REQUIREMENTS FOR CLEARANCE:

- Physical exam within 3 months of hire.
- 2 TB skin test (PPD)
  - 1st within one year
  - 2nd within three months of hire date
- If you have a prior history of positive PPD, complete the Positive PPD Assessment questionnaire.
- Copy of most recent chest x-ray report if +PPD
- 2 MMR vaccines or titers
- 2 Varicella vaccines or titer
- 3 Hepatitis B vaccines or titer
- Tetanus booster (Td/Tdap)
- Influenza vaccine (September-March)
- Enlarged copy of Identification card
Name________________________________________________ □ Male □ Female Date of Birth_____________________

Address_________________________________________________________ City________________________

State______ Zip code_______ Phone________________________ Social Security #________________________

Email___________________________________________________________ Start Date________________________

Department_________________________ Position________________________ Supervisor________________________

MEDICAL HISTORY

Do you have any allergies to food, medications, or other substances? □ No □ Yes □ If yes, please list:
________________________________________________________________________________________________

Do you take any medications on a daily basis? □ No □ Yes □ If yes, please list:
________________________________________________________________________________________________

Do you have any medical conditions? □ No □ Yes □ If yes, please list:
________________________________________________________________________________________________

Have you had any operations? □ No □ Yes □ If yes, please list:
________________________________________________________________________________________________

Have you had any work-related injuries or blood/body fluid exposures? □ No □ Yes □ If yes, please list:
________________________________________________________________________________________________

HEALTH BEHAVIORS

For Women                       For Men                       For Both
Do you practice monthly breast exams? □ Yes □ No
Date of last pap smear: __________
Date of last mammogram: ___________
Date of last colon test: __________

Do you practice monthly testicular exams? □ Yes □ No
Date of last prostate exam: _______
Date of last colon test: __________

Do you drink alcohol? □ Yes □ No
If yes, how many drinks per week? ______
Do you exercise? □ Yes □ No
If yes, how many times per week? _______
Do you smoke now? □ Yes □ No
If yes, how much? _________ ppd
Do you have regular dental visits? □ Yes □ No

FAMILY MEDICAL HISTORY

Does anyone in your family have:  high blood pressure _________, diabetes _________, colon cancer _________,
breast cancer _________, heart disease _________, prostate cancer _________
TO BE COMPLETED BY EXAMINER

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>BMI</th>
<th>BP</th>
<th>Pulse</th>
</tr>
</thead>
</table>

**Normal (√)**  | **Comments for abnormal findings**

| General appearance |  |
| Skin |  |
| Eyes |  |
| ENT |  |
| Mouth/teeth/gums |  |
| Neck |  |
| Lungs/Chest |  |
| Heart |  |
| Abdomen |  |
| Upper extremities |  |
| Lower extremities |  |
| Back/spine |  |
| Neurologic |  |
| Mental status |  |

**ASSESSMENT/PLAN:**

- PPD planted
- PPD read: ________ Neg:____ Pos:____
- ROS for h/o + PPD negative for active disease
- ROS for h/o + PPD positive for active disease
- Respiratory mask: N/A
- Style: __________ Size: __________
- PAPR: __________
- Color blind test: Pass Fail
- CXR ordered
- CXR attached
- Immunizations reviewed and documentation attached
- Immunization(s) given: Td/Tdap MMR
  - Other:
  - Titors ordered: measles mumps rubella
  - varicella HBsAb HBsAg

**Final Clearance**

- Discussed healthy lifestyle: diet/exercise smoke cessation health maintenance:
- Advised to follow-up with PCP regarding:
- Person is qualified to continue to perform the essential functions of the job, with or without accommodation.
  - Accommodation needed, if any:
- Person is not qualified to continue to perform the essential functions of the job, with or without accommodation, for the following reason:

**SIGNATURE OF EXAMINER**

**PRINT NAME**

**TITLE**

**DATE**

**THE GEORGE WASHINGTON UNIVERSITY HOSPITAL**

**PRE-PLACEMENT PHYSICAL EXAMINATION**

80-634
Pre-placement Latex Sensitivity Questionnaire

Name ________________________________ Date __________________

1. Do you have any allergies to medication or food?  Yes  No
   If yes, please list ________________________________________________________________

2. Have you suffered from any of the following?
   - Allergic rhinitis (runny nose)  Yes  No
   - Allergic conjunctivitis  Yes  No
   - Asthma  Yes  No
   - Difficulty breathing  Yes  No
   - Eczema  Yes  No
   - Hives  Yes  No
   - Seasonal allergies  Yes  No
   - Sinus problems  Yes  No

3. List any medications you take, including inhalers ______________________________________
   ______________________________________________________________________________

4. Have you ever had any skin rashes or breathing problems after handling, eating or being exposed
   to the following:
   - Gloves (latex or vinyl)  Yes  No
   - Band-Aids  Yes  No
   - Balloons, condoms, or other rubber products  Yes  No
   - Bananas, kiwis, papayas, chestnuts, avocado, passion fruit  Yes  No
   - Potatoes, oranges, peaches, or other tropical fruit  Yes  No
   - Dental, surgical, or gynecology exams  Yes  No

_______________________________________  ________________________________
Your Signature  Signature of EHS Provider
TB Skin Test History

Part of the initial screening at GWUH Employee Health is a TB skin test (PPD). It is important for our department to know if you ever had a positive reaction to the test, and any treatment or follow-up that you received. Please answer the following questions so we can determine the best way to screen you.

The BCG vaccine is given to many foreign-born persons during childhood for Tuberculosis (TB) disease prevention. (Please note that the BCG vaccine is NOT the same as the TB skin test (PPD) placed on the forearm and used to screen for TB exposure).

1. Have you ever received the BCG vaccine?       Yes       No

2. Have you ever had a positive PPD (TB) skin test reaction?
   Yes       No       If so, when________________

3. If positive, did you have a chest x-ray done?   N/A       Yes       No       If so, when__________

4. Have you ever taken anti-tuberculosis medicine following exposure to TB?
   N/A       Yes       No       If so, when____________
   How long did you take this medication for? _________

5. Have you ever been told you should not receive a TB skin test because of an adverse or allergic reaction?
   Yes       No

6. Do you live with or have you been in close contact with someone who was recently diagnosed with active TB (roommate, close friend, relative)?
   Yes       No

___________________________  _________________________  ___________
Your Signature                  EHS Provider Signature       Date
Have you worn a respirator mask to care for patients before?  [ ] Yes  [ ] No

Please describe the testing: ____________________________________________________________

Have you had, or do you currently have, any of the following:

- Lung or breathing problems  [ ] Yes  [ ] No
- Heart problems  [ ] Yes  [ ] No
- High blood pressure  [ ] Yes  [ ] No
- Skin problems  [ ] Yes  [ ] No
- Claustrophobia (fear of being in closed places)  [ ] Yes  [ ] No
- Seizures  [ ] Yes  [ ] No
- Any other chronic medical conditions that require treatment  [ ] Yes  [ ] No

Explain any "Yes" answers: ______________________________

Do you take any medications on a regular basis?  [ ] Yes  [ ] No

Please list: ______________________________

Do you smoke?  [ ] Yes  [ ] No

For how many years? ____________

Pack per day smoked: ____________

If not current, how many years ago did you quit? ____________

Do you have a beard or mustache?  [ ] Yes  [ ] No

Your Signature ______________________________

Signature of EHS Provider  ______________________________

May use respirator mask without restrictions  [ ] Yes  [ ] No

Restrictions: ____________________________________________________________

Further medical evaluation  [ ] Yes  [ ] No

Not approved for respirator use for the following reason(s): ____________________________________________________________

Employee Health Services
George Washington University Hospital
900 23rd Street, NW, Suite G-1092 • Washington, DC 20037
202/715-4275 (Phone)
202/715-4587 (Fax)

Occupational Health and Safety Administration (OSHA) regulations state that all Health Care Workers who will be assigned, or may perform tasks requiring a respirator mask (i.e. during the care of patients with TB) are required to complete a medical evaluation of their use, and periodically thereafter. As part of this evaluation process, please complete the following questionnaire. Please answer all questions and provide explanations for any "Yes" answers. If you have questions, please ask for assistance from the EHS.

May use respirator mask without restrictions  [ ] Yes  [ ] No

Restrictions: ____________________________________________________________

Further medical evaluation  [ ] Yes  [ ] No

Not approved for respirator use for the following reason(s): ____________________________________________________________