Wellstar Employee Health New Hire Packet

Employee Health Nurse's Job Aid

First Name: _____ Last Name: _____ Maiden Name: _____

Phone #: _____ Date of Birth: _____ Employee ID: _____Social Security #: _____

Address: _____ City: _____ State: _____

Wellstar Work Location: _____

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

Requirements	Date Completed	In Agility	Ordered	Results	Notes
Covid Vaccine #1					MFR: Clinic Site:
Covid Vaccine #2					MFR: Clinic Site:
Covid Booster/Bivalent					MFR: Clinic Site:
Covid Booster/Bivalent					MFR: Clinic Site:
Hepatitis B #1					
Hepatitis B #2					
Hepatitis B #3					
Hepatitis B Surf Ab Quant					
Influenza Vaccine					
MMR #1					
MMR #2					
Mumps Titer					
Rubella Titer					
Rubeola Titer					
Td/Tdap Vaccine					
Varicella #1					
Varicella #2					
Varicella Titer					
T-Spot/QuantiFERON					
TST #1					
TST #2					
Chest X-Ray/Health Dept					
Respiratory Fit Test				Size:	HT: WT: BP: / P:
Respiratory Questionnaire					
Vision Color					
Latex Questionnaire					
Medical Hold					

Clinician's Signature: _____ Start Date: _____

New Hire Pre-Placement Consent and Screening Verification

First & Last Name:	
Employee ID #:	Orientation Date:
Hospital/Facility:	Department/Role:

Welcome to the Wellstar Employee Health Pre-Placement Assessment. Your health assessment today will take approximately 2 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 System. I understand that my job office is contingent upon the completion of all Employee Health requirements and medical clearance by Employee Health.

Employee Signature: _____ Date: _____

EMPLOYEE HEALTH USE ONLY

Comments

	Staff Initials
▪ Height, Weight, B/P ▪ Nursing Assessment ▪ Respiratory Questionnaire	
▪ Fit Testing	
▪ Lab: A. Titers B. T-Spot/QuantiFERON	

Baseline Health History

Name:	**Employee ID#:**	
HAVE YOU HAD ANY OF THE FOLLOWING:	**Yes/No**	**IF YES, PLEASE EXPLAIN**
Previous positive TB skin test or blood 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**
Do you need any modifications or accommodations to perform the essential functions of your job?		
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, cartilage, or spine?		
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)

Do you take any medications? ☐ Yes ☐ No --- If yes, please list any medications, dose, and frequency: _____

_____

_____

ALLERGIES (INCLUDE MEDICATIONS, ENVIRONMENTAL, FOOD ALLERGIES)

Do you have a **latex** allergy or sensitivity? ☐ Yes ☐ No --- If yes, please complete the latex questionnaire

Do you have any allergies? ☐ Yes ☐ No --- If yes, please list: _____

_____

SURGERIES OR HOSPITALIZATIONS

Have you had any surgeries or hospitalizations? ☐ Yes ☐ No --- If yes, please list any surgeries or hospitalizations: _____

_____

_____

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:** _____

Clinician Signature: _____ **Date:** _____

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 (IP-05-01) 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 Human Resources Benefits before returning to work if you have taken an approved Leave of Absence.

Examples to Reportable Communicable Disease are as follows:

- Hepatitis A, B, or C
- Chickenpox
- Measles, Mumps or Rubella
- Influenza
- SARS/COVID-19
- Neisseria Meningitis
- Scabies/Lice
- Conjunctivitis
- Active TB
- Bordetella Pertussis

Please refer to PolicyTech on eSource for Infection Prevention information.
You may also contact your hospital's employee health office for any questions.

Thank you,

Employee Health Services
Infection Prevention Department

Employee Signature: _____ **Date:** _____

TB Follow-up Requirements*

Your baseline health screening today will include a TB blood test. Per Wellstar policy, if the results of your TB blood test are positive, you will be required to have a chest X-ray.

- If your chest X-ray shows no abnormalities and you have no symptoms of TB, you will be cleared by Employee Health.
- If your chest X-ray indicates that there are abnormalities, you will be placed on medical hold and may not attend New Employee Orientation or if you are already working you will be removed from the schedule until medical clearance is obtained.
- Any new hire with a positive TB blood test will be required to be seen and cleared by your local health department or a physician designated by Employee Health unless documentation of prior treatment for TB is provided.
- This referral visit must be completed within the first **15 days** of your employment.
- Employees who do not meet the above requirements will be restricted from work until requirements are completed.

There will be no cost for the chest X-ray completed at Wellstar.

Any charges for a health department visit will be paid by the employee.

The above has been explained to me by Employee Health and I have been given an opportunity to ask questions.

Employee Signature: _____ **Date:** _____

Clinician: _____ Date: _____

Wellstar Employee Health Requirements for Newly Hired Employees*

No follow up until your employment begins with Wellstar

___ Health screening to be completed annually **(Mandatory)**

___ Provide record or receive Influenza Vaccination. **Must submit flu vaccine documentation to ServiceNow portal or have approved exemption (via ServiceNow) prior to start date for current season (September 1st – March 31st)**

___ Provide record of vaccination/serology (titer) or receive Hepatitis B Vaccine series

___ Varicella Vaccine (Chicken Pox)

___ MMR Vaccine (Measles, Mumps, Rubella)

___ Provide record or receive Tetanus, diphtheria (Td) or Tetanus, diphtheria, Pertussis Vaccine (Tdap) **(recommended)**

___ Respirator Fit Testing annually, if required for your job role

___ USP-800 Handling Hazardous Drugs Annual Evaluation

___ Other: _____

Please report to the Employee Health clinic indicated below. It is your responsibility to contact the Employee Health (EH) office to schedule appointments, for hours of operation, and clinic schedule. All locations are by appointment only.

Location Name	Address	Phone/Fax Number	Email Address
☐ Cobb	1791 Mulkey Road Lower Level Austell, GA 30106	Office: 470-732-2248 Fax: 470-732-7212	CobbEmployeeHealth@wellstar.org
☐ Douglas	8954 Hospital Drive Douglasville, GA 30134	Office: 470-644-6864 Fax: 678-715-1031	DouglasEmployeeHealth@wellstar.org
☐ Kennestone	310 Kennestone Hospital Blvd 2nd Floor Marietta, GA 30060	Office: 470-793-7222 Fax: 470-793-7952	KennestoneEmployeeHealth@wellstar.org
☐ North Fulton	2500 Hospital Blvd, Suite 160 Roswell, GA 30076	Office: 770-751-2856 Fax: 770-751-2659	NorthFulton.EmployeeHealth@wellstar.org
☐ Paulding	2518 Jimmy Lee Smith Pkwy Hiram, GA 30141	Office: 470-644-8025 Fax: 470-644-7363	PauldingEmployeeHealth@wellstar.org
☐ Roosevelt Warm Springs	6135 Roosevelt Highway Warm Springs, GA 31830	Office: 706-655-5255	WarmSpringsEmployeeHealth@wellstar.org
☐ Spalding	618 S. 8th Street Griffin, GA 30224	Office: 470-935-4467 Fax: 470-935-4468	SpaldingEmployeeHealth@wellstar.org
☐ West Georgia	1514 Vernon Road LaGrange, GA 30240	Office: 706-803-5143 Fax: 706-803-8707	WGMCEmployeeHealth@wellstar.org
☐ Windy Hill	2540 Windy Hill Road Marietta, GA 30067	Office: 470-644-1162 Fax: 470-644-1166	WindyHillEmployeeHealth@wellstar.org
☐ Wellstar MCG	1481 Laney Walker Blvd, POB Suite AD 1300 Augusta, GA 30912	Office: 706-721-3418 Fax: 706-721-0882	WMCG_EmployeeHealth@wellstar.org

I understand it is my responsibility to complete any of the above requirements within 15 days of my start date. A copy of this form is notification by Employee Health of requirements needed. If required documents are faxed or emailed, I will confirm documents have been received by contacting the office to verify records have been received.

EMPLOYEE SIGNATURE: _____ **DATE:** _____

CLINICIAN: _____ DATE: _____

*Copy of page provided to new hire

Employee Emergency Contact Sheet

COMPLETE ENTIRE SHEET

Name: _____

DOB: _____

Primary Phone Number: _____

Primary Emergency Contact

Emergency Contact Name: _____

Relationship: _____

Emergency Contact #: _____

Secondary Emergency Contact

Emergency Contact Name: _____

Relationship: _____

Emergency Contact #: _____

EMPLOYEE HEALTH

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

NAME: _____

EMPLOYEE ID #: _____ **LAST FOUR DIGITS OF SSN:** _____

TELEPHONE NUMBER: _____ **DATE OF BIRTH:** _____

EMAIL ADDRESS: _____

Please check items to be released to Wellstar Employee Health:

☐ ALL RECORDS (TB Testing, Vaccinations, Vaccination Titers, Exposure Lab Tests, Chest X-Ray, & Georgia Immunization Registry (GRITS) records)

☐ Specific Records: _____

☐ Other Records Not Listed: _____

Acknowledgement to Release of Protected Health Information

I,_____ , hereby release Wellstar Employee Health from any liabilities, damages and claims arising from the release of protected health information authorized above. I give my permission for my protected health information to be released to Wellstar Employee Health, but I do not give permission for any other use or re-disclosure of this information. Unless I request in writing otherwise, this authorization will not expire.

_____

Full Name of Employee

_____

Signature of Employee

_____

Date