OCCUPATIONAL HEALTH SERVICES (OHS)
PRE-PLACEMENT HEALTH ASSESSMENT FORM
PERSONNEL WITH *PERSISTENT PRESENCE IN HEALTH CARE FACILITIES

NYC HEALTH+ HOSPITALS

Instructions for Completing Form HH 2097A

This form is to be completed by candidates or eligible rehired personnel with *persistent presence in health care facilities.

1. **OHS Pre-Placement Health Assessment Form (HH 2097A)**
   a. Number of pages 5
      i. Page 1 – To be completed by Candidate or Eligible Rehired Personnel
         - Answer all sections. If not applicable, write N/A
         - Answer all YES/NO questions in Health Assessment Questionnaire
         - Sign the attestation at bottom of page 1
      ii. Pages 2 and 3 – To be completed by Candidate or Eligible Rehired Personnel
         - Fill in Name and Date of Birth (DOB) at top of page
         - Answer all YES/NO questions in Past Medical History, Baseline Individual TB Risk Assessment, Substance Use Attestation/Testing (as applicable), and Bloodborne Pathogens sections
         - Include all allergies to medications, food, latex and environmental agents
         - Sign both attestations on page 3
      iii. Page 4 – To be completed by By Medical Provider ONLY, using documents provided by the Candidate or Eligible Rehired Personnel
      iv. Page 5 – To be completed by Candidate or Eligible Rehired Personnel and OHS Facility Fit Testing Staff ONLY
         - Fill in Name and DOB at top of page
         - Complete Respirator Fit Test Medical Evaluation if your job requires you to use a Respirator Mask (N95)
         - Answer questions 1-3 and sign attestation
         - Sign appropriate attestation at the bottom of page 5 [**Note:** If fit tested, attestation to be signed on date fit test completed or performed]

***Persistent Presence:**
Refers to those personnel whose assigned workplace is in a health care setting. Also refers to personnel who have recurring interactions with patients and direct care providers who work at a health care facility, at least two times per month every month each year. Includes all personnel who are providing clinical care.

All other personnel lack persistent presence.

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Clear Form

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CANDIDATE OR ELIGIBLE REHIRED PERSONNEL INFORMATION

Last Name:	**Middle Name:**	**First Name:**
Other Name Used (Preferred Name):		
Empl ID: (required)	**Date of Birth**:	
Home Address:		
Home Phone:	**Work Phone:**	**Email Address: (Personal)**
Cell Phone:		**Email Address: (Work)**

JOB INFORMATION

My role requires me to visit a facility and have regular in-person interactions with patients and staff at least twice a month, every month throughout the year.	☐ **Yes** ☐ **No**

Employer (please check) ☐ NYC H+H ☐ Volunteer ☐ Affiliate _____ ☐ Other _____	**Work Site Location:** ☐ Central Office ☐ 100% Remote ☐ Acute Care Facility ☐ Post-Acute Care Facility ☐ Gotham Health ☐ Correctional Health Services
Position/Job Title:	**Supervisor's Name:** **Phone:**
Department:	**Unit / Clinic:**

EMERGENCY CONTACT

Last Name:	**First Name:**	**Relationship:**	**Telephone:**

HEALTH ASSESSMENT QUESTIONNAIRE

Do you have any of these conditions? Please Check YES or NO

Anemia/Blood Disorder	☐ Yes ☐ No
Asthma / Lung Disease	☐ Yes ☐ No
Cancer	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No
Immune Disease (Deficiency or Auto-Immune)	☐ Yes ☐ No
Kidney Disease/Urinary Problem	☐ Yes ☐ No
Seizures/Epilepsy/Stroke	☐ Yes ☐ No
Stomach/Intestinal/Liver Problem	☐ Yes ☐ No
Vision or Hearing Problems	☐ Yes ☐ No
Other Medical Conditions not listed above:	☐ Yes ☐ No
Do you have chronic pain or limited motion in your Joints, Muscles, Neck or Back? **If yes, please explain:**	☐ Yes ☐ No

I acknowledge that NYC Health + Hospitals ("System") can contact me by e-mail or phone about Occupational Health matters.

Candidate Signature: _____ **Date:** _____

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Last Name: _____ **First Name:** _____ **DOB:** _____

PAST MEDICAL HISTORY

Please Check YES or NO

Have you had any chronic illnesses, hospitalizations, or injuries in the past that may interfere with the performance of your job duties? **If yes, please explain:**	☐ Yes ☐ No
Have you had any surgeries / operations in the past that may interfere with the performance of your job duties? **If yes, please explain:**	☐ Yes ☐ No
Are you allergic to any medicines, foods, latex or environmental agents? **If yes, please explain:**	☐ Yes ☐ No
Are you currently under modification of your job duties or have a reasonable accommodation from Equal Employment Opportunity (EEO)? **If yes, please explain:** Start Date: End Date:	☐ Yes ☐ No
Are you in need of a modification of your job duties or otherwise in need of a reasonable accommodation? If yes, you must contact the Office of EEO.	☐ Yes ☐ No

Baseline Individual TB Risk Assessment (Please check YES or NO)

Do you have any symptoms suggestive of active tuberculosis? i.e., prolonged (>3 weeks) unexplained fever, prolonged cough, hemoptysis, unintended weight loss or drenching night sweats?	☐ Yes ☐ No
Have you resided in a tuberculosis endemic area for >1 month since the last screening? (i.e., any country other than Australia, Canada, New Zealand, the United States, or those in western or northern Europe)	☐ Yes ☐ No
Do you have an immunocompromising condition, or one that requires immunosuppression, including HIV infection, receipt of an organ transplant, treatment with a TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone ≥15 mg/day for ≥1 month), or other immunosuppressive medication?	☐ Yes ☐ No
Have you had close contact with someone who has active tuberculosis without the use of a fit-tested N95 respirator?	☐ Yes ☐ No
Have you been involved with the performance of any cough inducing or aerosol generating procedures (e.g., sputum induction or bronchoscopy*) without the use of a fit-tested N95 respirator? **NYC Health + Hospitals defines the list of aerosol-generating procedures in the "GUIDANCE: AEROSOLIZED GENERATING PROCEDURES", DOC ID: HHCMPA232020*	☐ Yes ☐ No

Substance Use Screening (as applicable)

Have you been concerned about, diagnosed, or treated for substance use in the past 3 months?	☐ Yes ☐ No

Bloodborne Pathogens (Please check YES or NO)

Have you ever been diagnosed with Hepatitis B or C or HIV? (Circle infection)	☐ Yes ☐ No ☐ Decline to Disclose
Have you taken medication to treat Hepatitis B or C or HIV? (Circle infection)	☐ Yes ☐ No ☐ Decline to Disclose
Have you received Hepatitis B vaccines?	☐ Yes ☐ No
Would you like to be tested for Hepatitis B or C or HIV (Non-mandatory/Voluntary)?	☐ Yes ☐ No

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HEPATITIS B VACCINE DECLINATION STATEMENT

If you have never received Hepatitis B vaccines or are found to be not immune to Hepatitis B, you are eligible to receive free vaccines in OHS.

Do you wish to receive free Hepatitis B vaccines? ☐ **Yes** ☐ **No**

If no, read and sign below.

HEPATITIS B VACCINE DECLINATION STATEMENT

I understand that due to my occupational exposure to blood or 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 myself.

Candidate Signature: _____ **Date:** _____

Clinician Witness: _____ **Date:** _____

HEALTH STATUS ATTESTATION

I attest that: I am free from a health impairment which might interfere with the performance of my job duties with or without a reasonable accommodation, including no evidence of substance use. I understand that OHS maintains my OHS record and shall provide all additional instructions regarding job related issues and follow-up, as required.

The above information is true and accurate as reflected in the Terms and Conditions of Employment.

Candidate Signature: _____ **Date:** _____

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FOR MEDICAL PROVIDER USE ONLY

Height:	Weight:	BMI:	BP:	Pulse:	Respirations:	Temp:

Physical Exam	Normal	Abnormal	Explain Abnormality
Skin	☐	☐	
HEENT	☐	☐	
Cardiac	☐	☐	
Lung	☐	☐	
Abdomen	☐	☐	
Musculoskeletal	☐	☐	
Neuro	☐	☐	
Extremities	☐	☐	

TB Testing - IGRA test done within 3 months of start date. Attach copy of original lab reports showing name of laboratory, laboratory director and chest x-ray report if TB test is positive.

TEST	DATE		
QuantiFERON	Enter Date	☐ Negative ☐ Positive ☐ Indeterminant	
T Spot	Enter Date	☐ Negative ☐ Positive ☐ Invalid ☐ Borderline	
If positive TB test, Chest X-ray required	Enter Date	Result:	LTBI Treatment completed: ☐ Yes ☐ No

TITERS / LABS (Attach copy of original Lab Reports showing name of Laboratory and Lab Director)

TEST	DATE	IMMUNE	SUSCEPTIBLE	INDETERMINANT
☐ Rubeola/Measles IgG	*Enter Date*	☐	☐	☐
☐ Mumps IgG	*Enter Date*	☐	☐	☐
☐ Rubella IgG	*Enter Date*	☐	☐	☐
☐ Varicella IgG	*Enter Date*	☐	☐	☐
☐ HBsAb	*Enter Date*	Result:		
☐ HBsAg (as clinically indicated)	*Enter Date*	Result:		
☐ anti-HBcAb (as clinically indicated)	*Enter Date*	Result:		
☐ HCV RNA PCR (as clinically indicated)	*Enter Date*	Result:		
☐ HIV Viral Load (as clinically indicated)	*Enter Date*	Result:		
☐ HBV Viral Load (as clinically indicated)	*Enter Date*	Result:		

VACCINES (Proof of Vaccination)

MMR (Two doses 4 weeks apart)	1st Dose Date:	2nd Dose Date:	
Varicella (Two doses 4 weeks apart)	1st Dose Date:	2nd Dose Date:	
☐ Hepatitis B Series: ☐ Heplisav-B (**Two doses**) ☐ Engerix B (**Three doses**)	1st Dose Date:	2nd Dose Date:	3rd Dose Date:
☐ TD ☐ Tdap (within last 10 years)	Enter Date		
☐ Meningococcal (**for Microbiology Lab Personnel only**)	Vaccine Product:	Date:	
	Vaccine Product:	Date:	
☐ Influenza (annually)	Date of most recent vaccine:		

OTHER TESTS (toxicology results ONLY accepted from these labs: Alere, CRL, LabCorp, MedTox or Quest)

Color Vision Screening (for Lab Personnel and as applicable)	☐ Normal	☐ Deficient	☐ Color blind		
Visual Acuity	☐ With corrective lenses	☐ Without corrective lenses	Rt _____/20	Lt _____/20	
***Urine Toxicology** (within 30 days)	☐ PASS	☐ FAIL (Must attach Lab Results)	Date:		
Fit Testing result (N95):	☐ PASS	☐ FAIL	☐ N/A (Please attach the documentation. See next page)		
PAPR/CAPR Training (as applicable):	☐ PASS	☐ FAIL	Date:	Trainer's Name: _____	

As applicable; **Note: All motor vehicle operators must undergo toxicology testing.*

MEDICAL CLEARANCE CERTIFICATION

PLAN: ☐ Drug Toxicology ☐ Mumps IgG ☐ Measles IgG ☐ Rubella IgG ☐ HBsAb
☐ Td/Tdap ☐ QFT ☐ CXR ☐ Flu Vaccine ☐ Other (Please specify): _____

Based on this evaluation, can this individual be granted medical clearance? ☐ Yes ☐ No ☐ Pending

Provider/ Designee Name: _____ **License Number:** _____

Signature: _____ **Date:** _____

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RESPIRATOR FIT TEST MEDICAL EVALUATION

1. Have you ever worn or been fit-tested for a respirator mask? **If yes,** please list the name and size of the mask: _____	☐ Yes	☐ No
2. Did you have any problem wearing the respirator mask? **If yes, please explain:** _____	☐ Yes	☐ No
3. Did you have any of the following:		
a. Emphysema, COPD or chronic lung disease?	☐ Yes	☐ No
b. Uncontrolled Asthma or unexplained difficulty breathing?	☐ Yes	☐ No
c. Have you been told by your doctor that you have an irregular heartbeat or rhythm?	☐ Yes	☐ No
d. Have you been told by your doctor that you have angina or other serious heart conditions?	☐ Yes	☐ No

I attest that the answers I have provided on this form are true to the best of my knowledge. I understand that if I knowingly provide false information, it may affect my health.

Candidate Signature: _____ **Date:** _____

PROVIDER ASSESSMENT:
☐ CAN be fit tested ☐ CANNOT be fit tested ☐ CAPR/PAPR trained
☐ Needs further evaluation
☐ Not applicable due to 100% REMOTE work status or FACILITY location

Provider/ Designee Name: _____ **Signature:** _____ **Date:** _____

FIT TESTING RESULTS: ☐ Qualitative Seal Check: FIT TEST: ☐ PASS ☐ FAIL
☐ Quantitative: FIT TEST: ☐ PASS ☐ FAIL

Mask Type: _____ **Size:** _____

Fit Tester Name: _____ **Fit Tester Signature:** _____ **Date:** _____

I attest that I was fit tested today for a respirator mask. I received training on how to put on the mask and proper use of the mask.

Candidate Signature: _____ **Date:** _____

I attest that I was NOT fit tested today for a respirator mask.

Candidate Signature: _____ **Date:** _____