



North Shore-Long Island Jewish Health System

Pre-Placement Health Assessment

The New York State Department of Health (DOH) and/or North Shore-LIJ Health System mandates that all persons seeking employment and/or an appointment to the Medical Staff of a hospital in the North Shore-Long Island Jewish Health System have a current physical and recorded medical history as well as documented immunity as outlined in our infection control policy.

To insure your safety and the safety of our patients, all of the following requirements must be completed prior to employment or providing services.

For your convenience, you can elect to have many of your exams and tests performed by either your personal physician or North Shore-LIJ Employee Health Services (EHS).

Requirements include:

1. **Physical examination** (within last 12 months)
2. **Tuberculosis Screening** - *this may be satisfied by either of the approved tests to detect M. tuberculosis infection:*
 - **Blood based Tuberculosis Screen Tests**, approved FDA test are:
 - QuantiFERON-TB Gold
 - QuantiFERON-TB Gold In-Tube
 - TSpot.TB
 - OR**
 - **Two-step Tuberculin Skin Testing (TST/PPD)**
 - Provide documentation to EHS of two negative TSTs performed within the past 12 months. The 2nd TST must be within the past 3 months.
 - OR**
 - **Positive TST History**
 - Documentation of positive TST result
 - A standard chest x-ray report done within the past 12 month
3. **Immunizations:** submit either copies of laboratory titers or proof of vaccination
 - Rubeola (Measles)
 - Mumps
 - Rubella
 - Tetanus/Diphtheria or Tetanus/Diphtheria/Pertussis
 - Hepatitis B surface antigen and surface antibody results
 - Varicella

Vaccination documentation should include the signature of the person who administered the vaccine as well as the product and date administered
4. **Urine Toxicology Screening**
5. **Color Vision Testing** (as clinically required)
6. **Respiratory Questionnaire and Fit Testing** (as clinically required)
7. **Latex Allergy and Sensitivity Screening**

**If you have arranged an appointment at EHS,
please complete these forms prior to your appointment and bring them with you.**

Pre-Placement Health Assessment

Part I: To be completed by Applicant.

Today's Date: ____/____/____
 Employee Id# (If applicable): _____

Last Name: _____ First Name: _____ M. I.: _____

Date of Birth: _____ Sex: Male Female Maiden Name: _____

Address: _____
Street City State Zip

Home Phone #: () _____ - _____ Cell Phone #: () _____ - _____ Email: _____ @ _____

Name of hospital(s) that you are applying to: _____

Position/Job Title: _____ Phone #: () _____ - _____

Department: _____ Division: _____

Emergency Notification: Name: _____

Address: _____

Phone #: () _____ - _____ Relationship: _____

Personal Physician: Name: _____ Phone #: () _____ - _____

HEALTH HISTORY:

ILLNESS – Check Yes or No. If Yes, please explain and indicate year of occurrence.
 Have you ever had or do you have now:

	YES	NO		YES	NO
Any Skin Conditions			Seizure Disorder		
Hearing Problems			Cardiac Disease		
Vision Problems(Glaucoma, cataracts, color blindness)			Night Sweats		
Difficulty Breathing or other pulmonary disease			Weight Loss (not intentional)		
Hernias			Cough		
Diabetes			Cancer		
Rheumatoid Arthritis			Kidney Disease		
Immunosuppressive Disease			Other		

If you checked yes to anything listed above, please explain: _____

Chronic or recurring pain or limited motion associated with: (describe)

	YES	NO		YES	NO
Neck			Hand		
Arm			Wrist		
Back			Hip		
Knee			Other		

Please list all surgeries: _____

Do you take any medications? Yes No If YES, please list here: _____

ALLERGIES AND EXPOSURES – Check Yes or No.

Have you ever had a reaction, allergy and/or sensitivity to any medications, food, LATEX, plants or chemicals?

If Yes, please specify substance and reaction. Yes No _____

COMMUNICABLE DISEASES

Tuberculosis: Have you ever had a positive Tuberculin Skin Test? Yes No

If YES, When? _____ please complete the following:

- Size of induration (submit documentation if possible) : _____
- Country of Birth: _____
- BCG in the past: Yes No
- INH Therapy offered in the past: Yes No
- INH Therapy completed (year of completion): _____
- Year of Immigration to U.S. (Date of US Entry): _____
- INH Therapy refused (Risk and benefits discussed) Yes No

For persons who have had a previous **Positive** reaction to Tuberculin Skin Testing check all that apply:

During the previous year, have you suffered from any of the following:

- Unexplained persistent cough Yes No
- Coughing up blood Yes No
- Unexplained significant weight loss Yes No
- Unexplained persistent fevers and/or night sweats Yes No

Date of last Chest X-Ray: _____ (Attach Results, must be in the past 12 months)

Practitioner Notes (if applicable): _____

Part II:

To be completed by examining practitioner:

Date of Examination: _____
 Age: _____ Height: _____ Weight: _____ Pulse: _____ Blood Pressure: _____

Normal Abnormal Please Specify:

HEENT			
NECK			
CHEST			
HEART			
ABD			
EXT			
NEURO			
LYMPH			

ISHIHARA'S COLOR BLIND TEST RESULTS: (Plates 1-11) Test performed by (please initial): EHS staff _____ or Private Doctor _____
 Number of plates correct: _____ **Color vision Normal (10 or more plates correct)**
 Color vision Deficient (7 or less plates correct)

To be Read and Signed by Examining Practitioner:

I have personally examined the above named employee/practitioner and find him/her free from any physical/emotional impairment which is a potential risk to patients or which might interfere with the performance of employment and/or service duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other substances.

Examining Practitioner's Signature: _____

Print Name: _____ Date: ____/____/____

License #: _____

Address: _____

Tel #: _____

Name:

D.O.B: / /

Pre-Placement Health Assessment

To be Read and Signed by Applicant:

I consent to a Pre-Placement medical examination, collection of blood and/or urine, and administration of vaccination, as required by North Shore-LIJ Health System. The purpose of the examination is to insure that I am free from health impairment which might be of potential risk to patients and/or personnel or which might interfere with the performance of my duties at the institution. I understand that this is a limited examination solely for the purpose of determining fitness for employment and/or service. This exam is not intended to be a comprehensive medical examination.

I certify that I do not use illegal drugs, nor do I misuse/abuse controlled or other substances which may alter or impair my behavior and/or ability to function. I further understand that this medical examination will include a drug screen and that I will not be employed or be allowed to provide services if this screen reveals the presence of any of the above.

I furthermore authorize the Employee Health Services, its practitioner's and my private medical physician (if applicable) to release any and all information obtained in the pre-service medical examination to authorized representatives of this hospital for the purpose of determining my fitness for duty and/or services. I understand that giving false or misleading information or failure to disclose requested medical information will be grounds for denying my application or for dismissal. I certify that I have disclosed all known current health conditions which might pose a risk to others or which might interfere with the performance of my duties. I understand and the Hospital has agreed that it will not use or disclose any information obtained in my pre-service medical examination except for the purposes set forth above or as required by law.

Signature

Print Name

Date: ____ / ____ / ____

EHS Reviewer Name *Please Print*

Title

Signature

____ / ____ / ____
Date

Cleared

Referred To: _____

Comments:

