance, treatment program (name/location/frequency) and ongoing monitoring (e.g. repeat urine or blood tests):	Yes	No
Respirator Clearance --- To be completed by all employees ever working in patient care areas		
Have you ever worn a respirator? If 'yes' what type(s)? : _____ Did you have any difficulties when using the respirator (such as eye or skin irritation, anxiety, weakness or fatigue)? Explain:	Yes Yes	No No
Respiratory (All employees)		
Have you had any chest injuries/surgeries in the past year or that are still causing pain or breathing problems?	Yes	No

Employee name: _____

Do you have current shortness of breath?	Yes	No
Very short of breath when walking fast on level ground or walking up a slight hill or incline?	Yes	No
Very short 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 level ground?	Yes	No
Shortness of breath when washing or dressing?	Yes	No
Shortness of breath that interferes with your job?	Yes	No
Coughing that:		
Produces phlegm (thick sputum)	Yes	No
Wakes you early in the morning	Yes	No
Occurs mostly when you are lying down	Yes	No
Produces blood (in the last month)	Yes	No
Do you have wheezing?	Yes	No
Do you have wheezing that interferes with your job?	Yes	No
Cardiovascular (All employees)		
Have you had any problems with chest pain/tightness:		
While you are walking?	Yes	No
While you are resting?	Yes	No
That interferes with you job?	Yes	No
Have you had any chest pain when you breathe deeply?	Yes	No
Do you have an irregular heartbeat or palpitations?	Yes	No
Do you have swollen ankles/feet (not caused by walking)?	Yes	No
Do you have heartburn or indigestion that is not related to eating?	Yes	No
Do you have pain in your legs when walking that is relieved by rest?	Yes	No
Musculoskeletal (All employees)		
Do you have any problems with your joints or muscles?	Yes	No
Do you currently have neck pain, back pain, or pain in any of your joints?	Yes	No
Have you ever had an injury to your neck, back, extremities, or joints?	Yes	No
Have you ever had any broken bones including ribs?	Yes	No
If 'yes' what bone and when? _____		
If 'yes', is it still causing pain?	Yes	No
Do you have trouble bending at the waist?	Yes	No
Do you have any lifting restrictions?	Yes	No
If 'yes', describe restrictions (e.g. maximum weight you can lift):		
Do you have trouble doing a deep knee bend?	Yes	No
Do you have trouble lifting your arms above your head?	Yes	No
Do you have trouble making a fist with both of your hands?	Yes	No
Do you have any limitations in the amount of time you are able to sit, stand, or walk?	Yes	No
Do you have trouble going up and down stairs?	Yes	No
Neurological (All employees)		
Do you have loss of vision in either eye that cannot be corrected?	Yes	No
Do you have loss of vision requiring correction?	Yes	No
If 'yes' mark the type of correction Near Far Contact Lenses Eyeglasses		
Do you have hearing loss that requires hearing aids?	Yes	No
Do you have headaches more than twice a month, which limits your ability to work?	Yes	No
Do you have problems with weakness (loss of strength)?	Yes	No
Do you have numbness or tingling in your extremities?	Yes	No
Do you or have you ever had seizures (fits)?	Yes	No
If 'yes' when was the last episode?		
Do you have episodes of lightheadedness or dizziness?	Yes	No
If 'yes' when do these occur?		
Have you ever passed out (fainted)?	Yes	No
If 'yes' when was the last episode?		
Do you ever lose your coordination/balance?	Yes	No
Psychiatric/Other (All employees)		
Have you ever received treatment for, or missed work because of, any of the following:		
ADD/ADHD?	Yes	No
Depression?	Yes	No
Bipolar disease?	Yes	No
Anxiety?	Yes	No
Post traumatic stress disorder (PTSD)?	Yes	No
Schizophrenia?	Yes	No
Other psychological/psychiatric disorder?	Yes	No

Employee name: _____

Do you have decreased ability in any of the following? (Check all that apply) □ To stay awake or maintain consciousness (due to such causes as seizures, diabetes, or sleep disorder) □ Managing multiple tasks at one time □ Working rotating shifts	Yes	No

Medications --- All employees

Do you have a history of allergies or sensitivities to medications? □ Yes □ No
If 'yes' which medication(s)? _____

List all medications you are currently taking both prescription and over-the-counter:

Other Chronic Conditions --- All employees

Mark an **X** in the box next to any of the following illnesses you now have or have ever had.

□ Skin disorder	□ **Heart failure**	□ Hive or rashes	□ **Other heart problems**
□ Peripheral vascular disease	□ **Color blindness**	□ Liver disease/ hepatitis	□ **Hernia**
□ **Mental health problems**	□ Diverticulosis	□ **Anemia**	□ Current or frequent pneumonia
□ **Back problems/surgery**	□ **Cancer or tumor**	□ **Neck problems/surgery**	□ Pneumothorax (collapsed lung)
□ **Diabetes**	□ **Other lung disease**	□ **Shoulder problems/surgery**	□ **Asthma**
□ **High blood pressure**	□ **Knee problems/surgery**	□ Kidney/ bladder problems	□ **Stroke**
□ **Heart attack**	□ **Ankle problems/surgery**	□ **HIV, chronic Hepatitis B or Hepatitis C**	
□ **Fatigue that may interfere with your job**			

* If you have marked an **X** next to any of the above, provide additional information including: when you were diagnosed with the condition, duration, complications, hospitalizations related to the condition, and any ongoing issues related to the condition:

By signing this form, I am certifying that to the best of my knowledge I have provided answers truthfully and will provide medical records, as requested, to determine if I am medically fit to perform this job. I understand that misrepresenting facts may forfeit my employment opportunity.

Your signature_____ Date _____

****

To be completed by Employee Health Services

Physician/Physician Assistant/RN reviewing medical history _____ Date _____

Outstanding issues:

01 17 12 UMMC Initial Residents Fellows EHS Evaluation.doc

UNIVERSITY of MARYLAND MEDICAL CENTER

Treating Physician Pre-placement Medical Review

Dear Doctor _____ Date: _____

Your patient, _____, was seen at UMMC Employee Health Services for a pre-placement evaluation prior to beginning a position as a resident or fellow. We need additional information in order to recommend him/her for the position of _____.
Please complete the following form regarding:
_____

By signing this, I am granting permission for my treating physician listed above to provide the requested documentation to Employee Health Services.

_____
Employee's signature

To be completed by applicant's treating physician

Primary diagnosis:

How this diagnosis was established (e.g. special tests):

Other diagnoses:

Is the patient currently being treated? Yes No

Medications and dosages:

Is the condition medically optimized? Yes No

If 'no', what is the next step in the treatment plan?

Other treatment:

In your professional opinion, are you aware of any past performance issues related to this diagnosis(es)?

Yes No If 'yes', describe:

In your professional opinion, can he/she safely, regularly and reliably perform the essential duties?

Yes No If 'no', describe any restrictions:

Other comments:

Treating Physician's signature: _____ Date: _____

Phone number: _____ Fax # _____

Please fax completed form ASAP to 410-328-3079. For questions, call 410-328-0958.

□ Melissa Frisch, M.D., MPH, Medical Director □ Annique Nonnon-Jameson, CRNP

A. General Information and Instructions:
The University of Maryland Medical System (UMMS) is offering recombinant hepatitis B vaccine, a non-infectious subunit virus 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 from chronic active hepatitis B, cirrhosis and liver cancer.
If you have any questions regarding hepatitis B or the recombinant vaccine, contact the Employee Health Office @ 8-0958 or the Office of Infection Control @ 8-5757
B. Instructions:
Complete the required information below. A copy of this completed form will be provided for your records upon your request.
NOTE: By your signature below, you acknowledge that you have read the information about hepatitis B vaccine contained in this document and understand the risk of acquiring hepatitis B infection in the workplace. Your signature also indicates you have had an opportunity to ask questions about hepatitis B and the vaccine & understand the benefits and risks of the hepatitis B vaccine.
C. Employee Information & Verification

- ☐ Yes! I am interested in and willing to receive the hepatitis B vaccine
- ☐ I have already received all three (3) doses of the hepatitis B vaccine
- ☐ No! I do NOT desire vaccination against hepatitis B and will NOT agree to receive the hepatitis B vaccine series.

[If you have indicated NO above, read and initial the hepatitis B statement below]

Hepatitis B Statement:

I understand that should I sustain an occupational exposure to blood or bodily fluids or other potential infectious materials, I may be at risk for acquiring hepatitis B (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine free of charge or cost to me. HOWEVER, I decline the hepatitis B vaccine at this time. I understand that by declining this vaccine I continue to be at risk of acquiring hepatitis B viral infection, a serious disease with possible serious outcomes. If in the future I desire vaccination with the hepatitis B vaccine, I may do so by contacting the office of Employee Health Services @ extensions 410-328-0958 or 410-328-8632.

Initials _____

Signature	Printed Name	Title
Department	Date	Social Security No.

The Disease: **Information About Hepatitis B Vaccine**

Hepatitis B is a viral infection caused by the hepatitis B virus (HBV). Most people with hepatitis B recover completely, though approximately 5% to 10% of infected adults and most infected newborns become chronic carriers of the virus. Many of these people have no symptoms, but can continue to transmit the disease to others. Some develop chronic hepatitis and cirrhosis. HBV also appears to be a causative factor in the development of hepatic carcinoma (liver cancer). It is estimated that about 5,000 persons in the United States of America alone, die each year from causes related to HBV. Thus, immunization against hepatitis B can prevent acute hepatitis and also reduce sickness and death from chronic hepatitis, cirrhosis and liver cancer.

The Vaccine: Recombivax-HB or Enerix B is a non-infectious subunit viral vaccine derived from hepatitis B surface antigen (HBsAg) produced yeast cells using recombinant DNA technology. A portion of the hepatitis B virus genome coding for HnsAg is cloned and purified by a series of physical and chemical methods. It is a genetically engineered vaccine and is free of any association with human blood or blood products. It has been tested for safety and efficacy in humans and found to be safe and efficacious. A high % of healthy people who receive three (3) doses of vaccine, achieve high levels of protective surface antibody (HBsAb). Full immunization requires three doses of the vaccine over a six month period, although about 5% of vaccinated persons may not develop immunity even after three doses. The duration of immunity provided by this vaccine is unknown at this time.

Contraindications: Hypersensitivity to yeast proteins, formalin, aluminum hydroxide or (mercury derivative) thimerosal

Precautions: Pregnancy and Nursing mothers: studies have not been done on this vaccine in these settings. Therefore, it is not known whether or not Recombivax-HB or Enerix B can cause fetal harm to be excreted in human milk.

Possible Side Effects: The incidence of side effects is 10% at the injection site (soreness, tenderness, erythema, swelling, and bruising) Systemic complaints occur in 15% and include fatigue, weakness, headache, fever and malaise. The possibility exists that other S.E.'s may be identified in the future.