PLEASE COMPLETE HIGHLIGHTED SECTIONS ONLY

New Hire Pre-Placement Consent and Screening Verification

Last Name:	First Name:
Facility:	Orientation Date:

Welcome to the WellStar Employee Health Pre-Placement Assessment. Your health assessment today will take approximately 2 to 2.5 hours to complete. You will be seen by an Employee Health Nurse who will review your baseline health assessment and give you further instructions on how to complete the Employee Health requirements.

I give my permission to WellStar Employee Health to perform my Pre-Placement Health Assessment as a part of my requirements for employment at WellStar Health Systems. I understand that my job office is contingent upon the completion of all Employee Health requirements and medical clearance by Employee Health.

Signature: _____ *Date:* _____

	Staff Initials
☐ Triage 1. Respiratory Questionnaire/ Height, Weight, B/P/Assessment	
☐ Fit Testing	
☐ Lab: A. Titers B. T Spot	
☐ Human Resources	

EMPLOYEE HEALTH USE ONLY

Comments

_____

_____

_____

Wellstar HEALTH SYSTEM

Baseline Health History

Name:		Employee ID#:
Facility Name:	Department:	Date:

HAVE YOU HAD ANY OF THE FOLLOWING:	Yes	No	IF YES PLEASE EXPLAIN
Previous positive TB skin test			
Cough for more than 2 weeks			
Unexplained weight loss			
Unexplained fever			
Loss of appetite			
History of BCG vaccine			
History of taking medication for TB			
Previous exposure to active TB			
Family member with TB			
Illness within the last two weeks			
HEALTH HISTORY	**Yes**	**No**	**IF YES PLEASE EXPLAIN**
Are you under the care of a physician for High Blood Pressure?			
Do you currently have or have a history of Hepatitis A, B, or C?			
Do you have any diseases of the immune system?			
Do you currently take any medication that might affect your immune system?			
Do you have a history of or currently have any injuries or disorders of the muscles, nerves, tendons, joints,			
Are you able to perform the essential functions of your job without modifications or accommodations? If No, please explain.			
Have you traveled outside of the US in the last 6 months? If Yes, where?			
PREVIOUS WORK HISTORY	**Yes**	**No**	**IF YES PLEASE EXPLAIN**
Required to wear personal protective equipment, such as: gloves, goggles, face shields, safety glasses, mask, respirator or air-supplied respirator (Indicate type used).			
Have you been fit tested to wear a N95 mask?			
If yes, did you have difficulty wearing the mask? Explain			
WELLNESS AND PREVENTION	**Yes**	**No**	
Do you currently use tobacco products?			
Are you interested in participating in the Smoking Cessation Program that WellStar provides?			
Are you interested in participating in the Wellness Program?			

CURRENT MEDICATION LIST (PRESCRIPTIONS, OVER-THE-COUNTER, VITAMINS, HERBS)			
Name:	Dosage:	Name:	Dosage:
Name:	Dosage:	Name:	Dosage:
Name:	Dosage:	Name:	Dosage:

ALLERGIES (INCLUDE MEDICATIONS, ENVIRONMENTAL, FOOD ALLERGIES)
Do you have a latex allergy or sensitivity? YES _____, NO_____ (If yes, complete Latex Questionnaire)

LIST PREVIOUS SURGERIES OR HOSPITALIZATIONS			
	Date:		Date:
	Date:		Date:

To the best of my knowledge, the information provided by me on this form, and during the physical assessment is correct. I understand that intentional falsification may be considered cause for suspension or dismissal.

Employee Signature _____ ***Date:*** _____

Wellstar HEALTH SYSTEM

NOTES:

Signature of reviewing Clinician:

Pre-Placement Nurse's Job Aid

Date _____ Name _____ Emp. # _____

Address _____ DOB _____

Street Address, City, State, Zip

Soc Sec# _____ Phone _____ Facility _____

----------EMPLOYEE HEALTH TO COMPLETE BELOW THIS LINE----------

NH Requirements	Date Provided/ Completed	In Agility	Ordered	Results	Notes
MMR # 1					
MMR # 2					
Mumps Titer					
Rubella Titer					
Rubeola Titer					
Varicella # 1					
Varicella # 2					
Varicella Titer					
Hepatitis B # 1					
Hepatitis B # 2					
Hepatitis B # 3					
Hepatitis BSab Quant					
Td/Tdap Vaccine					
Influenza Vaccine					
TST	1- 2-				
IGRA Tspot/QuantiFERON					
Chest X-ray					
Color Vision					
Musculoskeletal					
Latex Questionnaire					
Medical Hold					
Chain of Custody	Date	ID #			

Clinician's Signature: _____

Reporting Communicable Disease

To: WellStar Health System Employees
From: Infection Control and Employee Health
RE: Reporting Communicable Disease

It is required by law that all Georgia Physician, Laboratories, and other Health Care Providers report any Communicable Disease to their County Health Department of District Health Office.

WellStar Communicable Disease Policy requires that all communicable disease be reported to Employee Health at the time you are exposed and/or become symptomatic. If work restrictions are indicated, employees are required to be cleared by Employee Health before returning to work.

Examples to Reportable Communicable Disease are as follows:

- Hepatitis A, B or C
- Chickenpox
- Measles, Mumps or Rubella
- Influenza
- SARS
- Neisseria Meningitis
- Scabies/Lice
- Conjunctivitis
- Active TB
- Bordetella Pertussis

Please refer to the Infection Prevention web page located on eSource, Sections: Communicable Diseases.
You may also contact WellStar Employee Health Office @770-793-7222 for any questions.

Thank you,

Employee Health Services
Infection Prevention Department