Occupational Health Services
Phone: (984) 974-4480 Fax: (984) 974-7414
UNIVERSITY OF
NORTH CAROLINA HOSPITALS
GME Resident Form

Today's Date: _____
mm/dd/YY

☐ **New Incoming Residents**: Please sign the Form Using the Approved Electronic Signature (Printed Name, Initials and EID)
☐ **Visiting Residents**: Please hand-sign the form

Immunization Review Form

All Information Must be Completed. Please fill in all applicable sections <u>electronically</u>.

Name (Last, First, MI)	**EID#**	**Social Security Number**	
Date of Birth (Mo/Date/Year)	**Home Phone**	**Start Date-** not orientation date Select to Choose	
Age	**Gender** Male ☐ Female☐	**Weight** ☐ Kgs. ☐ Lbs.	**Height** ft. in.☐ m. cm.☐
<u>Local</u> Street Address (if known)	**City**	**State**	**Zip**
Job Title	**Department Name**		

(LEAVE BLANK - to be completed by UNCHCS GME office). Status AN to be sent to UEOHC
RESIDENT_____(status-circle one- AG,AM,AO)
SUB-SPECIALTY RESIDENT_____(status-circle one- AG,AM,AO)
VISITING RESIDENT DATES: From:_____To:_____

VISITING RESIDENT RETURNING DATES: From: _____To: _____
From: _____To: _____

Proof of immunizations is required
OR
Have your Health Care Provider sign and fill out page 3

Every effort should be made to obtain documented proof of immunizations. The following are some examples of where records may be obtained: Health Department, School records (college/high school/elementary), previous/current employer, pharmacy, primary physician/pediatrician office, or ask your parent/guardian as many of these vaccinations are given during childhood. You will need to call these agencies to request records; a release of medical records forms may be required.

If you are unable to obtain proof of immunizations or have any questions about the form, please reach out to Occupational Health Services using the information below:

Phone: 984-974-4480 Email: ohs@unchealth.unc.edu

Please note that completion of these items is required and a condition of employment. Return ALL completed pages and immunization records to Graduate Medical Education (GME) Office.

UNIVERSITY OF NORTH CAROLINA HEALTH CARE PRE-EMPLOYMENT VACCINE CHECKLIST

All University of North Carolina Health Care employees are required to have documented immunity to the following diseases:

- Influenza
- Measles, mumps, and rubella (MMR)
- Pertussis (whooping cough)
- Tuberculosis (TB) screening
- Varicella (chicken pox)
- Hepatitis B (recommended, not required)

Healthcare personnel (HCP) can prove immunity for each of these diseases in the following ways:

☐ **Complete**	**Influenza**
VACCINE	HCP must provide official documentation of vaccination for the current flu season (Sept-May).

☐ **Complete - One (1) of the options below:**	**Measles, Mumps, and Rubella**
1. AGE	HCP born before 1957 are assumed to be immune from these diseases and require no further proof of immunity.
2. VACCINE	HCP must provide official documentation of 2 MMR vaccines. ---OR--- HCP must provide documentation of individual vaccines totaling 2 Measles, 2 Mumps, and 2 Rubella vaccinations.
3. TITER	Official documentation of positive laboratory titers.

☐ **Complete**	**Pertussis**
VACCINE	HCP must provide vaccine record of one Tdap as an adult or child.

☐ **Complete**	**Tuberculosis**
TESTING	HCP must provide record of 2 tuberculin skin tests performed within a 12 month period (2 step skin testing). If that testing was performed greater than 12 months ago, an annual screening must be completed. An IGRA performed within the last 12 months will be accepted as documentation for TB testing. (If HCP have a history of positive TST or IGRA, official documentation of the most recent chest x-ray with official interpretation by a radiologist should be provided. Please also provide any documentation of latent tuberculosis treatment.)

☐ **Complete - One (1) of the options below:**	**Varicella (Chicken Pox)**
1. VACCINE	HCP must provide official documentation of 2 Varicella (chicken pox) vaccines or 1 Zostavax vaccine (shingles).
2. TITER	Official documentation of positive laboratory titer.

☐ **Complete - One (1) of the options below:**	***Hepatitis B**
1. VACCINE	HCP must provide official documentation of vaccination. HCP should have a total of 3 vaccines to complete one series of Hepatitis B vaccines.
2. TITER	A positive laboratory titer is accepted as proof of immunity.

*Hepatitis B vaccination is not required but highly recommended for those HCP who work in job classifications that have potential for blood or body fluid exposure. If you are unsure if your job falls into these categories, please contact Occupational Health or your manager for clarification.

UNIVERSITY OF NORTH CAROLINA HEALTH CARE VACCINATION VERIFICATION FORM

Legal Name: _____Date of Birth: _____Job Title: _____

THIS FORM MUST BE COMPLETED AND SIGNED BY YOUR PERSONAL PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT.

SIGNATURE REQUIRED.

TUBERCULOSIS SCREENING

		Step 1	*Step 2*	*Annual*
TB Skin Test (TST) - 2 step history (2 TB skin tests placed at least 1 week apart but within 1 year) with at least one test in the last 12 months.	Date Placed:			
	Date Read:			
	Induration (mm):			
	Result (Pos/Neg.):			
IGRA (T-Spot, Quantiferon Gold, etc.)	Date:			
	Result:			
Chest x-ray - in the last two years with documentation of official report.	Date:			

REQUIRED IMMUNIZATIONS

	Vaccinations		**Titer(s)**		
Tdap (One vaccine as an adult or child).	(#1)				
MMR Two MMR vaccinations at least 1 month apart given after age 1. ---OR--- Born prior to 1957 (exempt) ---OR--- Positive titers to Measles, Mumps, and Rubella ---OR--- Documentation of 2 Measles, 2 Mumps, and 1 Rubella vaccination.	(#1)	(#2)	Titer - Measles	Titer - Mumps	Titer - Rubella
Varicella (chicken pox) Series of two doses or immunity by positive blood titer.	(#1)	(#2)	Titer		
Flu Vaccine (annually)	(#1)				

RECOMMENDED IMMUNIZATIONS

	Vaccinations			**Titer**
	mo/day/year	mo/day/year	mo/day/year	Titer Date/Result
Hepatitis B Vaccine (Hepatitis B vaccine is a 3 vaccine series that is completed at intervals recommended by the CDC. If a negative HBsAB is found after a completed first series, a second series may be indicated. If a second negative HBsAB is resulted after a completed second series, diagnosis of non-responder.)	*1st Series*			
	(#1)	(#2)	(#3)	Titer
	2nd Series (if given)			
	(#1)	(#2)	(#3)	Titer

FORM MUST BE COMPLETED AND SIGNED BY YOUR PERSONAL PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT.

SIGNATURE REQUIRED.

_____ _____

Signature of Physician/Nurse Practitioner/Physician Assistant Date

_____ _____

Printed name of Physician/Nurse Practitioner/Physician Assistant Phone number

_____

Office Address City State Zip Code

Select to Choose

LATEX QUESTIONNAIRE
To be Completed by the Employee

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1. Have you ever been diagnosed with a latex allergy by a physician?

☐ Yes ☐ No

If yes, provide the date, location and physician's name _____.

2. After handling latex products, have you ever experienced: (check all that apply)

☐ difficulty breathing
☐ chapping or cracking of hands
☐ runny nose
☐ itching of hands, eyes, etc.
☐ rash
☐ hives
☐ swelling
☐ other _____

3. Have you ever had a reaction to the following? (check all that apply)

☐ balloons
☐ rubber gloves
☐ hot water bottles
☐ rubber bands, balls
☐ ACE bandages
☐ baby bottle nipples
☐ pacifiers, teething rings
☐ shoe wear
☐ belts, bras, suspenders
☐ dental coffer dams
☐ erasers
☐ face mask
☐ foam pillows
☐ rubber grips
☐ ostomy bags
☐ cuffs, elastic waistbands
☐ latex birth control devices
☐ other

4. Do you have a history of contact dermatitis when wearing gloves?

☐ Yes ☐ No

If yes, please describe the reaction _____

5. Have you ever had facial swelling, hives, or difficulty breathing while wearing latex gloves?

☐ Yes ☐ No

If yes, please describe the reaction _____

6. Have you ever had facial swelling, hives, or difficulty breathing after being examined by a physician or dentist who was wearing latex gloves?

☐ Yes ☐ No

If yes, please describe the reaction _____

7. Do you have any allergies to medications or foods?

☐ Yes ☐ No

If yes, please list _____

Select to Choose

RESPIRATOR MEDICAL EVALUATION FORM

All Information Must be Completed

Can you read and understand English? Yes ☐ No ☐

	YES	NO
This form must be completed by the employee/volunteer as well as signed and approved by a health care professional before an employee can be fit-tested to wear a respirator. Should you have any questions about this form or about your ability to safely wear a respirator, please call OHS at **984-974-4480.** **The following question about respirators or protective masks is taken from an OSHA document and is a mandatory question. You may not be familiar with the different kinds of protective masks but we do have to ask the question to remain in compliance with OSHA.** **Check the type of respirator** (protective mask) **you will use (you can check more than one category):** a. N, R, or P disposable respirator (filter-mask, non-cartridge type only): b. Other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus): c. I am not sure and will need to check with Occupational Health at New Employee Orientation (NEO).	☐ ☐ ☐	☐ ☐ ☐
Have you worn a respirator? If "yes", what type(s)?	☐	☐

Respirator Medical Evaluation Questionnaire

	YES	NO		YES	NO
1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?	☐	☐	**3. Have you ever had any of the following conditions?**		
2. Do you currently have any of the following symptoms of pulmonary or lung illness?			a. Seizures (fits)	☐	☐
a. Shortness of breath:	☐	☐	b. Diabetes (sugar disease)	☐	☐
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline:	☐	☐	c. Allergic reactions that interfere with your breathing	☐	☐
c. Shortness of breath when walking with other people at an ordinary pace on level ground:	☐	☐	d. Claustrophobia (fear of closed-in places)	☐	☐
d. Have to stop for breath when walking at your own pace on level ground:	☐	☐	e. Trouble smelling odors	☐	☐
e. Shortness of breath when washing or dressing yourself:	☐	☐	**4. Have you ever had any of the following pulmonary or lung problems?**		
f. Shortness of breath that interferes with your job:	☐	☐	a. Asbestosis:	☐	☐
g. Coughing that produces phlegm (thick sputum):	☐	☐	b. Asthma:	☐	☐
h. Coughing that wakes you early in the morning:	☐	☐	c. Chronic bronchitis:	☐	☐
i. Coughing that occurs mostly when you are lying down:	☐	☐	d. Emphysema:	☐	☐
j. Coughing up blood in the last month:	☐	☐	e. Pneumonia:	☐	☐
k. Wheezing:	☐	☐	f. Tuberculosis:	☐	☐
l. Wheezing that interferes with your job:	☐	☐	g. Silicosis:	☐	☐
m. Chest pain when you breathe deeply:	☐	☐	h. Pneumothorax (collapsed lung):	☐	☐
n. Any other symptoms that you think may be related to lung problems:	☐	☐	i. Lung cancer:	☐	☐
			j. Broken ribs:	☐	☐
			k. Any chest injuries or surgeries:	☐	☐
			l. Any other lung problem that you've been told about:	☐	☐

Select to Choose

	YES	NO		YES	NO
5. Do you currently take medication for any of the following problems? a. Breathing or lung problems: b. Heart trouble: c. Blood pressure: d. Seizures (fits):	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	**6. Have you ever had any of the following cardiovascular or heart problems?** a. Heart attack: b. Stroke: c. Angina: d. Heart failure: e. Swelling in your legs or feet (not caused by walking): f. Heart arrhythmia (heart beating irregularly): g. High blood pressure: h. Any other heart problem that you've been told about:	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐
7. Have you ever had any of the following cardiovascular or heart symptoms? a. Frequent pain or tightness in your chest: b. Pain or tightness in your chest during physical activity: c. Pain or tightness in your chest that interferes with your job: d. In the past two years, have you noticed your heart skipping or missing a beat: e. Heartburn or indigestion that is not related to eating: f. Any other symptoms that you think may be related to heart or circulation problems:	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐	**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 next question) a. Eye irritation: b. Skin allergies or rashes: c. Anxiety: d. General weakness or fatigue: e. Any other problem that interferes with your use of a respirator:	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
9. Would you like to talk to a health care professional who will review this questionnaire with you?					

	YES	NO		YES	NO
10. Have you ever lost vision in either eye (temporarily or permanently)?	☐	☐	**11. Do you currently have any of the following vision problems?** a. Wear contact lenses: b. Wear glasses: c. Color blind: d. Any other eye problems:	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
12. Have you ever had an injury to your ears, including a broken ear drum?	☐	☐	**13. Do you currently have any of the following hearing problems?** a. Difficulty hearing: b. Wear a hearing aid: c. Any other hearing or ear problems:	☐ ☐ ☐	☐ ☐ ☐
14. Have you ever had a back injury?	☐	☐			
15. Do you currently have any of the following musculoskeletal problems? a. Weakness in any of your arms, hands, legs or feet: b. Back pain: c. Difficulty fully moving your arms and legs: d. Pain or stiffness when you lean forward or backward at the waist: e. Difficulty fully moving your head up and down: f. Difficulty fully moving your head side to side: g. Difficulty bending at your knees: h. Difficulty squatting to the ground: i. Climbing a flight of stairs or ladder while carrying more than 25 pounds: j. Any other muscle or skeletal problem that interferes with using a respirator:				☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Employee Electronic Signature:
(visiting residents: please hand sign)

☐ Approved ☐ Approved with Restrictions ☐ Denied ☐ More info Needed (Specify)

MEDICAL DEPARTMENT USE	**Health Care Professional** ***Signature:***	**Date:**