PSJMC Mini Orientation Acknowledgement

- *I acknowledge that I have read and will adhere to the Policies and Procedures provided within Provena Saint Joseph Medical Center's (PSJMC) New Employee Orientation.*
- **Name: _____**
- **Signature: _____**
- **Date: _____**
- **Agency:_____**

LATEX ALLERGY SURVEY DATE:_____

PRINT NAME:_____ JOB TITLE:_____

DEPARTMENT:_____

Answer all questions by circling appropriate response

Do you think you have an allergy to natural rubber latex?	YES	NO
Do you have a food allergy (hives; facial, lip, or tongue swelling) to bananas, kiwi, potatoes, tomatoes, avacado, chestnuts or hazelnuts, grapes, cherries, papaya, apple, carrots, or celery?	YES	NO
Do you wear latex gloves to do your job?	YES	NO
When you or the people working with you wear latex gloves, Do you notice any -		
itchy, red eyes,	YES	NO
sneezing,	YES	NO
runny stuffy nose,	YES	NO
itching inside the mouth	YES	NO
shortness of breath,	YES	NO
wheezing,	YES	NO
chest tightness or	YES	NO
difficulty breathing?	YES	NO
Have you had any itching, swelling, or other symptoms, or unexplained allergic reactions after dental or medical procedures?	YES	NO
Have you ever reacted to latex products (gloves, balloons, condoms, Ace wrap, urinary catheters, or diaphragms)?	YES	NO
Do rubber bands, rubber handles, or elastic bands on clothing cause any discomfort?	YES	NO

SIGNATURE:_____

PROVENA
Health

HEPATITIS B VACCINE DECLINATION STATEMENT

I understand that due to my occupational exposure to blood and other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. However, I decline 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 disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

I have been given and have read the CDC Hepatitis B vaccine sheet.

Printed Name: _____

Signature: _____

Date: _____

Witness's Signature: _____

☐ I have previously received the complete vaccine series but I am unable to supply proof. I exercise my right to decline to receive the vaccine at this time. (initials)_____

FPROVENA SAINT JOSEPH MEDICAL CENTER
JOLIET, ILLINOIS

MEDICAL HISTORY RECORD

NAME: _____ MAIDEN NAME: _____ SS# _____ DATE: _____
LAST FIRST INITIAL

ADDRESS: _____ PHONE:( ) _____
STREET & NO. CITY STATE ZIP

DEPARTMENT: _____ OCCUPATION: _____ AGE: _____ DOB: _____

SEX: _____ FAMILY PHYSICIAN: _____ ADDRESS: _____

CLOSEST RELATIVE OR FRIEND: _____ ADDRESS: _____

HAVE YOU HAD ANY OF THE FOLLOWING AND WHEN: CHICKEN POX _____ MUMPS _____ WHOOPING COUGH _____
RUBELLA (GERMAN OR THREE-DAY MEASLES) _____ RUBEOLA (REGULAR MEASLES) _____ HEPATITIS A _____
HEPATITIS B _____ RHEUMATIC FEVER _____ ARTHRITIS _____ PNEUMONIA _____ ASTHMA _____
SHORTNESS OF BREATH _____ DIZZINESS _____ FAINTING _____ CONVULSIONS _____
KIDNEY TROUBLE _____ STOMACH TROUBLE _____ JAUNDICE OR LIVER DISEASE _____ ALLERGIES _____

OPERATIONS: _____

AND WHEN: _____

WHAT OCCUPATIONAL EXPOSURES HAVE YOU HAD TO DUST OF FUMES OR LOUD NOISES: _____

DO YOU REQUIRE SPECIAL ACCOMMODATIONS DUE TO A PHYSICAL OR MENTAL CONDITION TO PERFORM YOUR JOB FUNCTIONS? YES____ NO____
EXPLAIN _____

NOTE: *WITHHOLDING OR GIVING FALSE INFORMATION TO THE ABOVE MAY RESULT IN DISMISSAL AFTER HIRING.*

I CERTIFY MY ANSWERS TO THE ABOVE QUESTIONS TO BE TRUE. I UNDERSTAND THAT ANY REPORTABLE DISEASE I MAY HAVE WILL BE REPORTED TO THE PROPER HEALTH AUTHORITIES AS REQUIRED BY LAW.

SIGNATURE: _____ WITNESS: _____

For Office Use Only:

Height:	Chronic Conditions:	DOH :
Weight:	Allergies:	B/P :
Back / Joint :	Medications :	Comments:

CONTRACT WORKERS CHECKLIST

Initials

- 1) Obtain Contact Information from LIP _____
  Name _____
  Address _____
  City, State, Zip _____
  _____
  Phone Number _____
  Agency Name _____

- 2) TB Testing according to CDC guidelines _____
  a) 2 step unless documentation of previous Tb within 12 months.
  b) Positive Reactors need a copy of CXR results.

- 3) Determine whether LIP has completed the Hepatitis B series. _____
  If not previously immunized educate regarding vaccine and obtain declination when necessary.

- 4) Determine if previous DRUG SCREEN AND TITRES have been completed. (**no drug screen for Vendors**) _____
  If so, advise to forward to EHS. If not, PCP needs To order the required blood word in order for the Insurance to pay. Give titre requirements to LIP.

- 5) Have employee fill out Immunization Program form. Medical History Record form, Titres and Immunizations with be billed to the employer, with no cost to the Contract Worker. _____

Please provide Roseann with charts for tracking. The nurse should initial each step as complete.

Provena Saint Joseph Medical Center

Particulate Respirator Medical Examination (Kimberly Clark PFR95 N95)

OSHA has mandated that employees be fit-tested for N95 masks annually and upon hire to protect the employee from the potential spread of airborne disease. Therefore it is necessary that this form be completed by the employee and forwarded to Employee Health Service for evaluation before the employee can be fit-tested for the N95 mask.

Can you read (circle one): Yes/No Today's Date:_____

Name:_____ Age:_____

Job Title:_____

Sex (circle one): Male/Female Your height: _____ ft. _____ in. Your weight: _____ lbs.

Work you will be expected to do while wearing the respirator: _____Direct Patient Care
Please check the appropriate area
_____ Environmental Service
_____ Lab/Xray
_____ Food and Nutrition
_____ Engineering
_____ Other Explain:_____

Have you worn a respirator before (circle one): Yes/No

A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): _____The best time to phone you at this number:_____

Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes/No

If you answer yes to any of the following questions, further evaluation by a physician may be required as determined by Employee Health Service.

Medical History

1. Do you **currently** smoke tobacco, or have you smoked tobacco in the last month: Yes/No

2. Have you **ever had** any of the following conditions?

   a. Seizures/Epilepsy (fits): 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'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. 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 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. 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. 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. 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 (fits): 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

Employee Signature:_____SSN:_____

Date:_____

FOR OFFICE USE ONLY

Recommendation: ____Approved
____Not Approved

Needs Further Medical Evaluation:_____

Evaluator:_____Date:_____

Comments:_____