UNIVERSITY OF MARYLAND
MEDICAL CENTER
UNIVERSITY OF MARYLAND MEDICAL SYSTEM

Medical Staff Services
110 South Paca Street, 8th Floor
Baltimore, MD 21201
Phone: 410.328.1151
Fax: 410.328.6433

Re: Credentialing requirement - initial and annual Medical Staff health assessments

Dear Prospective Medical Staff Member:

One of the requirements for medical staff membership and clinical privileges (including Advanced Practice Nurses and Physician Assistants) at UMMC is proof of current health screening. This includes vaccinations, tuberculosis screening, and initial medical clearance for respiratory protection and respirator fit testing. There are federal and state laws that mandate occupational health services to address these issues, and federal guidance to address related issues. **This is a high priority to protect you and your patients. UMMC will not be able to complete credentialing for privileges (including temporary privileges) for or re-credential you unless this requirement is fulfilled on an annual basis (i.e. defined as within the past 12 months of your date of hire).**

In order to comply, please **contact UMMC Employee Health Services (EHS) Appointment line at 410-328-6151** for an appointment. For your convenience, EHS is open from 7AM-4PM, Monday-Friday (except holidays) and remains open during lunch. It is best to make your appointment at least 2 weeks in advance given the volume of employees the clinic services. If the appointment hours are not convenient, you can contact Regina Hogan, Manager EHS, at 410-328-0958 to make alternative arrangements. The location for EHS is suite T1R05 (1st floor near the UMMC/STC Auditorium). During the flu vaccine campaign (October-January), you can also be vaccinated against the flu at the same time**.**

Thanks to a partnership between the University of Maryland Medical Center and the School of Medicine, **there is no cost to you** for the assessment, testing, or vaccinations (if needed).

The following documents are enclosed for your use:

1. **Annual Medical Staff Occupational Health Questionnaire**: *(This should be completed in full and brought with you on the day of your appointment.)*

   A. Please note that Maryland law requires written documentation that you have received measles, mumps, and rubella vaccinations. If documentation is no longer available, titers must be drawn. You may decline any vaccine by completing the attached **Vaccine Declination Form** and submitting it to EHS.

   B. If you have had a TB screening or chest x-ray elsewhere within the past twelve (12) months, that documentation should suffice. However, for new attendings, another TB test may be required as step 2 of CDC's recommended two-step process. For your convenience, the TB test can now be read by

any MD or RN (but not self-read) as long as there is no reaction, and then faxed back to EHS for documentation (410-328-6319 fax). However, if there is any induration or redness whatsoever, it must be read by an EHS clinician.

2. **Medical Clearance for Respiratory Protection Questionnaire**: *(This should be completed in full and brought with you on the day of your appointment.)* Respiratory fit testing (sizing) is required for any disposable respirator use, such as a N-95 respirator. You may decline the fit testing if you elect to use the Powered Air Purifying Respirator (PAPR) by completing **the Fit Testing Declination Form** and submitting it to EHS.

3. **Optional Cholesterol Screening**: EHS is pleased to offer a free 5-minute cholesterol profile (LDL, HDL and triglycerides). Overnight fasting is recommended.

CONFIDENTIALITY: UMMC EHS will maintain a medical record to document services provided and compliance with the required/recommended health and safety programs. Medical Staff Services and your Chair/Division Chief will be provided with compliance data. **Personal health information, as well as your social security number, will be maintained in confidence as per State and Federal requirements.** The UMMC Medical Director of Infection Control, will be notified of health information that could negatively affect patient care as per UMMC policy SP&CI-003 Prevention of Transmission of Infectious Disease from Personnel to Patients.

If you have any questions, whatsoever, please feel free to contact either Regina Hogan, RN, Manager or Dr. Melissa Frisch, Medical Director, Employee Health and Safety, UMMC at 410-328-0958.

Thank you for your cooperation.

Sincerely,

Allison M. Andrus, CPMSM
Director, Medical Staff Services

University of Maryland Medical Center
Annual Medical Staff Occupational Health Questionnaire

Today's Date:_____ Name: _____ Department: _____
Home Address: _____ City, State, Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____ ____
Pager: _____
SS#: _____ DOB: ____(mm)/____(dd)/____(year)

Part A. Vaccines: ***If you have completed this questionnaire before, skip this section and go to Part B*** **UNK=unknown**

a. Have you ever received 3 doses of hepatitis B vaccine?	Yes	No	UNK
If 'yes', what year? _____			
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 chickenpox or 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 had measles?	Yes	No	UNK
d. Mumps?	Yes	No	UNK
e. Rubella?	Yes	No	UNK
f. Have you ever received 2 doses of live measles vaccine?*	Yes	No	UNK
g. Were you born before 1957? (Note: this infers natural immunity to measles)	Yes	No	
h. Have you received at least 1 dose of mumps vaccine?*	Yes	No	UNK
i. At least 1 dose of rubella vaccine?*	Yes	No	UNK

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

Part B. Tuberculosis (TB) Screening: ***Complete this section annually***

a. Were you born in the U.S.A.?	Yes	No	
*If 'no', what is your country of birth?*_____			
What year did you move to the U.S.A.? _____			
b. Have you ever received BCG vaccine?	Yes	No	UNK
c. Have you traveled or lived outside the U.S.A. in the last 2 years?	Yes	No	
If 'yes', where? _____			
d. When was your last TB skin test? Month: _____ Year: _____			
Was it positive?	Yes	No	UNK
If positive, was a CXR required?	Yes	No	UNK
If CXR required, was it positive?	Yes	No	UNK
If CXR positive, describe intervention (e.g., medications and duration) on reverse side			
e. Since your last TB skin test, have you lived with or been in close contact with someone with TB?	Yes	No	UNK
If 'yes', provide details on reverse side			
f. Have you ever been diagnosed with TB?	Yes	No	
If 'yes', describe intervention (e.g., medications and duration) on reverse side			

g. Since your last TB skin test, have you had any of the following symptoms? *Check all that apply*:

__persistent cough (> 3 weeks) __excessive fatigue __coughing blood
__hoarseness __excessive night sweats
__persistent fever __excessive unintentional weight loss

Part C. Respirator Medical Clearance: If you have never completed the **UMMC Medical Clearance for Respiratory Protection (N95 or PAPR) Questionnaire** or if you have had a change in your health, you must complete it now. Annual fit testing is required for use of a disposable N-95 respirator, but you may sign a declination form and then use the Powered Air Purifying Respirator (PAPR) only. Please refer to the attached training sheet.

Part D. 5-minute cholesterol profile: We are pleased to offer you a free 5-minute cholesterol profile (LDL, HDL, and triglycerides) that requires a finger-stick only. Overnight fasting is recommended. You can come back for this anytime during regular hours.

The information supplied in this questionnaire is true to the best of my knowledge.
Your signature: _____

Notes:

****

Reviewing Employee Health professional's comments:		
_____	_____	_____
Signature	Printed Name	Date

8/06

UNIVERSITY OF MARYLAND
MEDICAL CENTER
UNIVERSITY OF MARYLAND MEDICAL SYSTEM

Employee Health Services
22 South Greene Street
Baltimore, MD 21201
Phone: 410.328.6151
Fax: 410.328.6319

Vaccination Declination Form

I _____ understand that measles, mumps, rubella (german
(Please print your name)
measles), varicella (chickenpox) and hepatitis B are vaccine-preventable diseases, and that susceptible health care workers can acquire and transmit them to patients. These diseases may result in serious morbidity or even death in health care workers and in patients.

I have been unable to provide documentation of the following:

1) Laboratory proof of immunity/titer, records of prior vaccination, or physician documentation of actual disease.

Or

2) Laboratory results show that I have insufficient or no immunity to:
   - □ Measles
   - □ Mumps
   - □ Rubella (German Measles)
   - □ Varicella (Chickenpox)
   - □ Hepatitis B

I am aware that Vaccine Information Sheets are available in Employee Health Services should I have any questions. Due to my lack of documented immunity, Employee Health Services has offered to vaccinate me against the disease(s) checked off above, at no charge to me, but I decline it. I acknowledge that it is my responsibility to contact Employee Health Services should I change my mind in the future and decide to be vaccinated, or if I am exposed to a person in the contagious state of the disease and did not wear the appropriate personal protective equipment. I understand that if I am exposed to a case of measles, mumps, rubella or varicella, I will automatically be relieved from all direct patient contact throughout the incubation period following my exposure, as per UMMC policy SP&CI-003 Prevention of Transmission of Infectious Disease from Personnel to Patients.

Reason for declination:

- □ For medical reasons, I am unable to receive the vaccine.
- □ For non-medical reasons, I decline the vaccine.

Your Signature:_____ **Date:**_____

Department:_____ **Job Title:**_____

University of Maryland Medical Center
Medical Clearance for Respiratory Protection Questionnaire

Today's Date:_____

Employee Name: _____
Home Address: _____
City, State, Zip: _____
Home Phone: _____
Work Phone: _____

SSN: _____/_____/_____ DOB: _____/_____/____

Job Title: _____Department:_____

Are you required to be certified to wear a respirator for your job? ☒Yes ❒ No

Note: If you are required to be fitted and ready to wear respiratory equipment, you must answer the following questions as required by the new OSHA Respiratory Protection standard. For your convenience, some questions have been answered for you, but you may change the answer.

Part A. Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Check the type of respirator you will use (you can check more than one category):
a. ___✓_ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
b. ___✓_Powered-air purifying respirator (PAPR)

2. Have you worn a respirator (circle one)?: Yes No

If "yes," what type(s):_____

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please circle "yes" or "no").

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month:
Yes No
If yes, and you want more information on how to quit smoking, please call Employee Health Service at 8-0958.

2. Have you <u>ever</u> had any of the following conditions?

a. Current seizures (fits):	Yes	No
b. Uncontrolled diabetes (sugar disease):	Yes	No
c. Allergic reactions that interfere with your breathing:	Yes	No
d. Claustrophobia (fear of closed-in places) that might interfere with using a respirator:	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 (i.e., ongoing cough or phlegm over several months):	Yes	No
d. Emphysema:	Yes	No
e. Current or frequent 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 in past year or still causing pain:	Yes	No
k. Any chest injuries/ surgeries in past year or still causing pain or breathing problems:	Yes	No
l. Any other long-term or current lung problem you've been told about:	Yes	No

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

a. Shortness of breath:	Yes	No
b. Very short of breath when walking fast on level ground or walking up a slight hill or incline:	Yes	No
c. Very short of breath when walking with other people at an ordinary pace 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. Cough 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. Coughing 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. Do you currently have any of the following cardiovascular or heart problems?

a. Heart attack in past year or current symptoms:	Yes	No
b. Stroke in past year or current symptoms:	Yes	No
c. Current angina:	Yes	No
d. Heart failure:	Yes	No
e. Current swelling in your legs or feet (not caused by walking):	Yes	No
f. Heart arrhythmia (heart beating irregularly):	Yes	No
g. Uncontrolled high blood pressure (>140/90):	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 (fits):	Yes	No
e. Do you have any side effects of any medication that might affect your ability to use a respirator?:	Yes	No

8. 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 question 9): ___

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. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?: Yes No

10. **Apart from patient care, describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well being of others?**:

_____

The information supplied in this questionnaire is true to the best of my knowledge.

_____ _____

Employee Signature Date

Reviewing Health Care Professional Comments:

_____

_____

_____

_____

Reviewing Health Care Professional Comments:

- ☐ **Medically Fit- No medical condition that would place the employee at increased risk to wear respiratory protection**
- ☐ **Fitness Determination Pending -**_____
- ☐ **Medically Fit with the following restrictions:**_____
- ☐ **Not Medically Fit: Reason**_____

_____

_____ _____ _____

Signature of Reviewing Physician Printed Name Date

RESPIRATOR TRAINING SHEET

What a respirator ('mask') is: a device to protect yourself from dangerous substances such as infectious agents (viruses such as the one which cases Severe Acute Respiratory Syndrome, or SARS, & bacteria such as tuberculosis, or TB) & various chemicals

There are many types of respirators including:

- Various types of Particulate Respirators such as the "N-95" respirators --- these protect against infectious droplets such as viruses & bacteria, but offer little/no protection against chemicals or gases. They must be properly fitted and a tight seal must exist between the respirator and your face
- Powered Air-Purifying Respirators (PAPR) --- which uses a powered fan with a battery pack to blow air through a filter (such as a HEPA filter) so that infectious agents are removed
- SCBA (breathing apparatus) commonly used by firefighters --- these have an air tank to supply clean air, Others --- such as escape respirators & gas masks

Respirators commonly used in hospitals/clinics:

N-95

- Advantages: disposable (so don't have to be disinfected), relatively inexpensive
- But: must be sized before use (or fit-tested --- see opposite page), men must be cleanly shaven daily for it to fit, & they do not absolutely reduce exposure to the same level as a PAPR
- If there is a change in your health, Employee Health must evaluate you to make sure respirator use is safe
- If there is a change in facial configuration (such as weight loss or gain, injury, major dental work, etc.), must be sized again to determine which size best fits
- The CDC has approved N-95 respirators to protect against SARS, TB & many other infectious agents

PAPR

- Advantages: more protective, can be used if you have not or cannot be properly fit-tested for other respirators (one size fits all!), makes breathing easier
- But: communication may be difficult, if the motor/battery fails there is little/no protection, they are costly, & must be properly disinfected after each use to prevent spread of some biological agents
- Also protect against various chemicals if appropriate filters are used
- If there is a change in your health, Employee Health must evaluate you to make sure respirator use is safe **(SEE OTHER SIDE->)**

Requirements for you to use a respirator:

- You must be medically cleared before you are fit-tested or use ANY type of respirator --- please complete the attached Respiratory Protection Questionnaire for review by Employee Health Services. In some cases, a more detailed medical evaluation may be required

- You must be fit-tested (exception: this is NOT required for PAPR) --- this is a process in which a tester will work with you to select the proper size & check the seal of the respirator to your face. You will be asked if you can taste a certain substance, & then re-asked if you can taste it with the respirator on. Also, each time you use a respirator, you will need to check the seal yourself & also look for any defects

Additional information:

- You can find out more information about respirators on the Internet at: http://www.cdc.gov/niosh/npptl/npptlrespfact.html
- Please ask any questions you have when you are being fit-tested
- When using a respirator, if you have any questions or concerns, please see your supervisor. If you experience breathing problems, cough, overheating, claustrophobia, skin irritation or other unusual symptom(s) when using the respirator, report this to Employee Health Services

THANK YOU