UCLA Health

Occupational Health Services
10833 Le Conte Avenue
CHS Bldg. Suite 67-120
Los Angeles CA 90095
Tel: (310) 825-6771
Fax: (310) 206-4585

PRE-EMPLOYMENT PHYSICAL
OCCUPATIONAL HEALTH QUESTIONNAIRE

Print Forms and Complete All Questions

Last Name: _____ **First Name:** _____ **MI:** ___

Date of Birth: _____ **SSN (last 4 only):** _____ ☐ Male ☐ Female ☐ Other

Address: _____
Street City State Zip

Email Address: _____ **Phone Number:** _____

I have reviewed the description of the job for which I am applying.

_____ _____
X Signature **Date**

Do you have any condition, illness, injury, or are you taking any medication that affects any of the following job related abilities for your position as identified in your job description?
(*Please answer ONLY the specific questions below that relate to the essential functions of the job for which you are applying, as outlined in your job description.)*

VISION
Do you have any impairment of vision which is not correctable?

☐ Yes ☐ No Please explain _____

HEARING
Do you have any impairment of hearing which is not correctable?

☐ Yes ☐ No Please explain _____

SPEECH
Do you have any impairment which interferes with your ability to communicate with others?

☐ Yes ☐ No Please explain _____

MOVEMENT & STRENGTH
Do you have any impairment of the following body parts:

SHOULDER OR ELBOW
☐ Yes ☐ No Please explain _____

HAND OR WRIST
☐ Yes ☐ No Please explain _____

FOOT OR LEG
☐ Yes ☐ No Please explain _____

NECK
☐ Yes ☐ No Please explain _____

BACK
☐ Yes ☐ No Please explain _____

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(Continued)

BREATHING

Do you have any problems with your breathing?

☐ Yes ☐ No Please explain _____

CARDIAC

Do you have any condition or medication which would limit you?

☐ Yes ☐ No Please explain _____

BALANCE AND/OR CONSCIOUSNESS

Do you have any condition or medication that can affect your balance and/or consciousness?

☐ Yes ☐ No Please explain _____

PSYCHOLOGICAL AND/OR EMOTIONAL DISORDERS

☐ Yes ☐ No Please explain _____

ALLERGIES (example Latex, Peanuts, Penicillin, etc.)

☐ Yes ☐ No Please list _____

_____

ANY OTHER CONDITION(S) that would limit your ability to do any of the essential job functions as described in the job description?

☐ Yes ☐ No If yes, please explain _____

_____

_____

I attest that the above is try to the best of my knowledge.

X Signature **Date**

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PRE-PLACEMENT
TUBERCULOSIS SCREENING

Occupational Health Only
TB Screen Result

☐ **CLEARED**
☐ **NOT CLEARED**

X _____
Reviewer Signature

_____
Reviewer Name

_____

Name: _____

Date of Birth: _____ **Cell Phone Number:** _____

Email Address: _____

Hiring Dept: _____ **Staff ID (if any):** _____

PLEASE ANSWER ALL QUESTIONS

1) **I have a history of a positive TB Skin Test, T-SPOT, or QuantiFERON Blood Test:**

☐ **Yes** ☐ **No**

2) **I have taken INH or other medication in the past for TB infection or disease:**

☐ **Yes** (complete information below) ☐ **No**

Dates: _____ **Number of Months:** _____ **Medication:** _____

3) **I was born, have resided in, or travelled in a foreign country for at least 1 month:**

☐ **Yes** (list countries) ☐ **No**

Countries: _____

4) **Do you have:**

Recent contact with a person with active tuberculosis?	☐ Yes	☐ No
Any condition that decreases your immune system?	☐ Yes	☐ No
An organ transplant?	☐ Yes	☐ No

5) **Have you had any of the following active TB symptoms for more than 3 weeks:**

Coughing up blood	☐ Yes	☐ No
Persistent coughing	☐ Yes	☐ No
Excessive fatigue	☐ Yes	☐ No
Excessive sweating at night	☐ Yes	☐ No
Persistent fever	☐ Yes	☐ No
Hoarseness	☐ Yes	☐ No
Unexplained weight loss	☐ Yes	☐ No

_____ _____
X Signature **Date**

Occupational Health Only

QuantiFERON Blood Draw: **Date:** _____ **Result:** ☐ **Negative** ☐ **Positive** ☐ **Indeterminate**

Chest X-Ray: **Date:** _____ **Date Read:** _____ **Result:** _____

Action: _____

Reviewed By: _____ **Date:** _____

Appendix A

CONSENT TO SUBSTANCE ABUSE SCREENING

I. I, _____, consent to submit a specimen of urine or breath (alcohol suspicion based only) under the direction of medical personnel of UCLA Health. I understand that this specimen or sample will be used for the purpose of conducting a chemical analysis to determine if I have engaged in use of alcohol or illegal drugs. I further give my permission to UCLA Health to release my screening results to any authorized Medical Review Officer and to medical personnel in the UCLA Occupational Health Facility, but to no other person without my further written consent. I understand that this examination is being conducted pursuant to UCLA Policy. I will cooperate fully with UCLA Health and its designated testing personnel in the administering of the drug and alcohol screening.

II. I have ☐ I have not ☐ taken ANY medication and/or drugs of any kind in the past thirst (30) days including: (check appropriate box)

☐ Over-the-counter medications ☐ Prescription or other drugs

III. Drugs that I have taken within the past thirty (30) days include (continue on separate sheet if necessary):

Brand Name of Drug	Dosage/Strength Per Day	Date and Time of Dosage	How Many Days Was it Used

Comments/Explanations _____

I certify that that any urine and/or breath specimen or sample given by me belongs to me and is given solely for the purposes of substance abuse screening. I further certify that the above information is correct to the best of my knowledge. I understand that UCLA Health may require me to produce documentation to verify the above information and that my refusal to do so may result in disciplinary action up to and including dismissal from employment.

In consideration of my continued employment, I hereby release and agree to hold UCLA Health and its representatives harmless against any and all claims, charges or causes of action whatsoever I now have or may have in the future, which may arise from this test. I understand that UCLA Health or any other laboratory selected by UCLA has the exclusive control over the method of conducting this test.

I CERTIFY THAT I HAVE READ AND AGREE TO THE ABOVE PROVISIONS.

_____ _____
Employee Signature Date

_____ _____
Witness Signature Date

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OCCUPATIONAL HEALTH SERVICES

New Hire Immunization/Titer Requirements

UCLA Health screens all new hires for Tuberculosis, Measles, Mumps, Rubella, Varicella and Hepatitis B immunity, as recommended by the Center for Disease Control and Prevention.

Please bring a printed copy of your immunization records with documentation of the following to your health screening appointment. If you are unable to provide documentation of these requirements, we will provide titers during your visit, a follow-up appointment may be required if any vaccines or chest x-ray are needed for clearance.

Measles, Mumps and Rubella Immunity

- Medical documentation of 2 MMR vaccinations at least 28 days apart
- Laboratory blood titers indicating immunity to Measles, Mumps and Rubella
- Documented evidence of all three diseases

Varicella Immunity

- Medical documentation of 2 Varicella vaccinations at least 28 days apart
- Laboratory blood titers indicating immunity to Varicella
- Documented evidence of disease

Tuberculosis Screening

All employees will receive a QuantiFERON-TB Test or provide documentation of a negative QFT within a 3-month window

If history of a positive TB screening test, please provide the following:

- Documented proof of a positive QuantiFERON Gold blood test
- Documentation of a chest radiograph medical report (for new employees dated within 3 months of credentialing)
- TB screening is an annual requirement

Hepatitis B Screening

- Proof of 3 Hepatitis B vaccinations
- Proof of positive Hepatitis B surface Antibody blood titer demonstrating immunity

Note that only completion of the 3 shot vaccine series plus a protective hepatitis surface antibody titer collected not earlier than 1-2 months after the 3 shot series is completed is considered evidence of protection against hepatitis B, so for the protection of healthcare personnel both are recommended.

Tetanus, Diphtheria, Pertussis Vaccine (Tdap)

- Proof of Tdap vaccine. Healthcare personnel should have documentation of current Tdap on file.

Flu Vaccination

- Please provide documentation of seasonal flu vaccine. Flu vaccination will be available during pre-employment screening generally late Sept - April. UCLA requires employees working in a clinical area to wear a mask if declining immunization, in patient rooms or patient areas within 6 feet of patients during the flu season: Nov.1 – March 31.

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Hepatitis B Vaccine

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.

(Please check appropriate box)

☐ **I would like to receive the hepatitis B vaccine.**

Hepatitis B Vaccine Declination (mandatory)

☐ I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to me; 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.

I decline the hepatitis B vaccine series due to the following reason(s):

(Please mark at least one choice)

☐ I have previously completed a hepatitis B 3-vaccine series with written documentation and choose not to repeat the vaccine series at this time.

☐ I have previously completed a hepatitis B 3-vaccine series, but I do not have written documentation and choose not to repeat the vaccine series at this time.

☐ I have been diagnosed with hepatitis B in the past.

☐ Other: _____

Signature **Date** **Date of Birth**

Print Name **Job Title/Department**

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Tdap Vaccine

I understand that due to my occupational exposure aerosol transmissible diseases, I may be at risk of acquiring infection with Pertussis.

(Please check appropriate box)

☐ **I would like to receive the Tdap vaccine.**

Tdap Vaccine Declination (mandatory)

☐ I have been given the opportunity to be vaccinated against this disease or pathogen at no charge to me; however, I **decline** the Tdap vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Pertussis, a serious disease.

I decline the Pertussis vaccine due to the following reason(s):

(Please mark at least one choice)

☐ I am declining because I choose not to have the Tdap vaccination.

☐ I have already received a Tdap vaccination. I have a record or know the date and location of that vaccination.

☐ I have already received a Tdap vaccination. I do not have a record or cannot recall when I received the vaccination.

☐ Other: _____

Signature **Date**

Date of Birth

Print Name

Job Title/Department

UCLA ID number