



2010 Harbor-UCLA Intern Orientation Employee Health Packet

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1000 West Carson Street
Torrance, CA 90509

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*To improve health
through leadership,
service and education.*

Welcome to Harbor-UCLA Medical Center. As a Los Angeles County Employee you are required to be cleared by Employee Health Services (EHS) prior to beginning your duties.

The Employee Health Packet includes medical evaluation forms and questionnaires that are required to be completed prior to your visit on **Wednesday, June 23, 2010** to Employee Health Services (EHS). All forms and questionnaires should be brought and presented to EHS the day of Orientation on **Wednesday, June 23, 2010**.

Form (A) - Workforce Member Pre-Placement Health Examination
Is required to be completed by a physician or other licensed health care professional along with Form C. The physical exam is not to be self administered.

Form (B) - Tuberculosis History and Evidence of Immunity
This form is used as a template to assist in mandated health requirements. **(DO NOT COMPLETE)**.

Form (C) - General Pre-Placement Medical Questionnaire
You are required to complete in full along with Form (A) prior to orientation.

Form (K) - Declination Forms
You are required to complete if declining Hepatitis B vaccinations.

Form (P) - Respirator Medical Evaluation Questionnaire
Must be completed prior to orientation.

Form (T1) - General Consent Form (DO NOT SIGN PRIOR)
Must be signed in the presence of staff at EHS on **June 23, 2010**.

***Providing the following Non-mandatory documents will assist in expediting your work clearance.**

- a. Copy of Tuberculosis Skin Test (TST) documented in millimeters or a single blood assay for M. tuberculosis (BMAT) completed within the last 12 months.
- b. Copy of any immunizations or titers to the following: Measles, Mumps, Rubella, Varicella-zoster, Tetanus, Diphtheria, Acellular Pertussis, Influenza, and Hepatitis B Vaccine.
- c. Copy of Chest X-Ray report within the last 12 months for individuals with positive (TST).

The following information will be obtained at the EHS on **June 23, 2010**. Completing the above documents will facilitate the health clearance process and avoid delays in your training program start date.

- a. A "2 step" TST will be conducted if you cannot provide documentation of a TST within the previous 12 months. This may require a total of 3 visits.
- b. If you have been documented with a positive TST in millimeters you will be required to have a baseline posterior anterior chest x-ray at hire/assignment or provide written documentation of a normal chest x-ray taken no more than 12 months prior to hire/assignment.
- c. Adequate presumptive evidence of immunity as determined by EHS for vaccine-preventable diseases shall be assessed at the time of pre-employment/pre-placement evaluation.
 - 1) Measles:
 - a) Documented administration of two doses of live measles virus vaccine or
 - b) Laboratory evidence of immunity or laboratory confirmation of disease.



www.dhs.lacounty.gov

- 2) Mumps:
 - a) Documented administration of two doses of live mumps virus vaccine or
 - b) Laboratory evidence of immunity or laboratory confirmation of disease.

- 3) Rubella:
 - a) Documented administration of one dose of live rubella virus vaccine or
 - b) Laboratory evidence of immunity or laboratory confirmation of disease.

- 4) Varicella-zoster:
 - a) Documentation of 2 doses of vaccine or
 - b) Laboratory evidence of immunity or laboratory confirmation of disease.

- 5) Tetanus-diphtheria:
 - a) tetanus-diphtheria (Td) booster is recommended for all workforce members every 10 years.

- 6) Acellular Pertussis:
 - a) Tdap should replace a one time dose of Td for adults aged 19-64 years who have not previously received a dose of Tdap.

- 7) Annual Influenza Vaccination or Declination:
 - a) Workforce members shall receive an annual seasonal influenza vaccination or
 - b) Submit a signed declination form.

- 8) Hepatitis B:
 - a) All workforce members shall have a documented post vaccination antibody to hepatitis B surface antigen HbsAb(anti-HBs) or
 - b) Submit a signed declination form prior to assignment.

Additional Tests or Procedures that may be performed during orientation:

- a. Chest x-ray
- b. Documentation and/or completion of a 2 Step PPD procedure
- c. Respiratory Fit Test

If you need an accommodation or have work restrictions, you will need to bring in specific orders written by your physician. These cases will be referred to our Return-To-Work Unit for an interactive meeting and an effective work assignment.

Harbor-UCLA Medical Center welcomes you. We want to ensure you to have a positive experience during your time in training with the County. Please contact your GME office at 310-222-2911 or the facility EHS at 310-222-2360 for further assistance.

Sincerely,

Employee Health Services

Attachments (A, B, C, K, P, T1)

A



Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES

**CONFIDENTIAL – WORKFORCE MEMBER
PRE-PLACEMENT HEALTH EXAMINATION**

General Instructions on Page 2

LAST NAME		FIRST, MIDDLE NAME		BIRTHDATE		EMPLOYEE/ID NO.	
ADDRESS			CITY		STATE	ZIP CODE	PHONE/CELL NO.
JOB CLASSIFICATION			ITEM NO.	WORK FACILITY	DEPARTMENT	WORK AREA/UNIT	SHIFT
<input type="checkbox"/> Check here if Non-County Workforce Member		NAME OF SCHOOL/CONTRACT AGENCY (If applicable):			PHONE NO.:		CONTACT PERSON:

SPECIALTY EXAM: Asbestos Antineoplastic DOT Hearing Color Vision RFT
 HazMat High Hazard Procedures Other: _____

Vital Signs			Vision Screening <input type="checkbox"/> NA	No Correction	With Correction			
Height	Weight	BMI	Right	20/	20/			
B/P	Pulse	ALG	Left	20/	20/			
Color Vision Screening: /15 <input type="checkbox"/> NA			Both	20/	20/			
Hearing <input type="checkbox"/> NA	Audiometer							
		250	500	1000	2000	3000	4000	8000
	Right							
	Left							
Nurse Signature: _____ Print Name: _____ Date: _____								

PHYSICAL EVALUATION			DESCRIPTION OF ABNORMAL FINDINGS
<i>Check each item in the appropriate column.</i>	NORMAL	ABNORMAL	
Skin			
HEENT			
Neck			
Lungs			
Heart			
Back/Spine			
Abdomen and Viscera			
Upper Extremities			
Lower Extremities			
Neurologic			
Psychologic			
REMARKS: _____ _____			

Recommendation: No Restrictions/Pass Restricted Fail Reasons for categories other than Pass: _____

Physician or Licensed Health Care Professional Signature	Print Name	License No.	Date
Address		Phone No.	

CONTINUE ON NEXT PAGE

PRE-PLACEMENT HEALTH EXAMINATION

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	EMPLOYEE/ID NO.:
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DHS-EHS STAFF ONLY			
DHS-Provider Signature	Print Name	Date	
MANDATORY FIELD			
<input type="checkbox"/> No Restrictions/Pass	<input type="checkbox"/> Restricted _____	<input type="checkbox"/> Fail	<input type="checkbox"/> Deferred _____
Completion of this form:	Reviewed By (Print)	Signature	Date

Mandatory field is for the database team.

 **GENERAL INSTRUCTIONS**

Pre-placement health assessment is performed to ascertain medical fitness for duty, document the absence of and/or immunity to certain infectious diseases, and to establish a baseline for those who require ongoing medical surveillance. This assessment also includes medical evaluation prior to respirator fit testing and respirator use. For Returning Retirees and Reinstatements, Pre-Employment Evaluations are required unless the rehire is within three months of the date of termination or rehired within six months of the date of termination and the physical demands of the job have not changed. Any potential workforce members requiring an accommodation must be referred to DHS Risk Management, Return-To-Work for review of needs.

DHS-EHS staff shall verify/review documentation(s) and record completion of this form for workforce member. This form and its attachment, if any, such as medical records shall be filed in workforce member's EHS medical file. All medical records of workforce member are confidential in accordance with federal, state and regulatory requirements.

B



Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES

CONFIDENTIAL
WORKFORCE MEMBER

TUBERCULOSIS HISTORY AND EVIDENCE OF IMMUNITY

See General Instructions on Page 3

LAST NAME:		FIRST, MIDDLE NAME:		BIRTHDATE:		EMPLOYEE/ID NO.:	
HOME ADDRESS:				CITY:		STATE:	ZIP CODE:
EMAIL ADDRESS:			HOME PHONE NO.:		CELL PHONE NO.:		
JOB CLASSIFICATION:		ITEM NO.:	WORK FACILITY:	DEPARTMENT:	WORK AREA/UNIT:	SHIFT:	
<input type="checkbox"/> Check here if Non-County Workforce Member		NAME OF SCHOOL/CONTRACT AGENCY (If applicable):			PHONE NO.:	CONTACT PERSON:	

EMPLOYEE HEALTH STAFF – OR – DESIGNATED WFM AGENCY TO COMPLETE

TUBERCULOSIS DOCUMENTATION HISTORY

A	Step 1 (<12 months)	Date Administered: Date Read:	Results _____mm	<input type="checkbox"/> LA County <input type="checkbox"/> Outside Document
	Step 2 (<12 months)	Date Administered: Date Read:	Results _____mm	<input type="checkbox"/> LA County <input type="checkbox"/> Outside Document
If either result is positive send for CXR and complete Section C.				

OR

B	Negative BAMT (<12 months)	Date:	Results	<input type="checkbox"/> LA County <input type="checkbox"/> Outside Document
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**If CXR is positive for TB, DO NOT CLEAR for hire/assignment.
Refer Workforce Member for immediate medical care.**

C	Positive TST	Date:	Results _____mm	<input type="checkbox"/> LA County <input type="checkbox"/> Outside Document
	CXR (<12 months)	Date:	Results _____	<input type="checkbox"/> LA County <input type="checkbox"/> Outside Document

OR

D	Positive BAMT	Date:	Results _____	<input type="checkbox"/> LA County <input type="checkbox"/> Outside Document
	CXR (<12 months)	Date:	Results _____	<input type="checkbox"/> LA County <input type="checkbox"/> Outside Document

OR

E	History of Active TB with Treatment	Date:	_____ months with _____	<input type="checkbox"/> Outside Document
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OR

F	History of LTBI Treatment	Date:	_____ months with _____	<input type="checkbox"/> Outside Document
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CONTINUE ON NEXT PAGE

CONFIDENTIAL
TUBERCULOSIS HISTORY AND EVIDENCE OF IMMUNITY

PAGE 2 OF 3

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	EMPLOYEE/ID NO.
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IMMUNIZATION DOCUMENTATION HISTORY								
G	Date	Titer	If not immune give Vaccination x 2, unless Rubella x 1	Date	Vaccine		Declination Signed	
	Measles		<input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune <input type="checkbox"/> Equivocal <input type="checkbox"/> Laboratory confirm of disease	OR			OR	<input type="checkbox"/> May be restricted from patient care areas
	Mumps		<input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune <input type="checkbox"/> Equivocal <input type="checkbox"/> Laboratory confirm of disease					<input type="checkbox"/> May be restricted from patient care areas
	Rubella		<input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune <input type="checkbox"/> Equivocal <input type="checkbox"/> Laboratory confirm of disease					<input type="checkbox"/> May be restricted from patient care areas
	Varicella		<input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune <input type="checkbox"/> Equivocal <input type="checkbox"/> Laboratory confirm of disease	OR			OR	<input type="checkbox"/> May be restricted from patient care areas

AND

	Vaccination	Date	Declination Signed
H	Tetanus-diphtheria (Td) Every 10 years		<input type="checkbox"/>
	Arcellular Pertussis (Tdap) X 1		<input type="checkbox"/>

AND

	Vaccination (MANDATORY for WFM who have potential to be exposed to blood or body fluid)	Date	Immunity	Declination Signed
I	Hepatitis B (HBsAb)		<input type="checkbox"/> Reactive <input type="checkbox"/> Non reactive	<input type="checkbox"/>

AND

	Vaccination (VOLUNTARY)	Date	Location	Declination Signed
J	Seasonal Influenza (annually)		PMD, employment, school, flu clinic, other <input type="checkbox"/> Verbal <input type="checkbox"/> Document	<input type="checkbox"/>

AND

	Vaccination (VOLUNTARY)	Date	Location	Declination Signed
K	H1N1 Influenza (annually)		PMD, employment, school, flu clinic, other <input type="checkbox"/> Verbal <input type="checkbox"/> Document	<input type="checkbox"/>



PLEASE ATTACH SUPPORTING DOCUMENTATION(S)

GENERAL INSTRUCTION ON NEXT PAGE

DHS-EHS STAFF ONLY			
L	Pre-Placement Health Examination (Form A)	Date:	<input type="checkbox"/> No restrictions/Pass <input type="checkbox"/> Restricted <input type="checkbox"/> Fail
M	FINAL RESOLUTION – EHS Health Clearance	Date:	<input type="checkbox"/> No restrictions/Pass <input type="checkbox"/> Restricted <input type="checkbox"/> Fail
Completion of this form:		Reviewed By (Print):	Signature:
			Date:

GENERAL INSTRUCTIONS

SECTION	
TUBERCULOSIS DOCUMENTATION HISTORY	
ALL WORKFORCE MEMBER (WFM) SHALL BE SCREENED FOR TB UPON HIRE/ASSIGNMENT	
A	<p>WFM shall receive a baseline TB screening using two-step Tuberculin Skin Test (TST). Step 1: Administer TST test, with reading in seven days. Step 2: After Step 1 reading is negative, administer TST test, with reading within 48-72 hours. If both readings are negative, WFM is cleared to work. WFM shall receive either TST or BAMT and symptom screening annually.</p> <p style="margin-left: 20px;">a. Documentation of negative TST within 12 months prior to placement will be accepted. WFM shall receive a one-step TST with reading within 48-72 hours. If result is negative, WFM is cleared to work;</p> <p style="margin-left: 20px;">b. Documentation of negative two-step TST within 12 months prior to placement will be accepted. WFM is cleared to work.</p> <p>If TST is positive, record results and continue to Section C.</p>
B	<p>WFM shall receive a baseline TB screening using a single blood assay for M. tuberculosis (BAMT). If negative result, WFM is cleared to work. WFM shall receive either TST or BAMT and symptom screening annually.</p> <p style="margin-left: 20px;">a. Documentation of negative BAMT within 12 months will be accepted. WFM is cleared to work.</p> <p>If BAMT is positive, record results and continue to Section D.</p>
TST POSITIVE RESULTS	
If CHEST X-RAY IS POSITIVE, DO NOT CLEAR FOR HIRE/ASSIGNMENT, AND REFER WORKFORCE MEMBER FOR IMMEDIATE MEDICAL CARE	
C	<p>If TST is positive during testing in Section A or C above, send for a chest x-ray (CXR). If CXR is negative, WFM is cleared to work. Documentation of negative CXR within 12 months prior to placement will be accepted for clearance to work. WFM shall be symptom screened for TB annually.</p>
D	<p>If BAMT is positive during testing in Section D above, send for a CXR. If CXR is negative, WFM is cleared to work. Documentation of negative CXR within 12 months prior to placement will be accepted for clearance to work. WFM shall be symptom screened for TB annually.</p>
E	<p>If WFM have a documented history of active TB, send for a chest x-ray (CXR). If CXR is negative, WFM is cleared to work. Documentation of negative CXR within 12 months prior to placement will be accepted for clearance to work. If documentation is supported, WFM is cleared to work. WFM shall be symptom screened for TB annually. Record documentation result in this section.</p>
F	<p>If WFM have a documented history of latent tuberculosis infection (LTBI) treatment, send for a chest x-ray (CXR). If CXR is negative, WFM is cleared to work. Documentation of negative CXR within 12 months prior to placement will be accepted for clearance to work. If documentation is supported, WFM is cleared to work. WFM shall be symptom screened for TB annually. Record documentation result in this section.</p>
IMMUNIZATION DOCUMENTATION HISTORY	
<p>Documentation of immunization or adequate titers will be accepted. If WFM is not immune against communicable diseases as listed in this section, WFM shall be immunized (unless medically contraindicated). WFM who declines the vaccination(s) must sign the mandatory declination form. WFM who declines the vaccination(s) may be restricted from patient care areas of the hospital or facility. If WFM is non-immune or decides at a later date to accept the vaccination, DHS or WFM contract agency will make the vaccination available.</p>	
G	<p>Documentation of laboratory evidence of immunity or laboratory confirmation of disease will be accepted OR documentation of two doses (live measles, mumps and varicella) and one dose of live rubella virus vaccine. Measles vaccine shall be administered no earlier than one month (minimum 28 days) after the first dose. Mumps second dose vaccine vary depending on state or local requirements. Varicella doses shall be at least 4 week between doses for WFM. If Equivocal, WFM needs either vaccination or re-draw with positive titer.</p>
H	<p>Td – After primary vaccination, Td booster is recommended every 10 years. If unvaccinated WFM, primary vaccination consists of 3 doses of Td; 4-6 weeks should separate the first and second doses; the third dose should be administered 6-12 months after the second dose.</p> <p>Tdap should replace a one time dose of Td for HCP aged 19 through 64 years who have not received a dose of Tdap previously. An interval as short as 2 years or less from the last dose of Td is recommended for the Tdap dose.</p>
I	<p>All WFM who have occupational exposure to blood or other potentially infectious materials shall have a documented post vaccination antibody to Hepatitis B surface antigen HBsAb (anti-HBs). Hepatitis B vaccine series is available to WFM. Non-responders should be considered susceptible to HBV and should be counseled regarding precautions to prevent HBV infection and the need to obtain HBIG prophylaxis for any known or probable parenteral exposure to HBsAg positive blood.</p>
J	<p>Seasonal influenza is offered annually to WFM when the vaccine becomes available.</p>
K	<p>H1N1 influenza is offered annually to WFM when the vaccine becomes available.</p>

DHS-EHS staff shall verify/review documentation(s) and record completion of this form for workforce member. This form and its attachment, if any, such as medical records shall be filed in workforce member's EHS medical file. All medical records of workforce member are confidential in accordance with federal, state and regulatory requirements.



Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES

CONFIDENTIAL
WORKFORCE MEMBER

GENERAL PRE-PLACEMENT MEDICAL HISTORY QUESTIONNAIRE

General Instructions below

Please complete this questionnaire in PEN and present to the staff at the examination clinic. To protect your confidentiality, it should not be given or shown to anyone else. On the day of your appointment, you must bring a valid driver's license or other form of identification which has both your photograph and signature.

LAST NAME:		FIRST, MIDDLE NAME:		BIRTHDATE:	AGE:	EMPLOYEE/ID NO.:	
ADDRESS:				CITY:		STATE:	ZIP CODE:
EMAIL ADDRESS:			HOME/CELL PHONE:		WORK FACILITY:		SHIFT:
JOB CLASIFFICATION:		ITEM NO.:	DEPARTMENT:	WORK AREA/UNIT:	WORK PHONE:		
OTHER NAME(S) USED INCLUDING MAIDEN NAME(S):		LAST NAME:		FIRST, MIDDLE NAME:			
<input type="checkbox"/> Check here if Non-County Workforce Member		NAME OF SCHOOL/CONTRACT AGENCY (If applicable):		PHONE NO.:		CONTACT PERSON:	
IF YOU PREVIOUSLY HAVE HAD AN EXAM FOR LOS ANGELES COUNTY POSITION, PLEASE PROVIDE:							
POSITION:		ITEM NO.:	DEPARTMENT:	DATE:			

A response is required for each item below. Do not leave any blanks. Check "Yes" if you have had any of the following conditions in the last ten (10) years. Be sure to not omit conditions that were treated through the Los Angeles County worker's compensation system. You must explain all "Yes" and "Not Sure" answers on Page 5.

NOT YES SURE NO			NOT YES SURE NO				
EYES, EARS, NOSE, THROAT			GASTROINTESTINAL				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Worn glasses/contact lenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	23. Vomited blood
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Worn retainer lenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	24. Persistent diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	25. Colitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Blurred or double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	26. Black/bloody bowel movement
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	27. Recurrent hemorrhoids
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Blind spot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	28. Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7. Impaired peripheral vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	29. Liver disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8. Refractive surgery/lasix	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	30. Trouble swallowing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9. Color vision impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	31. Pancreatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10. Abnormal color vision test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	32. Hernia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11. Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	33. Crohn's Disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12. Ruptured ear drum				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	13. Ringing/buzzing ears	CARDIOVASCULAR			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	14. Hearing trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	34. Heart attack
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	15. Abnormal hearing test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	35. Heart murmur
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16. Ear surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	36. Irregular heartbeat
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	17. Ear aches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	37. Heart valve abnormality
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	38. Enlarged heart
PULMONARY				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	39. Chest pain or discomfort
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	40. Heart failure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	19. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	41. Swelling of feet/legs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	20. Chronic or frequent cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	42. Leg pain while walking
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21. Chest tightness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	43. Painful varicose veins
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	22. Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	44. High blood pressure

CONTINUE ON NEXT PAGE

CONFIDENTIAL
GENERAL PRE-PLACEMENT MEDICAL HISTORY QUESTIONNAIRE

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	EMPLOYEE/ID NO.:
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NOT YES SURE NO		NOT YES SURE NO	
MUSCULO/SKELETAL		MISCELLANEOUS	
<input type="checkbox"/>	45. Fractures/broken bones	<input type="checkbox"/>	73. Kidney disease
<input type="checkbox"/>	46. Back trouble/pain/injury	<input type="checkbox"/>	74. Bladder trouble
<input type="checkbox"/>	47. Neck trouble/pain/injury	<input type="checkbox"/>	75. Blood in urine
<input type="checkbox"/>	48. Numbness of extremities	<input type="checkbox"/>	76. Prostatitis
<input type="checkbox"/>	49. Arthritis/Rheumatism	<input type="checkbox"/>	77. Referred for psychological help
<input type="checkbox"/>	50. Joint pain or swelling	<input type="checkbox"/>	78. Mental hospitalization
<input type="checkbox"/>	51. Shoulder injury/dislocation/pain	<input type="checkbox"/>	79. Drug/alcohol treatment
<input type="checkbox"/>	52. Elbow trouble/pain/injury	<input type="checkbox"/>	80. Diabetes
<input type="checkbox"/>	53. Wrist/hand trouble/injury/pain	<input type="checkbox"/>	81. Thyroid trouble
<input type="checkbox"/>	54. Hip trouble/pain/injury	<input type="checkbox"/>	82. Anemia
<input type="checkbox"/>	55. Knee trouble/pain/injury	<input type="checkbox"/>	83. Enlarge glands
<input type="checkbox"/>	56. Shin pain	<input type="checkbox"/>	84. Skin problems/cancer/rashes
<input type="checkbox"/>	57. Leg pain/injury	<input type="checkbox"/>	85. Sun/heat in tolerance
<input type="checkbox"/>	58. Ankle/foot pain/injury	<input type="checkbox"/>	86. Cyst/tumor
<input type="checkbox"/>	59. Carpal Tunnel Syndrome	<input type="checkbox"/>	87. Cancer/leukemia
CENTRAL NERVOUS SYSTEM		<input type="checkbox"/>	88. Chronic fatigue
<input type="checkbox"/>	60. Epilepsy	<input type="checkbox"/>	89. Night sweats
<input type="checkbox"/>	61. Convulsion/seizure	<input type="checkbox"/>	90. Undesired weight loss
<input type="checkbox"/>	62. Fainting spell	<input type="checkbox"/>	91. Claustrophobia
<input type="checkbox"/>	63. Loss of consciousness	<input type="checkbox"/>	92. Multiple chemical sensitivity
<input type="checkbox"/>	64. Recurrent dizziness	<input type="checkbox"/>	93. Wool allergy
<input type="checkbox"/>	65. Head injury	<input type="checkbox"/>	94. Sleep Apnea
<input type="checkbox"/>	66. Migraine headaches	<input type="checkbox"/>	95. Snoring
<input type="checkbox"/>	67. Frequent headaches	<input type="checkbox"/>	96. Trouble sleeping
<input type="checkbox"/>	68. Stroke	<input type="checkbox"/>	97. Low blood sugar
<input type="checkbox"/>	69. Tremors	<input type="checkbox"/>	98. Blood clot in lungs/legs
<input type="checkbox"/>	70. Traumatic Brain Injury	<input type="checkbox"/>	99. Other condition that may affect job performance _____
<input type="checkbox"/>	71. Chronic neurological disease	FOR WOMEN ONLY	
<input type="checkbox"/>	72. Attention Deficit Disorder	<input type="checkbox"/>	100. Irregular vaginal bleeding
<input type="checkbox"/>		<input type="checkbox"/>	101. Menstrual problem that kept you from work

NOT YES SURE NO	
<input type="checkbox"/>	102. Do you have any physical activity limitations?
<input type="checkbox"/>	103. Do you need any special accommodations to assist you in performing any job tasks?
<input type="checkbox"/>	104. Have you worked for the County of Los Angeles before?
<input type="checkbox"/>	If "yes", at what position, and in which department? _____
<input type="checkbox"/>	105. Have you been refused employment (including L.A. County positions) because of any physical, psychological, or medically related reason during the past 10 years?
<input type="checkbox"/>	106. Have you been rejected for or discharged from a military position because of physical, psychological, or medically related reasons in the past 10 years?
<input type="checkbox"/>	107. Have you failed a pre-placement medical or psychological exam in the past 10 years?

CONFIDENTIAL
GENERAL PRE-PLACEMENT MEDICAL HISTORY QUESTIONNAIRE

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	EMPLOYEE/ID NO.:
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NOT YES SURE NO				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	108. Have you been terminated or resigned from employment due to a physical, psychological, or medically related reason in the past 10 years?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	109. Have you had a positive drug or alcohol test in the past 10 years?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	110. Have you been absent from work due to job stress anytime in the past 10 years?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	111. Do you occasionally use or are you currently taking any prescription or over the counter medications? If "Yes", please list name, dosage, frequency of use, and the reason the medication is used on Page 5.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	112. Has anyone in your immediate family developed heart disease before the age of 60?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	113. Do you currently have a cold/cough or have you had any in the last two weeks?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	114. Have you ever had a positive skin test for tuberculosis?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	115. Are you pregnant? If "Yes", what is your due date? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	116. Have you seen a doctor for back/neck pain, injury, or problems in the past 10 years?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	117. Have you been off work because of back/neck problems in the past 10 years?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	118. Have you had a recent change in the size or color of a mole, or a sore that would not heal?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	119. Have you missed more than five days from work due to medical reasons in the past year?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	120. Have you been exposed to loud noise today? If "Yes", were you wearing ear protection? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	121. Do you have a commercial driver's license for driving trucks or buses?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	122. Are you a current cigarette smoker? A. How many packs of cigarettes do you smoke a day? _____ B. How long have you been smoking? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	123. Are you an ex-smoker? A. How many years did you smoke? _____ B. How many packs a day? _____ C. When did you quit? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	124. Have you used chewing tobacco or smoked cigars/pipe in the last 10 years?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	125. Has someone been concerned about your drinking or suggested that you cut down in the past 10 years?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	126. Have you been convicted of driving under the influence (DUI) in the last 10 years?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	127. Have you felt bad about your drinking at any time in the last 10 years?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	128. Have you had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye opener) in the last 10 years?

129. I am: Left handed Right handed

130. I drink _____ beers; _____ glasses/shots of hard liquor; _____ glasses of wine per week.

Describe any hobbies/recreational/work activities that have exposed you to noise, chemicals, or dusty conditions:

131. _____

132. Please describe your typical exercise or physical activity including any physical activity at work:

ACTIVITY	HOW MANY HOURS DO YOU SPEND DOING THIS PER WEEK?	HOW MANY MONTH/YEARS HAVE YOU BEEN DOING THIS ACTIVITY?
#1 _____	_____	_____
#2 _____	_____	_____
#3 _____	_____	_____
#4 _____	_____	_____
#5 _____	_____	_____

CONFIDENTIAL
GENERAL PRE-PLACEMENT MEDICAL HISTORY QUESTIONNAIRE

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	EMPLOYEE/ID NO.:
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ACTIVITY	HOW MANY HOURS DO YOU SPEND DOING THIS PER WEEK?	HOW MANY MONTH/YEARS HAVE YOU BEEN DOING THIS ACTIVITY?
----------	--	---

#6 _____

133. Please describe your current job and all jobs held in the last five (5) years (including military service):

JOB TITLE:	PRIMARY DUTIES:	EMPLOYER:	APPROXIMATE DATES OF EMPLOYMENT
_____	_____	_____	TO _____
_____	_____	_____	TO _____
_____	_____	_____	TO _____
_____	_____	_____	TO _____
_____	_____	_____	TO _____

NOT YES SURE NO	TUBERCULOSIS (TB) HISTORY
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	134. Do you have history of a negative TB skin test?
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	135. Do you have documentation of your negative test from the last 12 months?
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	136. Do you have a history of a positive TB skin test?
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	137. Do you have documentation of your positive skin test in millimeters?
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	138. Do you have documentation of a chest X-ray within the last 12 months?
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	139. Have you received treatment for TB (INH) or other regimen? If "yes", how many months? _____
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	140. Do you have treatment documentation?
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	141. Have you ever been diagnosed as having active or infectious TB?
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	142. Have you received a TB vaccine called BCG?
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	143. Have you had a weakened immune system due to (check all that applies): <input type="checkbox"/> Chemotherapy <input type="checkbox"/> HIV <input type="checkbox"/> Organ transplant <input type="checkbox"/> Leukemia <input type="checkbox"/> Cancer or medications <input type="checkbox"/> Hodgkin's Disease <input type="checkbox"/> Steroids (e.g., prednisone)
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	144. Would you like to be tested for HIV?
TUBERCULOSIS (TB) SCREENING	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	145. Do you have a cough lasting longer than 3 weeks?
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	146. Do you cough up blood?
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	147. Do you have unexplained or unintended weight loss?
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	148. Do you have night sweats (not related to menopause)?
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	149. Do you have a fever or chills?
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	150. Do you have excessive sputum?
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	151. Do you have excessive fatigue?
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	152. Have you had recent close contact with a person with TB?

153. Please list any allergies with reactions to medication, food, or substances.



CONFIDENTIAL
WORKFORCE MEMBER DECLINATION FORMS

LAST NAME:		FIRST, MIDDLE NAME:		BIRTHDATE:		EMPLOYEE/ID NO.:	
JOB CLASSIFICATION:		ITEM NO.:	WORK FACILITY:	DEPARTMENT:	WORK AREA/UNIT:	SHIFT:	
<input type="checkbox"/> Check here if Non-County Workforce Member		NAME OF SCHOOL/CONTRACT AGENCY (If applicable):		PHONE NO.:		CONTACT PERSON:	

8 CCR §5199. Appendix C1 - Vaccination Declination Statement (Mandatory)

I understand that due to my occupational exposure to aerosol transmissible diseases, I may be at risk of acquiring infection with _____ (letter of name of disease or pathogen). I have been given the opportunity to be vaccinated against this disease or pathogen at no charge to me. However, I decline this vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring _____, a serious disease. If in the future I continue to have occupational exposure to aerosol transmissible diseases and want to be vaccinated, I can receive the vaccination at no charge to me.

8 CCR §5193. Appendix A-Hepatitis B Vaccine Declination (Mandatory)

I understand that due to my occupational exposure to blood or OPIM I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. 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. If in the future I continue to have occupational exposure to blood or OPIM and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Specialty Surveillance Declination (Mandatory)

I understand that due to my occupational exposure to _____, I am eligible and have been given the opportunity to enroll in the _____ Medical Surveillance Program. This will enable me to receive specific initial, periodic and exit medical examinations for the hazard identified above, at no charge to myself and at a reasonable time and place.

However, I decline to be enrolled in this program at this time. I understand that by declining this enrollment, I will not be medically monitored for occupational exposure to this hazard. I understand that it is strongly recommended that I complete an _____. I also understand that if in the future I continue to have occupational exposure to _____ and I want to be enrolled in the _____ Medical Surveillance Program, I can do so at any time at no charge to me.

Place appropriate assigned letter in the provided spaces above, as needed.

A = Measles	B = Mumps	C = Rubella	D = Varicella	E = Hepatitis B
F = Seasonal Influenza**	G = H1N1 Influenza**	H = Td/Tdap	I = Asbestos	J = Hazardous / Anti-Neoplastic Drugs

****REASON (For Seasonal and H1N1 Influenza only): IT to make as Pop-Up menu when selected**

- | | |
|---|---|
| <input type="checkbox"/> I am allergic to vaccine components. | <input type="checkbox"/> I don't believe I need it. |
| <input type="checkbox"/> I believe I can get the flu if I get the shot. | <input type="checkbox"/> I'm concerned about vaccine safety |
| <input type="checkbox"/> I am concerned about vaccine side effects. | <input type="checkbox"/> I do not like needles. |
| <input type="checkbox"/> It's against my personal belief. | <input type="checkbox"/> Other: _____ |

WORKFORCE MEMBER SIGNATURE _____

DATE _____

EHS STAFF (PRINT NAME) _____

EHS SIGNATURE _____

DATE _____



See General Instructions on Page 2

COMPLETE ONCE EVERY FOUR (4) YEARS OR AS NEEDED

This Appendix is Mandatory if the Employer chooses to use a Respirator Medical Evaluation Questionnaire other than the Questionnaire in Section 5144 Appendix C.

To the PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL: Answers to questions in Section 1, and to question 6 in Section 2 do not require a medical examination. Workforce member must be provided with a confidential means of contacting the health care professional who will review this questionnaire.

To the WORKFORCE MEMBER: Can you read and understand this questionnaire (check one): Yes No

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Please complete this questionnaire in PEN and present to the staff at the examination clinic. **To protect your confidentiality, it should not be given or shown to anyone else.** On the day of your appointment, you must bring a valid driver's license or other form of identification which has both your photograph and signature.

SECTION 1

The following information must be provided by every workforce member who has been selected to use any type of respirator (please print).

				TODAY'S DATE:	
LAST NAME		FIRST, MIDDLE NAME		AGE	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
HEIGHT FT IN	WEIGHT LBS	JOB CLASSIFICATION			ITEM NO.:
PHONE NUMBER		Best Time to reach you?	Has your employer told you how to contact the health care professional who will review this questionnaire? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Check type of respirator you will use (you can check more than one category): <input type="checkbox"/> N, R, Or P disposal respirator (filter-mask, non-cartridge type only) <input type="checkbox"/> Other type (specify): _____	
Have you worn a respirator? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "yes", what type: _____

SECTION 2

Questions 1 through 6 below must be answered by every workforce member who has been selected to use any type of respirator (please check "YES", "NOT SURE" or "NO").

YES	NOT SURE	NO	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Have you ever had the following conditions?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. Allergic reactions that interfere with your breathing?
			If "yes," what did you react to? _____ _____

AEROSOL TRANSMISSIBLE DISEASES RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE
Page 2 of 4

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	EMPLOYEE/ID NO.:
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YES	NOT SURE	NO	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Claustrophobia (fear of closed-in places)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Do you currently have any of the following symptoms of pulmonary or lung illness:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. Shortness of breath when walking fast on level ground or walking up a slight hill or incline
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Have to stop for breath when walking at your own pace on level ground
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. Shortness of breath that interferes with your job
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. Coughing that produces phlegm (thick sputum)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	e. Coughing up blood in the last month
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	f. Wheezing that interferes with your job
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	g. Chest pain when you breath deeply
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	h. Any other symptoms that you think may be related to lung problems: _____ _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Do you currently have any of the following cardiovascular or heart symptoms?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. Frequent pain or tightness in your chest
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Pain or tightness in your chest during physical activity
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. Pain or tightness in your chest that interferes with your job
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. Any other symptoms that you think may be related to lung problems: _____ _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Do you currently take medication for any of the following problems?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. Breathing or lung problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Heath trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. Nose, throat or sinuses
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. Are your problems under control with these medications?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. If you've used a respirator, have you ever had any of the following problems while respirator is being used? (If you've never used a respirator, check the following space and go to question 6).
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	a. Skin allergies or rashes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Anxiety
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. General weakness or fatigue
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. Any other problem that interferes with your use of a respirator
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Would you like to talk to the health care professional about your answers in this questionnaire?
Workforce Member Signature			Date

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	EMPLOYEE/ID NO.:
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PROVIDE A COPY OF THIS PAGE TO WORKFORCE MEMBER

Part 1: Fit Testing Recommendation – Based on Questionnaire

Questionnaire reviewed.

Medical Approval to Receive Fit Test

1. Disposable Particulate Respirators (N-95)
2. Replaceable Disposable Particulate Respirator a. Half-Facepiece b. Full Facepiece
3. Powered Air Purifying Respirators (PAPRs) a. Tight Fitting b. Loose Fitting
4. Self-Contained Breathing Apparatus (SCBA)

Recommended time period for next questionnaire: 4 years Other _____ with justification _____

Date Completed: _____ Next Due Date: _____

Any recommended limitations for respirator use on workforce member: _____

The above workforce member has not been cleared to be fit tested for a respirator.

Additional medical evaluation is needed. Physician or Licensed Health Care Professional to complete Part 2 below.

Medically unable to use a respirator.

Informed workforce member of the results of this examination.

Part 2: Additional Medical Evaluations NOT APPLICABLE

Medical evaluation completed.

Medical Approval to Receive Fit Test

1. Disposable Particulate Respirators (N-95)
2. Replaceable Disposable Particulate Respirator a. Half-Facepiece b. Full Facepiece
3. Powered Air Purifying Respirators (PAPRs) a. Tight Fitting b. Loose Fitting
4. Self-Contained Breathing Apparatus (SCBA)

Recommended time period for next questionnaire: 4 years Other _____ with justification _____

Date Completed: _____ Next Due Date: _____

Any recommended limitations for respirator use on workforce member: _____

Medically unable to use a respirator.

Informed workforce member of the results of this examination.

Other: _____

Workforce Member Signature		Date	
Physician or Licensed Health Care Professional Signature	Print Name	License No.	Date
Address		Phone No.	

AEROSOL TRANSMISSIBLE DISEASES RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE
 Page 4 of 4

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	EMPLOYEE/ID NO.:
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DHS-EHS OFFICE STAFF ONLY			
Completion of this form:	Reviewed By (Print)	Signature	Date

 **GENERAL INSTRUCTIONS**

THIS QUESTIONNAIRE IS TO BE REVIEWED BY A PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL.

8 CCR §5199

Medical evaluation: DHS-EHS or contract agency shall provide a medical evaluation, in accordance with 8 CCR §5144(e) of these orders, to determine the workforce member's (WFM) ability to use the respirator before the WFM is fit tested or required to use the respirator. For WFM who use respirators solely for compliance with subsections (g)(3)(A) and subsections (g)(3)(B), this alternate questionnaire may be used.

8 CCR §5144(e)

1. General. DHS-EHS or contract agency shall provide a medical evaluation to determine the workforce member's (WFM) ability to use a respirator, before the WFM is fit tested or required to use the respirator in the workplace. DHS-EHS may discontinue a WFM's medical evaluations when the WFM is no longer required to use a respirator.
2. Medical evaluation procedures.
 - a. DHS-EHS or contract agency shall identify a physician or other licensed health care professional (PLHCP) to perform medical evaluations using a medical questionnaire or an initial medical examination that obtains the same information as the medical questionnaire.
 - b. The medical evaluation shall obtain the information requested by this questionnaire in Sections 1 and 2, Part A.
3. Follow-up medical examination.
 - a. DHS-EHS shall ensure that a follow-up medical examination is provided for a WFM who gives a **positive** response to any question among questions 1 through 8 in Section 2, Part A of this questionnaire or whose initial medical examination demonstrates the need for a follow-up medical examination.
 - b. The follow-up medical examination shall include any medical tests, consultations, or diagnostic procedures that the PLHCP deems necessary to make a final determination.

DHS-EHS staff shall verify/review documentation(s) and record completion of this form for workforce member. This form and its attachment, if any, such as medical records shall be filed in workforce member's EHS medical file. All medical records of workforce member are confidential in accordance with federal, state and regulatory requirements.

A copy of the respiratory protection regulation Title 8 CCR §5144, §5199 can be found at <http://www.dir.ca.gov/title8/5144.html> and <http://www.dir.ca.gov/Title8/5199.html>

T1



Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES

**WORKFORCE MEMBER
GENERAL CONSENT**

LAST NAME:		FIRST, MIDDLE NAME:		BIRTHDATE:		EMPLOYEE/ID NO.:	
JOB CLASSIFICATION:		ITEM NO.:	WORK FACILITY:	DEPARTMENT:	WORK AREA/UNIT:	SHIFT:	
EMAIL ADDRESS:			WORK PHONE:	CELL/PAGER NO.:	SUPERVISOR NAME:		
<input type="checkbox"/> Check here if Non-County Workforce Member		NAME OF SCHOOL/CONTRACT AGENCY (If applicable):		PHONE NO.:	CONTACT PERSON:		

Medical Consent: The undersigned Los Angeles County Department of Health Services workforce member, applicant, and/or responsible relative or person hereby consent to, authorize and request the Department of Health Services (DHS), its physicians, nursing and medical personnel assigned to and authorized by Employee Health Services to administer and perform any and all medical examinations and treatments. This may include, but not limited to, diagnostic procedures, medical surveillance, post exposure evaluation, tuberculosis screening, drawing blood to determine immunity to infectious diseases, vaccinations and immunizations against disease which may now or during the course of employment/assignment, be deemed advisable or necessary in accordance with federal, state, and local guidelines..

The undersigned further consent to, and authorize, demonstration and/or observations of patient during administration of medical treatment, by physicians, medical students, student nurses and any other proper student or technician whose presence is deemed appropriate by the attending physician.

The undersigned also agrees to fully comply with the rules of DHS and specifically affirm that the Director of DHS will be sole judge of such observance. They further agree that if the workforce member fails to comply with such rules, he/she may be forthwith discharge.

Release of the Information: Upon inquiry, DHS may make available to the public certain basic information about the workforce member, including name, address, age, sex, general description of the reason for treatment, general nature of the injury, and general condition. If the workforce member or workforce members' legal representative does not want such information to be released, he/she may check the box below to have the information withheld:

DO NOT release my information to the public. _____ Initials

CONTINUE ON NEXT PAGE

WORKFORCE MEMBER GENERAL CONSENT

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	EMPLOYEE/ID NO.:
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The undersigned acknowledges that all workforce members records maintained at any Los Angeles County Department of Health Services facility may be made available for workforce member care, statistical analysis, or research and/or special projects to authorized uses as needed.

The undersigned certifies that he/she has read the foregoing, receiving a copy thereof and is the patient, or duly authorized by or on behalf of the workforce member to execute the above and accept its terms.

WORKFORCE MEMBER OR RESPONSIBLE PERSON SIGNATURE		DATE	TIME
WITNESS SIGNATURE		DATE	TIME
WITNESS (PRINT NAME)		RELATIONSHIP TO WORKFORCE MEMBER	
EHS STAFF (PRINT)	EHS SIGNATURE	DATE	TIME