Atrium Health
Preparation for Your Health Assessment

Before you begin employment with Atrium Health, all new hires are required to pass a health screening performed by one of our Teammate Health offices.

The health screening is free and is for your protection and the protection of our patients. This may take up to 2 hours.

Please bring the following to your appointment.

- Document (s) that prove your authorization to work in the United States for completion of the I-9 Form (work authorization form). Refer to list of acceptable documents provided by your recruiter. Photo ID is required for drug screen.

- Immunization Records: **Measles, Mumps and Rubella** (record of 2 vaccination dates or positive titers). **Varicella** (record of 2 vaccination dates or positive titer). You may locate these records at your physician's office, college student health office, high school transcript, county health department, military or other hospitals/institutions that vaccinated you or tested you. Other records may be requested depending on your position.

- TST (Tuberculin Skin Test): If you have a record of a negative tuberculin skin test within the last 12 months, please bring it with you. If you have ever tested positive for tuberculosis, a copy of the positive record and a negative chest x-ray (dated within the past year) is required.

- Hepatitis B vaccine series of 3 vaccines or positive titer if applicable to your job.

- A statement from your medical doctor if you are currently under the care of a physician for a chronic or serious medical problem. Examples include back injuries, anaphylactic latex allergies; undergoing any physical therapy; or have any work restrictions.

- A list of prescription medications you are currently taking.

- Prescription eyewear and/or contact lenses for the eye exam.

Important Information

- **Children**: Please do not bring children to your health assessment as childcare is not provided and CHS cannot be responsible for your child's safety.

- **Pending**: If any required information is not provided at the time of your health assessment, you will not be permitted to attend orientation until the information is brought to Teammate Health. All items are due to Teammate Health no later than 5:00 PM on Wednesday for the following Monday orientation.

- Your exam will consist of a health history, an eye exam, vital signs, vaccinations, urine drug screen, tuberculin skin test (TST), respirator fit testing for a HEPA mask (if applicable).

- If SBI/FBI fingerprints are required for your job, this will be done during your appointment. Your recruiter will notify Teammate Health if this is required.

Atrium Health

Atrium Health will begin verifying all employment eligibility electronically as of June 13, 2016. Federal law requires all employers to verify the identity and employment eligibility of all persons hired to work in the United States.

In preparation for your Health Assessment, please follow the link below to complete the electronic Form I-9 prior to your appointment. Please reference the list of acceptable I-9 documents as you are required to present the appropriate documentation at the time of your Health Assessment.

- Please logon to complete your work authorization Form I-9 online by visiting this site: www.applicationstation.com
  - Enter the Application Station Code: **CarolinasI9**
  - The code is case sensitive

- The online I-9 form should be completed prior to your health assessment appointment

- You will need to bring documents to support your work authorization to your health assessment appointment

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**8.** Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Atrium Health

TEAMMATE HEALTH
Health History Form

Last Name: _____ First Name: _____ SSN: _____-_____-_____

Date of Birth: _____/_____/_____ Current Phone #: (_____) _____- _____ Permission to leave voicemail at this number? ☐Yes or ☐No

Email address: _____ Orientation Date: _____

Department of Labor Requirements: The Department of Labor requires that employers collect certain employee data. For this purpose and to help us understand the diversity of our staff, please assist us by voluntarily answering the questions below. This will also help us ensure your benefits are set up correctly. ***Select at least one item in the multiple selection areas. "Do not leave Blank"***

1. Gender: ❑Male ❑Female ❑I do not wish to answer
2. Race/Ethnicity: ❑Black/African American ❑White ❑Native American/Alaska Native ❑Asian ❑Hispanic/Latino ❑Native Hawaiian/Other Pacific Islander ❑Two or More Races ❑I do not wish to answer
3. Military Service: ❑Yes ❑No
4. Veteran Status: ❑Disabled Veteran ❑Recently Separated Veteran ❑Armed Forces Service Medal Veteran ❑Other Protected Veteran ❑I am not a protected Veteran ❑I am a protected veteran but choose not to self-identify the classifications to which I belong ❑Other Honorably Discharged Military Service ❑Reservist ❑National Guard
5. Disability Status: ❑Yes, I have a disability (or previously had a disability) ❑No, I don't have a disability ❑I don't wish to answer

Please write the name and number of the physician we should contact in case of an emergency. *"Write None if you do not have a provider"*

Name:	Specialty:	Phone:

Documentation from healthcare provider

Documentation from healthcare provider will be needed for conditions such as ***blood pressure greater than or equal to 140/90***, ***existing communicable disease HIV, Hepatitis C, Hepatitis B*** **or if you are** ***currently under care for illness, injury or surgery***.

Do you have or have you ever been treated for the following? *(Check Yes or No for each condition.) "Do not leave blank"*

Heart Disease ❑ YES ❑ NO History of a positive TB skin test ❑ YES ❑ NO Kidney Disease ❑ YES ❑ NO Epilepsy ❑ YES ❑ NO
Lung Disease/Asthma ❑ YES ❑ NO Drug therapy for tuberculosis ❑ YES ❑ NO Hepatitis C ❑ YES ❑ NO Hepatitis B ❑ YES ❑ NO

Do you have any Immunity Problems? ❑ Yes or ❑ No *(If Yes, check appropriate box below.) "Do not leave blank"*

❑AIDS ❑Cancer ❑Chemotherapy ❑Currently taking Steroid Medications ❑History of organ transplant ❑HIV
❑Immunosuppressant Medication ❑Leukemia ❑Lupus ❑Lymphoma ❑Radiation Therapy/Treatment ❑Renal disease

Please answer the following questions: (*Check Yes or No for each.) " Do not leave blank"*

☐ Yes ☐ No	Do you wear any type of corrective lenses? ☐ Contact Lenses ☐ Prescription Glasses ☐ Non-Prescription Reading Glasses
☐ Yes ☐ No	Any hearing difficulties or hearing device?
☐ Yes ☐ No	Have you received treatment for any medical condition or injury in the past twelve (12) months? If yes, describe:

Please list all surgeries and hospitalizations that you have had in the past 12 months and approximate dates:

1. ☐ Yes ☐ No 2. ☐ Yes ☐ No 3. ☐ Yes ☐ No 4. ☐ Yes ☐ No 5. ☐ Yes ☐ No 6. ☐ Yes ☐ No 7. ☐ Yes ☐ No 8. ☐ Yes ☐ No 9. ☐ Yes ☐ No	Have you in the past 12 months or do you currently have any of the following problems? 1. Do you have areas of pain, numbness or weakness? Back shoulder neck arm wrist hand hip ankle Knee 2. Loss of balance or dizziness? _____ 3. Do you wear a brace or use an appliance? _____ 4. Recent exposures to infectious diseases? _____ 5. Cumulative trauma disorders, such as tendonitis or carpal tunnel? _____ 6. Have you ever had a back injury? If so, describe: _____ 7. Have you ever had lifting restrictions? Describe event, date: _____ 8. Have you ever been involved in a Workers' Compensation injury? 9. Based on your job description, do you currently have any physical or mental limitations and/or restrictions that would keep you from performing the essential functions of your new position? If yes, please describe or list the limitations: _____
Additional Comments	_____ _____

Atrium Health

TEAMMATE HEALTH
Health History Form

Print Name: _____ **Date**: _____

Please list all medications you are currently taking. (Include vitamins, herbs, over-the-counter medications, pain medications and opioids/narcotics). ***If you do not take any medications write None or NA. "Do not leave blank"***

Medication	Reason for Taking (Required)

Please list any allergies: ☐ **No known allergies**

❑ Medication allergies:

❑ Food allergies:

☐ **Latex, powder, vinyl, nitrile or dye allergies** → Type of Reaction: ❑ Contact – skin, rash, itching at site
❑Systemic -short of breath, red eyes, sneezing

❑ Other allergies:

Applicant Acknowledgement:

I certify that the information provided is true and accurate to the best of my knowledge. I have not misrepresented my health history.

Applicant Signature: _____ **Date**: _____

PERSONAL HEALTH MEASUREMENTS: Teammate Health Nurse Only

BP: ____/____ Pulse: ____ *(Recheck BP and/or Pulse after 1-2 minutes if not WNL: BP_____/_____ Pulse____)* **MedCenter Air Only: Weight** ____
Both eyes: 20/ _____ Left Eye: 20/_____ Right Eye: 20/_____ Color Blindness Testing: ☐ WNL ☐Not WNL
Abnormal color vision results: Document on CHS Colorblind Testing Form

Notes:

Clinician Signature/Title: _____ **Date:** _____

Initial after complete: **I9**_____ **Fit Test**_____ **Drug Screen**_____ **Fingerprints**_____ **Psych Test**_____ **PAT**_____ **Health Screen**_____

ATRIUM HEALTH
TEAMMATE HEALTH
Respirator Medical Evaluation Questionnaire

Part A Section1. **(Mandatory)** The following information must be provided by every teammate who has been selected to use any type of respirator. **Please Print**

1. Name _____ Job Title: _____ Hospital/Dept._____ Today's Date_____

2. Age _____ Gender: Male ☐ Female ☐ Height _____ft. _____in. Weight_____lbs.

3. A phone number that you can be reached by a health care professional:(____) _____ The best time to phone this number _____

4. Has your employer told you how to contact the health care professional who will review this questionnaire? Yes ☐ No ☐

5. Check the type of respirator you will use (you can check more than one category):

   a. ☐ N, R, or P disposable respirator (filter-mask, non-cartridge type only)

   b. ☐ other types (for example, half or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus)

6. Have you worn a respirator Yes ☐ No ☐ If yes, what type_____

Part B Section 2. **(Mandatory)** Question 1 through 9 below must be answered by every teammate who has been selected to use any type of respirator. (**Please check Yes or No)**

	Yes	No
1. Do you currently smoke tobacco, or have you smoked in the last month?	☐	☐
2. Have you ever had any of the following conditions?		
a. Seizures	☐	☐
b. Diabetes (sugar disease)	☐	☐
c. Allergic reactions that interfere with your breathing	☐	☐
d. Claustrophobia (fear of closed in places)	☐	☐
e. Trouble smelling odors	☐	☐
3. Have you ever had any of the following pulmonary or lung problems?		
a. Asbestosis	☐	☐
b. Asthma	☐	☐
c. Chronic bronchitis	☐	☐
d. Emphysema	☐	☐
e. Pneumonia	☐	☐
f. Tuberculosis	☐	☐
g. Silicosis	☐	☐
h. Pneumothorax (collapsed lung)	☐	☐
i. Lung cancer	☐	☐
j. Broken bones	☐	☐
k. Any chest injuries or surgeries	☐	☐
l. Any other lung problems that you've been told about	☐	☐
4. Do you currently have any of the following symptoms of pulmonary of lung illnesses?		
a. Shortness of breath	☐	☐
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline	☐	☐
c. Shortness of breath when walking with other people at an ordinary pace on ground level	☐	☐
d. Have to stop for breath when walking at your own pace on level ground	☐	☐
e. Shortness of breath when washing or dressing yourself	☐	☐
f. Shortness of breath that interferes with your job	☐	☐
g. Coughing that produces phlegm (thick sputum	☐	☐
h. Coughing that wakes you early in the morning	☐	☐
i. Coughing that occurs mostly when you are lying down	☐	☐
j. Coughing up blood in the last month	☐	☐
k. Wheezing	☐	☐
l. Wheezing that interferes with your job	☐	☐
m. Chest pain when you breathe deeply	☐	☐
n. Any other symptoms that you think may be related to lung problems	☐	☐

	Yes	No
5. Have you ever had any of the following cardiovascular or heart problems?		
a. Heart attack	☐	☐
b. Stroke	☐	☐
c. Angina	☐	☐
d. Heart failure	☐	☐
e. Swelling in your legs or feet (not caused by walking)	☐	☐
f. Heart arrhythmia (heart beating irregularly)	☐	☐
g. High blood pressure	☐	☐
h. Any other heart problem that you've been told about	☐	☐
6. Have you ever had any of the following cardiovascular or heart symptoms?		
a. Frequent pain or tightness in your chest	☐	☐
b. Pain or tightness in your chest during physical activity	☐	☐
c. Pain or tightness in our chest that interferes with your job	☐	☐
d. In the past two years, have you noticed your heart skipping or missing a beat	☐	☐
e. Heartburn or indigestion that is not related to eating	☐	☐
f. Any other symptoms that you think may be related to heart or circulation problems	☐	☐
7. Do you currently take medication for any of the following problems?		
a. Breathing or lung problems	☐	☐
b. Heart trouble	☐	☐
c. Blood pressure	☐	☐
d. Seizures	☐	☐
8. Has your wearing a respirator caused any of the following problems? If you never used a respirator, check the following space☐ and go to question 9		
a. Eye irritation	☐	☐
b. Skin allergies or rashes	☐	☐
c. Anxiety that occurs only when you use the respirator	☐	☐
d. Usual weakness or fatigue	☐	☐
e. Any other problem that interferes with your use of a respirator	☐	☐
9. Would you like to talk to the health care professional who will review this questionnaire about the answers to this questionnaire?	☐	☐

Teammate Health Use Only

I have reviewed the respirator medical evaluation questionnaire. If applicable, a copy of my written opinion and recommendations, including relevant medical examinations and tests is attached.

_____ _____ _____

Evaluating Licensed Health Care Professional Signature | Print Name | Date

Atrium Health Teammate Health

Teammate Health Demographics Form

Name: _____

1. **Gender:**
   - ☐Male
   - ☐Female
   - ☐I do not wish to answer

2. **Race/Ethnicity:**
   - ☐Black/African American
   - ☐White
   - ☐Native American/Alaska Native
   - ☐Asian
   - ☐Hispanic/Latino
   - ☐Native Hawaiian/Other Pacific Islander
   - ☐Two or More Races
   - ☐I do not wish to answer

3. **Military Service:**
   - ☐Yes
   - ☐No

4. **Veteran Status:**
   - ☐Disabled Veteran
   - ☐Recently Separated Veteran
   - ☐Armed Forces Service Medal Veteran
   - ☐Other Protected Veteran
   - ☐I am not a protected Veteran
   - ☐I am a protected veteran but I choose not to self-identify the classifications to which I belong
   - ☐Other Honorably Discharged Military Service
   - ☐Reservist
   - ☐National Guard

5. **Disability Status: please check one of the boxes below:**
   - ☐Yes, I have a disability (or previously had a disability)
   - ☐No, I don't have a disability
   - ☐I don't wish to answer

TEAMMATE HEALTH USE ONLY- Place check beside completed items

Nurse _____

Drug Screen _____

Fit Test _____

Finger Prints _____

Psychological Test _____

Physical Ability Test (PAT) _____ Other_____

Atrium Health