Penn Medicine
Lancaster General Health

Penn Medicine Lancaster General Health Infection Control Policy requires all staff to be immune to certain communicable diseases. **Please provide vaccination history and/or serological (lab) testing results for the following at the time of your Pre-Employment Assessment Appointment with Occupational Medicine:**

Measles (Rubeola)
German Measles (Rubella)
Mumps
Chicken Pox (Varicella)
Hepatitis B
Full COVID-19 vaccination
Flu vaccination

**All candidates will also have a Quantiferon Gold test drawn*

It is your responsibility to obtain records prior to presenting for your appointment. If records are not provided, serum blood testing will be ordered to establish immunity.

If you were a previous employee of Penn Medicine Lancaster General Health:
Prior to your pre-employment assessment appointment, please contact Employee Health at 717-544-5984 to request a copy of your previous vaccination history.

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CONSENT FOR DRUG TESTING

I, _____, acknowledge that I have been conditionally offered employment at Lancaster General Health pending successful completion of a medical examination and drug screening. In order to enable Lancaster General Health to fulfill its obligations to provide a safe environment for patients and employees and to ascertain my ability to perform the essential functions of my employment, I consent to the performance of a medical evaluation and diagnostic procedures, including but not limited to the collection of blood and/or urine samples to test for the presence of illicit substances. I furthermore authorize the release of any and all medical information obtained during the examination and testing procedure to Employee Health, LG Health's Occupational Medicine Department, and any other physician or medical personnel who may need to evaluate my suitability for employment. I further authorize the release of the results to LG Health, including Human Resources. If, after evaluation by Occupational Medicine or Employee Health, further evaluation is deemed necessary, I furthermore consent to the release of any and all medical information which is relevant to my ability to perform the essential functions of my employment and any reasonable accommodations necessary to persons at LG Health who have a need to know such information, including Human Resources.

I understand that during my employment LG Health may request additional medical evaluations which are job-related and consistent with business necessity and that situations may further arise where I am asked to undergo drug and alcohol testing consistent with the policy of LG Health. I understand that my refusal to cooperate fully in such medical examinations and testing procedures constitutes insubordination and may be grounds for disciplinary action, including termination. I understand that I may be ineligible for employment or subject to termination if the results of such testing are positive for drugs and/or alcohol. I release Lancaster General Health and its employees, agents, and physicians from any claims, liability or damages arising out of its performance of a medical evaluation and/or diagnostic procedures.

_____ _____

Signature Date

Penn Medicine
Lancaster General Health

Pre-employment Health Questionnaire

GINA Safe Harbor Notification:

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

CONFIDENTIAL

Name: _____Date of Birth: _____
(First, Middle Initial, Last)

Address: _____
(Street) (City) (State) (Zip)

Phone Number: _____Social Security Number: _____ Sex: _____

Entity (Check One):

☐ LGH ☐ LGMG ☐ Horizon HealthCare ☐ Affilia ☐ PA College (Clinical)

Department: _____ Job Title: _____

Orientation Date: _____

Have you ever worked at Lancaster General Health before? Yes____ No____

WORK HISTORY—EMPLOYMENT

Previous Employer:_____Dates of Employment_____
Describe Job Duties_____
Previous Employer:_____Dates of Employment_____
Describe Job Duties_____

☐ YES ☐ NO According to the job description provided for the position you have been offered, are you able to perform the essential functions of the job with or without reasonable accommodation? Please indicate any restrictions or functions of your job you are unable to perform.

_____
_____
_____

☐ Restrictions are temporary ☐Restrictions are permanent ☐N/A

If a reasonable accommodation is necessary, please identify the proposed accommodation(s). Note: A reasonable accommodation must enable you to perform the essential functions of the job.

_____
_____
_____

□ YES □ NO Do you have a physical or mental impairment that substantially limits you in any major life activity, e.g., performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, or working?

If your answer is yes, please identify the precise nature of the substantial limitation and the activity (ies) in which you are substantially limited.

_____
_____
_____

□ YES □ NO Have you received treatment for any medical condition or injury in the **last 12 months** or are you currently under the care of a healthcare provider (physician, chiropractor, pain management, etc)?
If yes, which condition(s):_____
_____
_____

□ YES □ NO Have you ever filed a workers' compensation claim because of a job related injury?
If yes, date of injury:_____Employer_____

SOCIAL HISTORY

□ YES □ NO Do you exercise regularly (i.e.: running, jogging, swimming, walking aerobics, etc)?
If you play sports, please list: _____

□ YES □ NO Have you ever used tobacco or nicotine products?

□ YES □ NO Are you currently using tobacco?
If yes, how many packs/pouches per day:_____Number of years:_____

□ YES □ NO Do you drink alcohol?
If yes, how many drinks at a time**?** _____How many days per week? _____

□ YES □ NO Are you currently, or have you ever, been treated for substance abuse?
If yes, please describe:_____

□ YES □ NO Do you currently have an emotional/psychological disorder? _____
_____

□ YES □ NO Are you currently receiving treatment for any of the above?
If yes, please describe: _____

ALLERGIES

List any allergies you may have and the reactions you have to them:
□ **Check here if no known allergies to medications.**

Allergies		Reactions
_____	_____	_____
_____		_____

List all current prescription medications (Prescription, over-the-counter, herbal)

Medications	Dosage	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DO YOU HAVE or EVER HAD the following:

ALLERGIES	**YES**	**NO**	***IF YES, GIVE DETAILS***
Reaction to any substance which resulted in hives, swelling, itching, trouble swallowing or breathing			
Reaction to rubber products (balloons, condoms, diaphragms, dental procedures)			
Reaction to latex gloves			
Reaction to vinyl gloves			
Foods			
Skin rash or history of eczema			

GENERAL	**YES**	**NO**	***IF YES, GIVE DETAILS***
Diabetes			
Stroke			
Cancer			
HIV			
Liver disease, jaundice			
Serious accident			
Eye problems – decreasing vision, eye pain, double vision, loss of vision, eye infection, photophobia, eye injury or disease			
Hearing problems – decreased hearing, pain in ears, ringing or throbbing ears?			
A hernia or rupture?			
Convulsions or seizure and/or taken medication for seizures?			
Brain trauma/concussion, head injury of any type?			

HEART	**YES**	**NO**	***IF YES, GIVE DETAILS***
Heart Disease or heart attack			
High blood pressure			
Treatment for heart condition			
Rheumatic fever or heart murmur			
Passed out or nearly passed out			
Discomfort, pain or pressure in your chest/neck or arm			
Does your heart race or skip beats?			
High cholesterol			
Heart infection			
Has your doctor ever ordered a test for your heart? (e.g., EKG, echo cardiogram, stress test, heart catheterization)			
Phlebitis, varicose veins or blood clots/poor circulation?			
Have you ever refused medical care for heart related issues?			

DO YOU HAVE or EVER HAD the following:

LUNGS	**YES**	**NO**	***IF YES, GIVE DETAILS***
Asthma or wheezing?			
Positive skin test for TB?			
Treatment for + TB test? -If YES, bring documentation			
Have you been exposed to someone who has TB?			
Had a Chest X-Ray?			
Have you ever refused medical treatment for any lung-related disorder? (asthma, bronchitis, pneumonia)			
Productive cough, bloody sputum, excessive sweating at night, chills, fever?			

MUSCLE-SKELETAL	**YES**	**NO**	***IF YES, GIVE DETAILS***
Arthritis, rheumatism, neck, back, spine injury or disease?			
Fibromyalgia, rheumatoid arthritis, systematic lupus, nerve disorder or neurological problems?			
Herniated disc?			
Treated for any back problems?			
Recurrent stiffness or back pain?			
Bursitis, tendonitis?			
Recurrent pulled muscles or sprains?			
Hand or wrist injury or problems?			
Any discomfort, pain or numbness in hands?			
Hip or knee injury or problems?			
Ankle or foot injury or problems?			
Shoulder injury or problems?			
Job requiring heavy lifting or standing/sitting for long periods of time?			
Any broken bones? -If YES, please list……..			

SURGERIES/OPERATIONS	**YES**	**NO**	***IF YES, GIVE DETAILS***
On your back, neck, arm, leg, knee?			
To treat a hernia?			
Varicose veins?			
Other operations?			
Have you ever been hospitalized?			

DO YOU HAVE or EVER HAD the following:

BLOOD, OTHER	**YES**	**NO**	***IF YES, GIVE DETAILS***
Hepatitis A,B, C, Other			
Blood transfusion, needle stick or splash of blood or body fluid? -If YES, when…….			
Bleeding disorder or anemia?			
Difficulty urinating, blood in urine, burning, irritation?			
Anorexia, loss of appetite, difficulty swallowing, chronic indigestion, nausea, vomiting, abdominal pain, chronic diarrhea, chronic constipation, bloody or black bowel movements?			

I have answered the questions to the best of my knowledge. I understand that this questionnaire is to assist the Occupational Medicine staff in determining my medical suitability to safely perform the functions of this position for which I have applied at LGH.

I believe I can perform those functions in a safe manner. YES NO

If no, please explain:_____

I understand that deliberate falsification of information on this form, or the omission of information requested on this form, may be reason for disciplinary actions up to and including termination.

_____ _____

Applicant Signature Today's Date

~For Occupational Medicine Department Use Only~

Additional Provider Notes:

_____

_____

_____

_____

_____

_____

_____

_____

_____

~For Occupational Medicine Department Use Only~

Occupational Medicine Determination

Identification: YES NO

Vitals: Blood Pressure _____ Pulse _____ Height _____ Weight _____

Vision: ☐ Corrected ☐ Uncorrected
FAR Right _____ **NEAR** Right _____ **COLOR** ☐ Normal ____/15
Left _____ Left _____ ☐ Abnormal

AMSLER (Only if working in Operating Room) ☐ Normal ☐ Abnormal

Flu Shot Given: YES NO N/A(outside of flu season only) If no, reason: _____

Drug Screen: NEG POS PENDING → UPDATED RESULT: NEG POS

	Dates of Immunization	**Record Not Available** (check box if applies)	**Ordered** (check box if ordered)
Hepatitis B			
Varicella			
Rubella			
Rubeola			
Mumps			
Hepatitis C			
Quantiferon Gold			

Recommendations:

☐ **Able to work without restrictions/accommodations**

☐ **Able to work with restrictions/accommodations**
Restriction/Accommodation:_____

☐ **Medical hold pending further evaluation:** _____

☐ **Unable to safely perform the essential functions of this job**

_____ _____
Occupational Medicine Representative Signature **Date**