

Carolinas HealthCare System

Preparation for Your Health Assessment

All new hires are required to pass a health screening performed by our Teammate Health department. 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:

- **Two forms of ID** for completion of the work authorization I-9 form. This form should be completed electronically prior to your health assessment (www.applicationstation.com) using the code: "CarolinasI9". The code is case sensitive.

Refer to the attached list of acceptable identification documents.

- **Completed Forms:** Health History Form, Respirator Evaluation Questionnaire, and Teammate Health Demographics Form.
- **Photo ID** is required for drug screen.
- **Immunization Records** for **Measles, Mumps and Rubella** (record of the vaccine or titers) and **Varicella** (record of 2 vaccination dates or positive titer). If you do not have these records, the vaccine will be provided at your health assessment. 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** if applicable to your job.
- **A statement from your medical doctor** if you have been under care for a chronic or serious medical problem (i.e. - back injuries, anaphylactic latex allergies, undergoing any physical therapy) or if you 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 start work or attend orientation until the information is brought to Teammate Health. All items are due to Teammate Health no later than 5:00 PM on Thursday for the following Monday orientation.
- Your exam will be performed by one of our Teammate Health nurses and will consist of an overall physical exam (*you will not get undressed*), eye exam, vital signs, vaccinations (*if applicable*), urine drug screen, tuberculin skin test (TST), Fit Testing for 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.



Carolinus HealthCare System

Carolinus HealthCare System 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 **attached list of acceptable I-9 documents** as you are required to present the appropriate documentation at the time of your Health Assessment.

- Please log-on to complete your work authorization Form I-9 online by visiting this site: www.applicationstation.com
 - Enter the Application Station Code: **CarolinusI9**
 - 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
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (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. 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 	OR	<ol style="list-style-type: none"> 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 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 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <li style="text-align: center;">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 	AND	<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 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. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security



CAROLINAS HEALTHCARE SYSTEM
TEAMMATE HEALTH
 Health History Form

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

Date of Birth: ___/___/___ Age: _____ Mailing Address: _____

Preferred telephone contact: _____ Alternate Telephone Contact: _____

Orientation Date: ___/___/___ Recruiter: _____ Manager: _____

Job Title: _____ Department: _____ Facility: _____

Please write the name and number of the physician we should contact in case of an emergency.

Name:	Specialty:	Phone:
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Please check if you have now or had in the past any of the following medical conditions:

High Blood Pressure	<input type="checkbox"/> YES <input type="checkbox"/> NO	Chicken Pox/Shingles	<input type="checkbox"/> YES <input type="checkbox"/> NO
Kidney Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Measles	<input type="checkbox"/> YES <input type="checkbox"/> NO
Heart Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Rubella	<input type="checkbox"/> YES <input type="checkbox"/> NO
Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO	Mumps	<input type="checkbox"/> YES <input type="checkbox"/> NO
Epilepsy	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hepatitis B	<input type="checkbox"/> YES <input type="checkbox"/> NO
Lung Disease/Asthma	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hepatitis C	<input type="checkbox"/> YES <input type="checkbox"/> NO
Any eczema/skin problems	<input type="checkbox"/> YES <input type="checkbox"/> NO	Tetanus	<input type="checkbox"/> YES <input type="checkbox"/> NO
Drug or Alcohol Problem	<input type="checkbox"/> YES <input type="checkbox"/> NO	Rabies	<input type="checkbox"/> YES <input type="checkbox"/> NO
Emotional Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO	Positive TB Skin Test	<input type="checkbox"/> YES <input type="checkbox"/> NO
Immunity Problems (Lupus, HIV, Chemotherapy)	<input type="checkbox"/> YES <input type="checkbox"/> NO	Drug Therapy for TB	<input type="checkbox"/> YES <input type="checkbox"/> NO
		BCG Vaccine	<input type="checkbox"/> YES <input type="checkbox"/> NO

Chronic health conditions or concerns: _____

Please complete the following questions:

Please check the reason you are completing this health screening:	New Employee <input type="checkbox"/> Student <input type="checkbox"/>
<input type="checkbox"/> Yes <input type="checkbox"/> 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 and approximate date: _____

<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you or do you currently have any of the following problems? ♦ Do you have areas of pain, numbness or weakness: shoulder neck arm wrist hand hip ankle back ♦ Loss of balance or dizziness? _____ ♦ Do you wear a brace or use an appliance? _____ ♦ Experience any breathing difficulties? _____ ♦ Recent exposures to infectious diseases? _____ ♦ Cumulative trauma disorders, such as tendonitis or carpal tunnel? _____ ♦ Have you ever had a back injury? If so, describe: _____ ♦ Have you ever had lifting restrictions? Describe event, date: _____ ♦ 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: _____
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<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently under the care of a healthcare provider (doctor, chiropractor, pain management, etc.)? If yes, for what condition(s)?
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<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been involved in a Workers' Compensation injury?
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CAROLINAS HEALTHCARE SYSTEM
TEAMMATE HEALTH
 Health History Form

HEALTH HISTORY FORM, page 2

Name: _____

<input type="checkbox"/> Yes <input type="checkbox"/> No	Were you exposed to hazards during previous work assignments? This could include chemicals/cleaning compounds, radiation, dust or other respiratory hazards, excessive sun, infectious disease or bloodborne pathogen potential, etc. If yes, please describe: _____
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<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you suffered from heat intolerance? If so, describe event: _____
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<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had special hearing or vision testing because of previous work hazards? _____
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Please list all medications you are currently taking. (Include vitamins, herbs, over-the-counter medications, pain medications and narcotics)

Medication	Dosage/Frequency	Reason for Taking

Please list any allergies: No known allergies

Medication allergies:

Food allergies:

Latex, powder, vinyl, nitrile or dye allergies:

Other allergies:

PERSONAL HEALTH MEASUREMENTS: Teammate Health Nurse Only

BP: ____/____ Pulse: ____ Hearing: WNL Not WNL **MedCenter Air Only: Weight** ____

Vision: glasses/contact lenses/no correction Both eyes: 20/____ Left Eye: 20/____ Right Eye: 20/____

Have you had corrective surgery on your eyes: Yes No _____

Color Blindness Testing: WNL Not WNL Abnormal results: Document on CHS Colorblind Testing Form

Nurse notes

Teammate Signature: _____

Date: _____

Teammate Health Nurse: _____

Date: _____

**CAROLINAS HEALTHCARE SYSTEM
TEAMMATE HEALTH
Respirator Medical Evaluation Questionnaire**

Part A Section 1. **(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		Yes	No
1. Do you currently smoke tobacco, or have you smoked in the last month?	<input type="checkbox"/>	<input type="checkbox"/>	5. Have you ever had any of the following cardiovascular or heart problems?		
2. Have you ever had any of the following conditions?			a. Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
a. Seizures	<input type="checkbox"/>	<input type="checkbox"/>	b. Stroke	<input type="checkbox"/>	<input type="checkbox"/>
b. Diabetes (sugar disease)	<input type="checkbox"/>	<input type="checkbox"/>	c. Angina	<input type="checkbox"/>	<input type="checkbox"/>
c. Allergic reactions that interfere with your breathing	<input type="checkbox"/>	<input type="checkbox"/>	d. Heart failure	<input type="checkbox"/>	<input type="checkbox"/>
d. Claustrophobia (fear of closed in places)	<input type="checkbox"/>	<input type="checkbox"/>	e. Swelling in your legs or feet (not caused by walking)	<input type="checkbox"/>	<input type="checkbox"/>
e. Trouble smelling odors	<input type="checkbox"/>	<input type="checkbox"/>	f. Heart arrhythmia (heart beating irregularly)	<input type="checkbox"/>	<input type="checkbox"/>
			g. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
			h. Any other heart problem that you've been told about	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had any of the following pulmonary or lung problems?			6. Have you ever had any of the following cardiovascular or heart symptoms?		
a. Asbestosis	<input type="checkbox"/>	<input type="checkbox"/>	a. Frequent pain or tightness in your chest	<input type="checkbox"/>	<input type="checkbox"/>
b. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	b. Pain or tightness in your chest during physical activity	<input type="checkbox"/>	<input type="checkbox"/>
c. Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	c. Pain or tightness in our chest that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>
d. Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	d. In the past two years, have you noticed your heart skipping or missing a beat	<input type="checkbox"/>	<input type="checkbox"/>
e. Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	e. Heartburn or indigestion that is not related to eating	<input type="checkbox"/>	<input type="checkbox"/>
f. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	f. Any other symptoms that you think may be related to heart or circulation problems	<input type="checkbox"/>	<input type="checkbox"/>
g. Silicosis	<input type="checkbox"/>	<input type="checkbox"/>			
h. Pneumothorax (collapsed lung)	<input type="checkbox"/>	<input type="checkbox"/>			
i. Lung cancer	<input type="checkbox"/>	<input type="checkbox"/>			
j. Broken bones	<input type="checkbox"/>	<input type="checkbox"/>			
k. Any chest injuries or surgeries	<input type="checkbox"/>	<input type="checkbox"/>			
l. Any other lung problems that you've been told about	<input type="checkbox"/>	<input type="checkbox"/>			
4. Do you currently have any of the following symptoms of pulmonary or lung illnesses?			7. Do you currently take medication for any of the following problems?		
a. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	a. Breathing or lung problems	<input type="checkbox"/>	<input type="checkbox"/>
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline	<input type="checkbox"/>	<input type="checkbox"/>	b. Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>
c. Shortness of breath when walking with other people at an ordinary pace on ground level	<input type="checkbox"/>	<input type="checkbox"/>	c. Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
d. Have to stop for breath when walking at your own pace on level ground	<input type="checkbox"/>	<input type="checkbox"/>	d. Seizures	<input type="checkbox"/>	<input type="checkbox"/>
e. Shortness of breath when washing or dressing yourself	<input type="checkbox"/>	<input type="checkbox"/>	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		
f. Shortness of breath that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>	a. Eye irritation	<input type="checkbox"/>	<input type="checkbox"/>
g. Coughing that produces phlegm (thick sputum)	<input type="checkbox"/>	<input type="checkbox"/>	b. Skin allergies or rashes	<input type="checkbox"/>	<input type="checkbox"/>
h. Coughing that wakes you early in the morning	<input type="checkbox"/>	<input type="checkbox"/>	c. Anxiety that occurs only when you use the respirator	<input type="checkbox"/>	<input type="checkbox"/>
i. Coughing that occurs mostly when you are lying down	<input type="checkbox"/>	<input type="checkbox"/>	d. Usual weakness or fatigue	<input type="checkbox"/>	<input type="checkbox"/>
j. Coughing up blood in the last month	<input type="checkbox"/>	<input type="checkbox"/>	e. Any other problem that interferes with your use of a respirator	<input type="checkbox"/>	<input type="checkbox"/>
k. Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	9. Would you like to talk to the health care professional who will review this questionnaire about the answers to this questionnaire?	<input type="checkbox"/>	<input type="checkbox"/>
l. Wheezing that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>			
m. Chest pain when you breathe deeply	<input type="checkbox"/>	<input type="checkbox"/>			
n. Any other symptoms that you think may be related to lung problems	<input type="checkbox"/>	<input type="checkbox"/>			

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

CHS 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 _____

