FOR CLINIC USE ONLY

Pre-Employment **Screening**

Cottage Urgent Care location: _____

Patient Name: _____

Staff Member uploading results: _____

Date: _____

Please make sure the following forms are completed and signed where indicated:

- ☐ Pre-Employment Physical Examination - *Clinical Concierge to add* Pre-Employment
- ☐ Exam Appointment Details
- ☐ Pre-Employment Registration Form - *Patient signature required*
- ☐ Health Questionnaire
- ☐ Respiratory Protection Program Health Questionnaire and Fit Test Completed
- ☐ Tuberculosis (TB) Questionnaire ☐ Employee Health & Safety to Order Chest X-Ray
- ☐ Labs Collected
  - ☐ New Hire Titers sent to lab ☐ Unsuccessful collection, EH&S notified by phone
  - ☐ TB IGRA (QFT-GOLD) sent to lab
- ☐ Drug Screen – Custody Control Form - *Patient signature required*
- ☐ Influenza Compliance - *Patient signature required* (Not required May-August)

PROVIDER CLEARANCE

I hereby certify that I have personally reviewed all forms and documentation included in this pre-employment health packet, including the results of the employee's physical examination and related medical history. Based on my review and evaluation, I have determined that the employee is:

- ☐ Cleared for work with no restriction
- ☐ Cleared for work with the following restrictions: _____

_____

_____

- ☐ Not cleared due to the following reasons: _____

_____

_____

Provider Signature: _____

Date: _____

Pre-Employment **Packet**

Please complete the forms in this packet prior to your pre-employment exam. Take time to research your immunization history and past medical history so you can provide correct information. There are four pages that require your signature — look for the blue signature boxes on pages 2, 10, and 11.

Your pre-employment exam is scheduled for:

Date: _____ Time:_____

Report to: _____

Address: _____

If you have any questions about the exam, please call Cottage Urgent Care at:_____

Please bring the following to your scheduled appointment:

- Completed forms
- Picture ID (driver's license, passport, employee badge)
- Corrective lenses (if applicable)

REMINDERS:

- Please make appropriate childcare arrangements for children who cannot be left by themselves in the waiting room.
- Please arrive with a full bladder, as you will be required to provide a urine sample.

Cottage Urgent Care

Patient Name:

Pre-Employment Patient **Registration**

PATIENT INFORMATION

Patient Legal Name: _____

Patient Preferred Name: _____

Gender Identity: ☐ Male ☐ Female ☐ Non-Binary ☐ Prefer not to answer ☐ Other (please specify) _____

Address: _____

City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Sex: _____ Marital Status: _____

Height: _____ Weight: _____

Date of Birth: _____ Age: _____

Employer: _____ Occupation: _____

PATIENT EMERGENCY INFORMATION

Emergency Contact: _____

Relationship to Patient: _____

Address: _____

City/State/Zip: _____

Home Phone: _____ Other Phone: _____

By signing below, I authorize Cottage Urgent Care to disclose my protected health information (PHI) to my employer or prospective employer, or to any other entity designated for the sole purpose of evaluating my suitability for initial or continued employment; or other activity required by my employer, or law imposed upon my employer.

Name of current or prospective employer is: _____

PHI may include results of tests, examinations and medical history obtained in the course of an evaluation such as drug and alcohol screens, physical examinations, mental or physical fitness for duty examinations or other tests required by the above named employer during the course of my employment.

✳ Patient Signature: _____ Date: _____

Patient Name:

Health **Questionnaire**

The purpose of this questionnaire is to gather information concerning your health and physical condition, both now and in the past. This information will be used only to determine whether you can safely and adequately perform the duties of the job which you have been offered. Please read carefully and answer all the questions.

EMPLOYMENT / EXPOSURE HISTORY

List your last six jobs, job title, type of work and any health hazards.

1. Employer: _____

From (mm/yyyy): _____ To: _____

Job Title: _____

Description of Work: _____

List Hazards: _____

Any Health Effects? ☐ Yes ☐ No

2. Employer: _____

From (mm/yyyy): _____ To: _____

Job Title: _____

Description of Work: _____

List Hazards: _____

Any Health Effects? ☐ Yes ☐ No

3. Employer: _____

From (mm/yyyy): _____ To: _____

Job Title: _____

Description of Work: _____

List Hazards: _____

Any Health Effects? ☐ Yes ☐ No

4. Employer: _____

From (mm/yyyy): _____ To: _____

Job Title: _____

Description of Work: _____

List Hazards: _____

Any Health Effects? ☐ Yes ☐ No

5. Employer: _____

From (mm/yyyy): _____ To: _____

Job Title: _____

Description of Work: _____

List Hazards: _____

Any Health Effects? ☐ Yes ☐ No

6. Employer: _____

From (mm/yyyy): _____ To: _____

Job Title: _____

Description of Work: _____

List Hazards: _____

Any Health Effects? ☐ Yes ☐ No

WORK / SERVICE HISTORY

Have you ever been injured in a vehicle accident?

☐ Yes ☐ No

Are you able to perform the essential functions of your job?

☐ Yes ☐ No

Did you ever receive, or do you have pending, a compensation award or pension for a work-related injury or illness?

☐ Yes ☐ No

Have you ever received a veteran's pension for a service connected disability?

☐ Yes ☐ No

Have you ever been rejected for life insurance or by the Armed Forces for medical reasons?

☐ Yes ☐ No

Explain all "yes" answers to the above questions.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Name:

CURRENT MEDICAL HISTORY

Are you now under a doctor's care? ☐ Yes ☐ No

If yes, give details:

HOSPITALIZATIONS AND SURGERIES

List date, reason for hospitalization or surgery, and hospital name:

MEDICATIONS

List all medications you are currently taking, both prescription and over-the-counter medications:

Have you ever had, or been treated for any of the following?

Mark yes or no. If yes, give the date of occurrence. Explain all yes answers in the space at the end of this list.

MUSCULOSKELETAL

Arthritis	☐ No	☐ Yes, Date:
Swollen or painful joints	☐ No	☐ Yes, Date:
Bursitis or tendonitis	☐ No	☐ Yes, Date:
Back pain	☐ No	☐ Yes, Date:
Repetitive motion syndrome	☐ No	☐ Yes, Date:
Carpal tunnel syndrome	☐ No	☐ Yes, Date:
Low back pain or problem	☐ No	☐ Yes, Date:
Neck or upper back problem	☐ No	☐ Yes, Date:
Shoulder pain or problem	☐ No	☐ Yes, Date:
Wrist/hand/elbow pain or problem	☐ No	☐ Yes, Date:
Knee pain or problem	☐ No	☐ Yes, Date:
Foot/ankle pain or problem	☐ No	☐ Yes, Date:
Chiropractic treatments	☐ No	☐ Yes, Date:
Persistent or severe muscle aches or pains	☐ No	☐ Yes, Date:
Disc injury	☐ No	☐ Yes, Date:
Broken bones	☐ No	☐ Yes, Date:
Other muscle-skeletel conditions	☐ No	☐ Yes, Date:
Whiplash	☐ No	☐ Yes, Date:

ENDOCRINE/METABOLIC

Diabetes	☐ No	☐ Yes, Date:
Thyroid problems	☐ No	☐ Yes, Date:
Hypoglycemia	☐ No	☐ Yes, Date:
Unexplained weight gain or loss	☐ No	☐ Yes, Date:
Gout	☐ No	☐ Yes, Date:
Osteoporosis or bone disease	☐ No	☐ Yes, Date:

BLOOD/LYMPH SYSTEMS

Anemia	☐ No	☐ Yes, Date:
Fatigue or lack of energy	☐ No	☐ Yes, Date:
Bleeding disorder	☐ No	☐ Yes, Date:
Phlebitis or clots	☐ No	☐ Yes, Date:
Blood transfusions	☐ No	☐ Yes, Date:
Chills, fevers, night sweats	☐ No	☐ Yes, Date:
Swelling of lymph glands	☐ No	☐ Yes, Date:

SKIN

Dermatitis or eczema	☐ No	☐ Yes, Date:
Hives	☐ No	☐ Yes, Date:
Moles that bleed or get larger	☐ No	☐ Yes, Date:
Frequent boils or abscesses	☐ No	☐ Yes, Date:
Acne	☐ No	☐ Yes, Date:
Trouble with fingernails/toenails	☐ No	☐ Yes, Date:
Skin cancer	☐ No	☐ Yes, Date:
Other skin problems	☐ No	☐ Yes, Date:
Psoriasis	☐ No	☐ Yes, Date:
Any other skin conditions	☐ No	☐ Yes, Date:

HEART AND LUNGS

Asthma	☐ No	☐ Yes, Date:
Bronchitis	☐ No	☐ Yes, Date:
Chronic cough	☐ No	☐ Yes, Date:
Shortness of breath	☐ No	☐ Yes, Date:
Metal fume fever	☐ No	☐ Yes, Date:

Patient Name:

Heart trouble	☐ No	☐ Yes, Date:
Lung disease	☐ No	☐ Yes, Date:
Pneumonia	☐ No	☐ Yes, Date:
Coronary disease	☐ No	☐ Yes, Date:
Hypertension	☐ No	☐ Yes, Date:

NEUROLOGICAL SYSTEM

Head injury	☐ No	☐ Yes, Date:
Concussion	☐ No	☐ Yes, Date:
Dizziness	☐ No	☐ Yes, Date:
Ear trouble	☐ No	☐ Yes, Date:
Fainting spells	☐ No	☐ Yes, Date:
Seizures or epilepsy	☐ No	☐ Yes, Date:
Glaucoma	☐ No	☐ Yes, Date:
Migraine	☐ No	☐ Yes, Date:
Mental illness	☐ No	☐ Yes, Date:
Depression	☐ No	☐ Yes, Date:
Poliomyelitis	☐ No	☐ Yes, Date:
Stroke	☐ No	☐ Yes, Date:
Tingling in arms or legs	☐ No	☐ Yes, Date:
Fibromyalgia	☐ No	☐ Yes, Date:
Chronic Fatigue Syndrome	☐ No	☐ Yes, Date:

ALLERGIES

Food *(specify which food(s) at right)*	☐ No	☐ Yes, Date:
Soaps or detergents	☐ No	☐ Yes, Date:
Metal *(nickel, chromium, other)*	☐ No	☐ Yes, Date:
Hay fever	☐ No	☐ Yes, Date:
Epoxy resins	☐ No	☐ Yes, Date:
Poison oak or other plants	☐ No	☐ Yes, Date:
Rubber or latex	☐ No	☐ Yes, Date:
Medications *(list at right)*	☐ No	☐ Yes, Date:

List any other allergies in space at right

INTESTINAL AND URINARY SYSTEMS

Hepatitis	☐ No	☐ Yes, Date:
Ulcer	☐ No	☐ Yes, Date:
Hernia	☐ No	☐ Yes, Date:
Pancreatitis	☐ No	☐ Yes, Date:
Digestive problems	☐ No	☐ Yes, Date:
Reflux disease	☐ No	☐ Yes, Date:
Jaundice	☐ No	☐ Yes, Date:
Gallbladder problems	☐ No	☐ Yes, Date:
Kidney or bladder infections	☐ No	☐ Yes, Date:
Kidney stones	☐ No	☐ Yes, Date:
Prostate problems	☐ No	☐ Yes, Date:
Any other urinary or intestinal problems *(describe below)*	☐ No	☐ Yes, Date:

INFECTIOUS DISEASES

Tuberculosis	☐ No	☐ Yes, Date:
Rheumatic fever	☐ No	☐ Yes, Date:
Malaria or tropical diseases	☐ No	☐ Yes, Date:

SOCIAL HISTORY

Have you ever used tobacco products? ☐ No ☐ Yes

List type and quantity per day or week:

If you quit, when? *(month/year)*

Do you drink alcohol? ☐ No ☐ Yes

List what you drink and quantity:

Please explain "yes" answers here:

Please describe food or medication allergies here:

Patient Name:

Respiratory Protection Program **Health Questionnaire**

The following information is required in order to maintain accurate records of your participation in the Respirator Protection program. All health-related information will be kept in the Employee Health Record and is confidential. Your supervisor will be notified if you are cleared or not cleared for respirator use. Otherwise, your information may only be released with your signed written consent. Please print all information requested.

Have you ever worn a respirator? ☐ Yes ☐ No

If yes, which type(s)? (Check all that apply)

☐ N95 Mask ☐ Half Face w/cartridge ☐ Full Face w/cartridge

☐ Self-Contained Breathing Apparatus (air supplied)

Do you currently smoke tobacco, or have you smoked tobacco in the last month? ☐ Yes ☐ No

If yes, when:

How much do you or did you smoke?

For how long:

Do you use any other tobacco products? Please describe:

Have you ever had any of the following conditions?

Seizures (fits)	☐ Yes ☐ No
Diabetes (sugar disease)	☐ Yes ☐ No
Allergic reactions that interfere with your breathing	☐ Yes ☐ No
Claustrophobia (fear of closed-in places)	☐ Yes ☐ No
Trouble smelling odors	☐ Yes ☐ No

Have you ever had any of the following pulmonary or lung problems?

Asbestosis, silicosis, or tuberculosis	☐ Yes ☐ No
Asthma, chronic bronchitis, or emphysema	☐ Yes ☐ No
Pneumothorax, broken ribs, or any chest injuries or surgeries	☐ Yes ☐ No
Lung cancer or any other lung problems that you've been told about	☐ Yes ☐ No
Pneumonia	☐ Yes ☐ No

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

Shortness of breath at rest or walking fast on level ground or walking up a slight hill	☐ Yes ☐ No
Shortness of breath when walking at an ordinary pace on level ground	☐ Yes ☐ No
Shortness of breath when washing or dressing yourself	☐ Yes ☐ No
Shortness of breath that interferes with your job	☐ Yes ☐ No
Have to stop for breath when walking at your own pace on level ground	☐ Yes ☐ No
Coughing that produces phlegm (thick sputum) or that wakes you early in the morning	☐ Yes ☐ No
Coughing that occurs mostly when you are lying down	☐ Yes ☐ No
Coughing up blood in the last month	☐ Yes ☐ No
Wheezing at rest or that interferes with your job	☐ Yes ☐ No
Chest pain when you breathe deeply	☐ Yes ☐ No
Any other symptoms that you think may be related to lung problems	☐ Yes ☐ No

Have you ever had any of the following cardiovascular or heart problems?

Heart attack, angina, heart failure, or heart arrhythmia (heart beating irregularly)	☐ Yes ☐ No
Stroke or high blood pressure	☐ Yes ☐ No
Swelling in your legs or feet (not caused by walking)	☐ Yes ☐ No
Any other heart problem that you've been told about	☐ Yes ☐ No

Patient Name:

Have you ever had any of the following cardiovascular or heart symptoms?

Frequent pain or tightness in your chest at rest or during physical activity	☐ Yes ☐ No
Pain or tightness in your chest that interferes with your job	☐ Yes ☐ No
In the past two years, have you noticed your heart skipping or missing a beat	☐ Yes ☐ No
Heartburn or indigestion that is not related to eating	☐ Yes ☐ No
Any other symptoms that you think may be related to heart or circulation problems	☐ Yes ☐ No

Do you currently take medication for any of the following problems?

Breathing or lung problems, heart trouble	☐ Yes ☐ No
Blood pressure	☐ Yes ☐ No
Seizures	☐ Yes ☐ No

If you've used a respirator, have you ever had any of the following problems?

Eye irritation, skin allergies or rashes	☐ Yes ☐ No
General weakness, fatigue, or anxiety	☐ Yes ☐ No
Any other problem that interferes with your use of a respirator	☐ Yes ☐ No

Please explain or comment on any YES answers and whether it impacts your ability to use a respirator:

Every employee who has been selected to use any type of respirator must answer these questions.

At work or at home or when working on hobbies, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or has your skin come into contact with hazardous chemicals?

☐ Yes ☐ No

Have you ever worked with any of the materials, under any condition, listed below? (check all that apply):

- ☐ Asbestos
- ☐ Beryllium
- ☐ Coal (e.g., mining)
- ☐ Tin
- ☐ Silica (e.g., in sandblasting)
- ☐ Aluminum
- ☐ Iron
- ☐ Dusty environments
- ☐ Tungsten/Cobalt (e.g., grinding/welding this material)
- ☐ Any other hazardous exposures

If yes to any above, please describe exposure:

Do you have any second jobs or side businesses? ☐ Yes ☐ No

If yes, please list:

Have you had any previous occupations? ☐ Yes ☐ No

If yes, please list:

Have you ever been in the military service? ☐ Yes ☐ No

If yes, were you exposed to biological or chemical agents (either in training or combat)? ☐ Yes ☐ No

Have you ever worked on a HAZMAT team? ☐ Yes ☐ No

Will you be wearing protective clothing and/or equipment when you are using your respirator? ☐ Yes ☐ No

If yes, describe this protective clothing and/or equipment (i.e. apron, splash shield, mask, whole body disposable clothing, head protection):

Will you be working under hot conditions (temperatures exceeding 77° F)? ☐ Yes ☐ No

Patient Name:

Tuberculosis (TB) **Questionnaire**

In the last 12 months, have you experienced any of the following symptoms for more than three weeks at a time?

Persistent coughing	☐ Yes	☐ No
Night sweats	☐ Yes	☐ No
Unexplained weight loss	☐ Yes	☐ No
Coughing up blood	☐ Yes	☐ No
Excessive fatigue	☐ Yes	☐ No
Loss of appetite	☐ Yes	☐ No
Persistent fever	☐ Yes	☐ No

Have you ever been told by your healthcare provider that your immune system is suppressed or compromised due to a medical condition and/or medications that you are taking?

☐ Yes ☐ No

Have you received any of the following vaccines in the past 4 weeks*:

☐ MMR (Measles, Mumps, Rubella)

☐ Yellow Fever

☐ Varicella (Chickenpox)

**If Yes: TB screening will be deferred for at least one month after the administration of a live-virus vaccine. Screening will be completed by EH&S after the appropriate waiting period.*

Did you receive childhood immunizations in a foreign country (outside of the U.S.)?

☐ Yes ☐ No

Have you ever received the Bacille Calmette Guerin (BCG) vaccine?

☐ Yes ☐ No

Do you have a written copy of a positive blood test for TB? (e.g. Quantiferon or T-SPOT)*

☐ Yes ☐ No

**If Yes: No additional TB blood testing is required if proof is provided. The patient must have a chest x-ray completed by EH&S to meet screening requirements.*

Have you ever had a POSITIVE TB skin test in the past?

☐ Yes ☐ No

If yes, when? _____

_____

_____

Have you ever had a screening chest X-ray for TB?

☐ Yes ☐ No

If yes, when was the last X-ray performed and what were the results? _____

_____

_____

Are you currently pregnant?

☐ Yes ☐ No

If yes, what is your due date? _____

_____

In the last 12 months, have you been in close contact with any individuals who are suspected or positive for TB?

☐ Yes ☐ No

Have you ever been diagnosed with TB?

☐ Yes ☐ No

If yes, when? Did you receive treatment? _____

_____

_____

_____

Have you traveled outside of the U.S. in the past two years?

☐ Yes ☐ No

If yes, when and where did you travel? _____

_____

_____

_____

Patient Name:

Drug Screening Acknowledgement

I understand that Cottage Health is a drug-free workplace and that a drug test is a condition of employment.

I acknowledge a pre-employment drug screen is required for all positions and that applicants who test positive for a controlled substance, including marijuana, are not eligible for employment.

Cottage Urgent Care is a collection site only.

I will direct any questions regarding my results to Cottage Employee Health & Safety by calling 805-569-8270.

* Patient Signature: _____ Date: _____

FOR CLINIC USE ONLY

☐ Specimen Collected, Resulted via eCup

☐ Specimen Collected, Requires Send Out to Lab. Tracking Number: _____

☐ Unable to Collect Specimen (e.g. shy bladder, patient left clinic, etc.)

Test Request Form- PDL

Submitter: Cottage Employee Health
Provider: David Quincy, MD

Patient details

Name: (Last, First) _____ Date of Birth: _____ Employee # _____ DEPT: _____ **Collection Date:** **Collection Time:** **Collected by:**	☒**Employee** ☐**Med Staff** ☐**Volunteer** ☐**Other** **PDL TO ADD DETAILS ABOVE IN COTTAGEONE COMMENTS** ☒ **New Hire- Baseline** ☐ **Annual** ☐ **Exposure- Baseline** ☐ **Exposure- Follow Up** ☐Z20.1 Contact with and (suspected) exposure to Tuberculosis ☐Z11.1 Encounter for screening for respiratory tuberculosis (symptoms)

Sample details:

Requested Test(s)

Draw 1st	**Draw 2nd**
☐ New Hire Titers [Lab10961] ☒ Z11.59 Encounter for screening for other viral diseases **DRAW 2 GOLD TOP 5mL TUBES** **Collect 3mL/2 mL min (each)** **Allow specimen to clot for at least 30 minutes before centrifugation. Centrifuge within 2 hours of collection.**	☐ QuantiFERON- TB Gold Plus [LAB9907] ☒ Z11.7 Encounter for testing for latent tuberculosis infection (no symptoms) **DRAW 1 LITHIUM HEPARIN 10mL TUBE** **Collect 6mL/5mL min** **DO NOT SPIN** **SAMPLE MUST BE SENT REFRIGERATED**

IMPORTANT:
Label specimen with employee first and last name, date of birth, date and time of collection.
Gently invert specimen 10 times.
You must submit this form with the specimen.