JOHNS HOPKINS
UNIVERSITY & MEDICINE

JOHNS HOPKINS OCCUPATIONAL HEALTH

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF HEALTH INFORMATION

All items on this authorization must be completed or the request will not be honored. Use "N/A" if not applicable.

Name: _____ **Birth Date:** _____
(first) (m. initial) (last)

Address: _____ **Phone #:** _____
(street address)

_____ **Medical Record #** (if known)**:** _____
(city) (state) (zip code)

For purposes of this authorization, "My Health Information" means the health information held in my Johns Hopkins Occupational Health records. My Johns Hopkins Occupational Health records may include, but is not limited to health questionnaire or history, tests performed, drug screens, test results, vaccination status, inability or ability to work, work limitations, rehabilitation information, and medical complaints related to exposure to hazardous substances and diagnosis.

I authorize Johns Hopkins Occupational Health to disclose My Health Information for any safety and/or job-related purpose to the staff (for example, supervisor, Human Resources representative, medical review officer, and legal counsel) of my employer. My employer may include, Johns Hopkins Health System Corporation and/or The Johns Hopkins University ("Johns Hopkins") or their affiliates, my agency staff employer, the volunteer office, and/or the medical staff office or the Johns Hopkins employer where I am or where I am applying to be credentialed, employed, or a volunteer. I further authorize Johns Hopkins Occupational Health to disclose My Health Information in any and all employment related proceedings. Employment related proceedings may include, but are not limited to, workers compensation claims, unemployment insurance proceedings and/or other local, State or federal regulatory agency complaint proceedings arising during or after my employment.

This Authorization is valid until _____ (not to exceed 1 year in Maryland), unless I revoke/withdraw this Authorization. If no date is included in the blank, this Authorization will expire one year after the date it is signed.

I may revoke this authorization at any time in writing by mailing or faxing my written request, along with a copy of this authorization if possible, to the location where I obtained my employment or volunteer related screening. My revocation will not affect any disclosures that occurred prior to the location receiving my revocation.

Signature of Patient Only: _____ **Date**:_____
(Required)

If you are NOT the patient but are signing on behalf of the patient, complete the following:

I, _____**, am the (circle which applies)**
(print your name)

- **Parent with Parental Rights**
- **Registered Kinship Care Relative**
- **Court Appointed Guardian**
- **Legally Appointed Healthcare Agent**
- **Medical Power of Attorney**
- **Power of Attorney with Right to See Medical Records**

Representative's Signature: _____ **Date**:_____
(Required)

Address: _____ **Phone**:_____

You must attach proof of your authority to act on behalf of the patient as circled above (other than parent).

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REGISTRATION FOR OCCUPATIONAL HEALTH

Please Print

SSN: _____ DATE OF BIRTH: _____ GENDER: _____

NAME: _____
First Middle Last

ADDRESS: _____
Number Street Apt #

_____
City State Zip

CELL PHONE: _____ EMAIL: _____

PREFERRED LANGUAGE: _____

EMERGENCY CONTACT NAME: _____

EMERGENCY CONTACT PHONE: _____

RELATIONSHIP TO EMPLOYEE: _____

Have you ever been employed by the Johns Hopkins Hospital or University? ◯NO ◯YES

If Yes, Location: _____

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OCCUPATIONAL HEALTH

PLEASE READ THE FOLLOWING IMPORTANT INFORMATION CAREFULLY

Why am I being asked to complete a Health Questionnaire?
You have accepted a conditional offer of employment. The offer is contingent upon the conditions listed in your offer letter, including being cleared by Occupational Health, which requires the following:

a) Satisfactory completion and review of the Health Questionnaire;
b) Satisfactory completion and review of any required medical examination or follow-up;
c) Timely submission of any supporting documentation requested;
d) Confirmation of your ability to perform the essential functions of the position with or without accommodations.

Completion of the Health Questionnaire is not intended to diagnose or treat any condition you may have or create a provider-patient relationship. The Questionnaire will be used to determine your ability to perform job-related functions, whether any restrictions or reasonable accommodations may be necessary or whether you can perform the job without posing a direct threat to the health or safety of yourself or others in the workplace.

Upon successful completion of the criteria listed above, you will be cleared by Occupational Health.

Occupational Health Contacts

Johns Hopkins All Children's Hospital Campus 500 Seventh Ave S., Suite: 103 St. Petersburg, FL 33701 **Phone:** 727-767-4190 **Fax**: 727-767- 8399 **Email:** ach-occhealth@jhmi.edu	**Johns Hopkins Bayview Medical Center Campus** 5300 Alpha Commons Dr, Suite 105 Baltimore, MD 21224 **Phone:** 410-550-0477 **Fax**: 410-550-0732 **Email:** ohsclinic@jhmi.edu	**East Baltimore Campus** 98 N. Broadway, Suite: 421 Baltimore, MD 21231 **Phone:** 410-955-6211 **Fax**: 410-955-1617 **Email:** ohsoffice@jhmi.edu	**Homewood Campus** 1101 East 33rd Street, Rm. C-160 Baltimore, MD 21218 **Phone:** 443-997-1700 **Fax:** 443-997-1701 **Email:** OHS-Homewood@jh.edu
Howard County Campus 11085 Little Patuxent Pkwy, Suite: 104 Columbia, MD 21044 **Phone:** 410-740-7838 **Fax**: 410-740-7685 **Email:** hcghemployeehealth@jhmi.edu	**Johns Hopkins Health Care at Live Well Clinic** 7231 Parkway Drive, Suite: 100 Hanover, MD 21076 **Phone**: 410-424-4886 **Fax**: 410-762-5965 **Email**: jpaydo@jhhc.com	**Sibley Memorial Hospital Campus** 5255 Loughboro Rd. NW, Building B, Ground Floor Washington, DC 20016 **Phone:** 202-537-4265 **Fax**: 202-537-4442 **Email:** SMH-Occ-Health@jh.edu	**Suburban Hospital Campus** 8600 Old Georgetown Rd, 4th floor Bethesda, MD 20814 **Phone:** 301-896-3167 **Fax:** 301-897-1355 **Email:** shemployeehealth@jhmi.edu

Disclosure:
Do not provide any genetic information when completing this questionnaire or when reviewing the questionnaire with a representative of Occupational Health. Genetic information includes your family medical history, the results of your or your family members' genetic tests, the fact that you or a family member sought or received genetic services, or genetic information of a fetus carried by you or a family member or an embryo lawfully held by you or a family member receiving assistive reproductive services.

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Occupational Health Post-Offer Health History Questionnaire

Last Name: _____ First Name:_____ MI: _____

Date of Birth_____ Email:_____

Position:_____ Department:_____

Contact Phone Numbers (Cell): _____ (Home): _____

Allergies: ☐ I have no known allergies.

OR I have the following allergies:

☐ Latex Explain Reaction:_____

☐ Other Explain: _____

Medications & Supplements:

Are you taking any medications or supplements that could impair your ability to do your job?

☐ No

If yes, please list below:

_____
_____
_____
_____

Are you taking any medications or supplements that could affect you such that you may need to be restricted from working in certain areas?

☐ No

If yes, please list below:

_____
_____
_____
_____

Prior Injuries or limitations:

☐ I have no known injuries or limitations that will affect my performing the duties of my job.

OR list Present or Anticipated Limitations:

_____
_____
_____
_____

Accommodations: I have read the job description for which I have been offered conditional employment.
I can perform the job tasks and functions essential to this job:

☐ without reasonable accommodations.

☐ with reasonable accommodations.

If you need to request a reasonable accommodation, please indicate what specific accommodations are needed and the reason why they are necessary:

_____
_____
_____
_____

Candidate Verification:
I certify that this information is true and complete to the best of my knowledge. I understand that giving false information may result in dismissal. I understand that this health screening does not constitute a complete and comprehensive medical exam. I also understand that any abnormal findings that may interfere with my work performance, or the safety of patients or hospital employees, is identified, this may be discussed with my supervisors and Human Resource personnel if necessary.

_____ _____
(Candidate Signature) (Date)

Provider Verification:
I have reviewed the Post-Offer Health History Questionnaire and the job tasks with the candidate and addressed their questions and/or need for an accommodation.

Comments:
_____
_____
_____

_____ _____
(Clinician Signature) (Date)

Johns Hopkins Health System and affiliates and Johns Hopkins University are Equal Opportunity / Affirmative Action employers. All qualified applicants will receive considerations for employment without regard to race, color, religion, sex, sexual orientation, gender identity and expression, age, national origin, mental or physical disability, genetic information, veteran status, or any other status protected by federal, state and local law.
Johns Hopkins Health system and its affiliates are drug-free workplace employers.

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Respirator Medical Evaluation Questionnaire

The following questionnaire is part of the respiratory protection program requirements.
To the employee: Can you read (check one): ☐ Yes ☐ No

Part A Section 1. (Mandatory)
Name: _____ **Date:** _____ **Last 4 of SSN#**: _____
Age: _____ **Sex:** ☐ male ☐ Female **Height**:_____ **Weight (lbs)**: _____
Job Title: _____ **Phone Number**: _____
Check the type of respirator you will use (you can check more than one category):

☐ N, R or P disposable respirator (filter mask, non-cartridge type only)
☐ Other (half/full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

Part A. Section 2. (Mandatory) Must be answered by every employee who has been selected to use any type of respirator.

1. **Do you currently smoke tobacco or have you smoked tobacco in the last month**? ☐ Yes ☐ No

2. **Have you ever had any of the following conditions**?

Seizures	☐ Yes	☐ No
Diabetes (sugar disease	☐ Yes	☐ No
Allergic reactions that interfere with your breathing	☐ Yes	☐ No
Claustrophobia (fear of closed-in places)	☐ Yes	☐ No
Trouble smelling odors	☐ Yes	☐ No

3. **Have you ever had any of the following pulmonary or lung problems**?

Asbestosis	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Chronic Bronchitis	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No
Pneumonia	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Silicosis	☐ Yes	☐ No	Pneumothorax	☐ Yes	☐ No
Lung Cancer	☐ Yes	☐ No	Broken Ribs	☐ Yes	☐ No

Any chest injuries or surgeries: _____
Lung problem that you've been told about: _____

4. **Do you currently have any of the following symptoms of pulmonary or lung illness**?

Shortness of breath (SOB)	☐ Yes	☐ No
SOB when walking fast on level ground or up a slight hill	☐ Yes	☐ No
SOB when walking on level ground at an ordinary pace	☐ Yes	☐ No
Have to stop for breath when walking at own pace	☐ Yes	☐ No
SOB when washing or dressing self	☐ Yes	☐ No
SOB that interferes with your job	☐ Yes	☐ No
Coughing that produces phlegm (thick sputum)	☐ Yes	☐ No
Coughing that wakes you early in the morning	☐ Yes	☐ No
Coughing that occurs mostly when you are lying down	☐ Yes	☐ No
Coughing up blood in the last month	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No
Wheezing that interferes with your job	☐ Yes	☐ No
Chest pain when you breathe deeply	☐ Yes	☐ No

List any other symptoms that you may have that you think are related to lung problems:

_____

5. **Have you ever had any of the following cardiovascular or heart problems**?

Heart attack	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Angina:	☐ Yes	☐ No
Heart failure	☐ Yes	☐ No
Heart palpitations	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Leg or feet swelling (not caused by walking)	☐ Yes	☐ No
Frequent pain/ chest tightness that interferes with your job	☐ Yes	☐ No
Pain or chest tightness during physical activity	☐ Yes	☐ No
Heartburn or indigestion that is not related to eating	☐ Yes	☐ No
In the past 2 years have you noticed your heart missing a beat or skipping	☐ Yes	☐ No

Any other symptoms that you think may be related to heart or circulation problems:

_____

6. **Do you currently take medication for any of the following problems**?

Breathing or lung problems	☐ Yes	☐ No
Heart Trouble	☐ Yes	☐ No
Blood Pressure	☐ Yes	☐ No
Seizures	☐ Yes	☐ No

7. **Have you worn a respirator in the past**? ☐ Yes ☐ No ***(If "NO", go to question 8)***

If you have used a respirator in the past, have you had any of the following problems?

Eye irritation	☐ Yes	☐ No
Skin allergies or rashes from mask	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
General weakness or fatigue	☐ Yes	☐ No
Any other problem that interferes with your respirator use	☐ Yes	☐ No

Please explain any "YES" answers: _____

8. **Would you like to talk to the health care professional that will review this respiratory questionnaire**? ☐ Yes ☐ No

SUPPLEMENTAL: If you are selected to use a full-facepiece respirator or a Self-Contained Breathing Apparatus (SCBA), you must complete the following questions: (*If not, please sign below*)

9. **Have you ever lost vision in either eye?** ☐ Yes ☐ No

10. **Do you *currently* have any of the following vision problems**?

Wear contact lenses	☐ Yes	☐ No	Wear glasses	☐ Yes	☐ No
Color blind	☐ Yes	☐ No			
Any other eye or vision problem	☐ Yes	☐ No			

11. **Have you ever had an injury to your ears, including a broken ear drum?** ☐ Yes ☐ No

12. **Do you currently have any of the following hearing problems?**

Difficulty hearing	☐ Yes	☐ No
Wear a hearing aid	☐ Yes	☐ No
Any other hearing or ear problem	☐ Yes	☐ No

13. **Have you ever had a back injury?** ☐ Yes ☐ No

14. **Do you currently have any of the following musculoskeletal problems?**

Back pain	☐ Yes	☐ No
Weakness in any of your arms, hands, legs, or feet	☐ Yes	☐ No
Difficulty fully moving your arms and legs	☐ Yes	☐ No
Pain/stiffness when you lean forward or backward at your waist	☐ Yes	☐ No
Difficulty fully moving your head up and down	☐ Yes	☐ No
Difficulty fully moving your head side to side	☐ Yes	☐ No
Difficulty bending at your knees	☐ Yes	☐ No
Difficulty squatting to the ground	☐ Yes	☐ No
Difficulty climbing a flight of stairs or ladder carrying more than 25lbs	☐ Yes	☐ No
Any other muscular/skeletal problem that interferes with using a respirator	☐ Yes	☐ No

Employee Signature: _____ **Date**: _____

Thank you for taking the time to complete this questionnaire. **Please do not write below this line.**

Clinician Signature: _____ **DATE**: _____

*Employees working in certain designated roles should also complete Respiratory Medical Evaluation Questionnaire-**Part B**.*

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Occupational Health Tuberculosis (TB) Screening

First Name _____ **Last Name**_____ **Date of Birth:** _____

Home Address: _____**City:** _____**State:**_____ **Zip:**_____

Last 4 SS#: _____ **Cell phone #**_____**Work #** _____ **Email:**_____

1. Have you EVER had a positive TB test result (via skin testing or through T-spot or Quantiferon blood testing)? ☐ YES ☐ NO ☐ UNSURE

2. Date of last TB Testing:_____ Result:_____ If this result was *positive* was this a conversion? ☐ YES ☐ NO ☐ UNSURE

3. Have you ever needed a chest x-ray due to TB Testing? ☐ YES ☐ NO *If *YES*-date of last chest x-ray:_____ Results:_____

4. Have you ever lived outside the U. S. for more than 1 month? ☐ YES ☐ NO *If *YES*-which countries:_____

5. Country of Birth: _____ Have you had the BCG vaccine (a vaccine for TB): ☐ YES ☐ NO ☐ UNSURE

6. Do you have a weakened immune system or are you currently taking any immunosuppressive medication? This can be caused by steroids, chemotherapy, medications for rheumatologic disease, OR because of having cancer, an organ transplant, major stomach surgery or uncontrolled diabetes. ☐ YES ☐ NO ☐ UNSURE

7. Have you had close contact with someone who has had infectious TB disease since your last TB test? ☐ YES ☐ NO ☐ UNSURE

8. Have you ever had Tuberculosis? ☐ YES ☐ NO ☐ UNSURE Did you ever take medication for TB? ☐ YES ☐ NO ☐ UNSURE
*If "*YES*", Medication Name/How Long Taken: _____

9. Have you ever been told to never get any more TB Skin tests? ☐ YES ☐ NO

10. Do you have any of the following symptoms during the past year for more than 2 weeks not associated with a specific illness? ☐ **NONE**

☐ Chest pain ☐ Fatigue/weakness ☐ Persistent fever (over many days > 100.4 F)

☐ Soaking night sweats ☐ Chronic cough lasting more than 3 weeks ☐ Loss of appetite

☐ Coughing up phlegm or blood ☐ Difficulty breathing/wheezing ☐ Unexplained weight loss of more than 5 pounds

***Signature:** _____ **Date:**_____

Clinician Name/Signature:_____ **Date:**_____

FOR OFFICE USE ONLY

*	
	Reason for Test: **Pre-employment:** ☐ 1st ☐ 2nd ☐ **Annual** ☐ **AESP** ☐ **Exposure:** ☐ Baseline ☐ Post
1	**Tuberculin Skin Test** Date placed Site Administered by (PRINT) Manufacturer Lot # Exp. Date Date read NEG mm induration (No Induration = 0 mm) POS Appearance Reader
2	**IGRA** Date Collected: _____ Time Collected: _____ AM PM Collected by:_____ # of Tubes:_____ RESULT:_____ Reviewed by Staff (Initials): _____
3	**Known Positive Symptom Review:** ☐ Symptom Review Completed ☐ CXR date:_____ Result: _____ Staff initials: _____
4	**Follow-up for Positive Result:** Date CXR completed:_____ Result: _____ Health Department notified per state guidelines (date/staff initials): _____
5	Surveillance Program based off of TB screening: ☐ Yes ☐ No If yes: ☐ Annual TB Screening (KPR, High Risk Staff) OR ☐ Annual TB screening & TB testing per current protocols *Annual TST or IGRA is not indicated except for designated high-risk groups based on the facility risk assessment and recommendations.