HEALTH HISTORY QUESTIONAIRE ASSESSMENT

This form is to help determine your capability of performing your job functions at Howard County General Hospital.

___ Male ___ Female Next of Kin/Emergency Contact & Phone Number

Past	Present	Never	CHEST & LUNGS
			Chronic lung disease
			Bronchitis
			Emphysema
			Pneumonia
			Chronic Cough
			Coughing of blood
			Tightness or constriction
			Cough up a lot of phlegm
			Pneumothorax
			Wheeze or have to gasp to breath
			Night sweats
			Have you ever breathed in hazardous airborne chemicals (gases/fumes/dust)?
			Broken ribs/Chest injury/surgeries
			Tuberculosis
			Asbestos
			Lung cancer
Past	**Present**	**Never**	**CARDIOVASCULAR (Heart)**
			Heart pain at rest
			Heart pain on exertion (angina)
			Radiation of pain to arms, jaw or back
			Fast pulse
			Irregular heartbeat/Palpitations
			High blood pressure
			Heart attack/Heart failure
			Swollen arms/legs
			Varicose veins
			Clots in veins
			Poor circulation in fingers/toes
			Stroke
			Heart surgery
			Rheumatic fever
			Heart murmur
			Abnormal EKG
			High Blood Cholesterol Heart disease
Past	**Present**	**Never**	**THROAT**
			Persistent hoarseness
			Difficulty swallowing
			Consistent sore throats
			Infections or disease
			Tumors or lumps in throat
			Hyperthyroidism
			Hypothyroidism
Past	**Present**	**Never**	**EARS**
			Middle ear infection
			Ringing in ears
			Hearing loss
			Draining of eardrum
			Other ear disease
			Hearing aid
Past	**Present**	**Never**	**NOSE**
			Disease of nose
			Loss of smell
			Frequent nosebleeds
			Sinusitis
			Discharge with pus
			Ulcer of nasal septum
Past	**Present**	**Never**	**PREGNANCY**
			If current - how many weeks & delivery date

Past	Present	Never	EYES
			Inflammation
			Excessive tearing
			Blurring of vision
			Hemorrhage
			Pains
			Blind spots
			Double vision
			Cataracts
			Glaucoma
			Color vision problems
			Do you wear glasses or contacts?
			If so, to see far or near?
			Eye prosthesis?
Past	**Present**	**Never**	**MOUTH**
			Dentures or plates
			Bleeding/sore gums or mouth
			Disease of mouth or lips
			Loss of taste
			Discoloration or white areas
Past	**Present**	**Never**	**NEUROLOGY & PSYCHIATRY**
			Nervous breakdown
			Mood swings
			Depression
			Anxiety
			Bipolar disorder
			Psychiatric disorder
			Attention deficit disorder
			Learning disability
			Multiple sclerosis
			Numbness/tingling in hands/feet, neuropathy
			Severe dizziness
			Blackout/Fainting spells
			Unconsciousness, altered consciousness
			Convulsions, Seizures, or Epilepsy
			Difficulty with speech
Past	**Present**	**Never**	**URINARY**
			Trouble urinating
			Poor bladder control
			Frequent urination
			Blood or pus in urine
			Kidney stones
			Bladder infections
			Chronic kidney disease, dialysis
Past	**Present**	**Never**	**HEMATOLOGY (blood) & ENDOCRINE**
			Immunodeficiency/Low immune functioning
			Chronic fatigue
			High blood sugar/Diabetes
			Excessive red blood cells
			Anemia (low blood count)
			Leukemia, Lymphoma, Cancer, tumor
			Sickle Cell Disease
			Hodgkins'Disease
			Bleeding disorder
			Hemophilia
			Bruise easily
			Blood transfusion – when/year?

Past	Present	Never	SKIN
			Inflammation
			Hives
			Rash
			Allergic reaction
			Eczema
			Contact dermatitis
			Cracked or thickened skin
			Psoriasis or other skin disease
			Frequent cold sores
			Frequent skin contact with hazardous chemicals
Past	**Present**	**Never**	**LATEX RISK ASSESSMENT**
			Atopic, eczema
			Asthma, reactive airway disease
			Contact dermatitis
			Food allergies (banana, kiwi, water chestnuts, drupe)
			Symptomatic when exposed to latex products at home, work, surgery or dental procedure
			Itching, swelling of lips or face
			Sneezing, rhino-conjunctivitis
			Hives, wheezing, chest tightness, tachycardia
			Anaphylactic allergic reaction during surgery, medical, or dental procedure
			IgE mediated, immediate-type, contact urticarial
Past	**Present**	**Never**	**GASTROINTESTINAL (*Stomach, Intestines*)**
			Excessive weight change
			Cancer of bowel or stomach
			Cirrhosis or enlarged liver
			Abnormal liver tests
			Constipation (frequent or chronic)
			Diarrhea (frequent or chronic)
			Rectal fissure or fistulae
			Hemorrhoids
			Bowel or stomach tumors
			Jaundice
			Gall bladder disease
			Black or bloody stool
			Change in bowel habits
			Colitis
			Diverticulitis
			Stomach or duodenal ulcer
			Loss/change in appetite
			Severe stomach pains
			Hepatitis
			Hernia

Past	Present	Never	BONES & JOINTS
			Fibromyalgia
			Fractured bones in any parts of the body
			Gout
			Arthritis
			Osteoarthritis
			Sacroiliac Pain
			Herniated, Ruptured disc
			Scoliosis
			Sciatica
			Injured back
			Carpel tunnel syndrome Numbness with use and normal sensation? Decrease sensation with or without pain? Prior surgery? Pain related with carpel tunnel syndrome?
			Rheumatoid arthritis
			Autoimmune disorder
			Osteoporosis
Past	**Present**	**Never**	***Have you ever experienced pain, stiffness, weakness, tingling, loss of motion or sensation of the:***
			Shoulders, any injury or pain with use? Surgeries?
			Elbows, any injury or pain with use? Surgeries?
			Wrists, any injury or pain with use? Surgeries?
			Fingers, any injury or pain with use? Surgeries?
			Hips, any injury or pain with use? Surgeries?
			Knees, any injury or pain with use? Surgeries
			Ankles, any injury or pain with use? Surgeries?
			Toes, any injury or pain with use? Surgeries?
			Cervical/Neck, any injury or pain with use? Surgeries?
			Thoracic/Mid,-back any injury or pain with use? Surgeries?
			Lumbar/Lower, back any injury or pain with use? Surgeries? **Prior back fractures?** **Prior episodes of lower back pain/.** **Current intermittent pain, spasms, or muscle weakness/** **Current frequent significant pain with muscle weakness?**
			Tendonitis?
Past	**Present**	**Never**	**TREATMENTS**
			Radiation or Chemotherapy

Surgeries:
Any current surgeries within last 4-5 months?

Hospitalizations:

List medications/drugs you have taken in the last 3 months

Do you have any physical limitations or weight restrictions?

If yes, please describe:

				Have you ever been exposed to biological or chemical agents in the military?
				If so, describe:
				Have you ever worked on a hazmat team?
				Yes or No

EMPLOYMENT	NO	YES	IF YES, PLEASE EXPLAIN
Have you ever been refused employment because of your health?			
Have you ever been discharged from the Armed forces for medical reasons?			
Have you ever been involved in a motor vehicle accident?			Date of the accident? What was the injury?
Have you ever had an on-the-job accident?			Date of injury?
			How long?
			What was the injury?
			Did you miss work?
			Did you receive compensation
			Were you hospitalized?
			Where were you employed when the injury occurred?
DRINKING HISTORY	**NO**	**YES**	**IF YES PLEASE EXPLAIN**
1-4 Drinks Monthly			
1-4 Drinks Weekly			
1 or 2 Drinks Daily			
Recovering alcoholic			
Substance abuse program			
SMOKING HISTORY	**NO**	**YES**	**IF YES PLEASE EXPLAIN**
Have you ever smoked?			

DRUG HISTORY	PAST	NOW	NEVER	If yes, Explain. Last time used?
Morphine				
Marijuana				
Methadone				
Cocaine				
PCP				
Heroin				
Darvon				
Barbiturates				
Amphetamines				
Addiction/Abuse of Prescription Medication				

I certify that the information contained in this personal medical history is true. I understand that any misrepresentation or omission of fact is sufficient basis for a refusal to hire me, or for my immediate dismissal. I authorize its investigation and agree that any misleading or false statement would render my employment application void, and would be sufficient cause for immediate dismissal in the event of employment. I understand that this physical screening does not duplicate or replace the physical done by my physician.

_____ _____

Date Signature of applicant

PARENTAL CONSENT FOR MINOR APPLICANTS

I have read and understand all the information presented to me and give my permission for _____ to receive the appropriate immunizations, PPD test (tuberculosis screening) or chest X-ray, and blood work that is necessary for a pre-employment screening at Johns Hopkins Bayview Medical Center.

_____ _____ _____

Date Parent/Guardian Signature Relationship to applicant

RESPIRATOR ASSESSMENT

	YES	NO		YES	NO
1. Do you have medical problems that might interfere with mask/respirator use?					
2. Do you currently smoke tobacco, or have you smoked tobacco in the last month?			**6. Have you ever had any of the following cardiovascular or hear problems?**		
3. Have you ever had any of the following conditions?			Heart attack		
Seizure (fits)			Stroke		
Diabetes			Angina		
Allergic reactions that interfere with your breathing			Heart failure		
Claustrophobia (fear of closed-in spaces)			Swelling in your legs or feet (not caused by walking)		
Trouble smelling odors			Heart arrhythmia (heart beating irregularly)		
4. Have you ever had any of the following pulmonary or lung problems?	5.		High blood pressure		
Asbestos			Any other heart problem that you've been told about		
Asthma			**7. Have you ever had any of the following cardiovascular or heart symptoms?**		
Chronic bronchitis			Frequent pain or tightness in your chest		
Emphysema			Pain or tightness in your chest during physical activity		
Pneumonia			Pain or tightness in your chest that interferes with your job		
Tuberculosis			In the past two years, have you noticed your heart skipping or missing a beat		
Silicosis			Heartburn or indigestion that is not related to eating		
Pneumothorax (collapsed lung)			Any other symptoms that you think may be related to heart or circulation problems		
Lung cancer			**8. Do you currently take medication for any of the following problems?**		
Broken ribs			Breathing or lung problems		
Any chest injuries			Heart trouble		
Any other lung problems that you've been told about			Blood pressure		
5. Do you currently have any of the following symptoms of pulmonary or lung illness?			Seizures (fits)		
Shortness of breath			**9. If you've used a respirator, have you ever had any of the following problems?**		
Shortness of breath when walking fast on a level ground or walking up a slight hill or incline			Eye irritation		
Shortness of breath when walking with other people at an ordinary pace on level ground			Skin allergies or rashes		
Have to stop for breath when walking at your own pace on level ground			Anxiety		
Shortness of breath when washing or dressing yourself			General weakness or fatigue		
Shortness of breath that interferes with your job			Any other problem that interferes with your use of a respirator		
Coughing that produces phlegm (thick sputum)			Type of respirator used:		
Coughing that wakes you up in the morning					
Coughing that occurs mostly when you are lying down			NEVER USED RESPIRATOR		
Coughing up blood in the last month					
Wheezing					
Wheezing that interferes with your job					
Chest pain when you breathe deeply					
Any other symptoms that you think may be related to lung problems					

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

For this authorization, "My Health Information" means all of my health information held in my Johns Hopkins Occupational Health medical records and includes, but is not limited to, my name, address, other contact information, date of birth, age, gender, health questionnaire or history, tests performed (including drug screens), test results, inability or ability to work, work limitations, rehabilitation information, medical complaints related to exposure to hazardous substances and diagnosis.

I authorize Johns Hopkins to disclose My Health Information to my employer, Johns Hopkins affiliates for safety and job related purposes, my agency staff employer, and/or the medical staff office or Johns Hopkins employer where I am or where I am applying to be credentialed or employed:

_____
[insert company name]

(for example, to the supervisor, Human Resources representatives, medical review officer, and legal counsel). I further authorize Johns Hopkins to disclose My Health Information in any and all employment related proceedings (including, but 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 for one year, unless I revoke this authorization, or unless an earlier date is specified here: _____.

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 related physical. 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).

CONSENT FORM
EMPLOYMENT SUBSTANCE ABUSE TEST

This consent form is intended to apply to all applicants who wish to be employed by (or who wish to transfer to) any of the following Johns Hopkins Health System organizations:

The Johns Hopkins Medical Services Corporation (JHMSC)
Johns Hopkins Bayview Medical Center (JHBMC)
Broadway Medical Management Corporation, including Intrastaff (BMMC)
Howard County General Hospital (HCGH)
Howard County Health Services (HIS)
The Johns Hopkins Health System Corporation (JHHSC)
The Johns Hopkins Hospital

You are required to submit to employment drug testing as part of the hiring and/or transfer process of any organization within The Johns Hopkins Health System following: (1) an offer of employment, or (2) for probable cause during the course of your employment. Such testing will be performed consistent with applicable law, including but not limited to the Americans with Disabilities Act.

You may expect the following to happen:

1. You will be required to take a breath or salvia analysis, or blood test, and/or provide a urine specimen for substance abuse screening;

2. The results of your substance abuse test will be reported to the employer's Occupational Health office (or its equivalent). If you take a prescription drug or other medication, you may be required to provide the prescription container and/or other certification. A specimen that tests positive may be retested at your own expense by making arrangements through Occupational Health Services;

3. An occupational health representative will examine you and may contact your physician, pharmacist, or other appropriate medical care provider to verify a prescription and the medical condition that requires the prescription medication. (Confirmation of a controlled substance, or a positive breath analysis examination, that is not properly verified could terminate your current employment, and/or pending or future employment opportunities within any of the organizations listed above to which you wish to transfer);

4. If you wish to transfer to an organization listed above, The Office of Occupational Health and Safety could report and discuss your test results with your current employer, if your employer is listed above.

5. The occupational health office could also report your test results to:

    a. any board, licensing agency, or school program with which you are affiliated, if required by law; **or**
    b. to any governmental agency or court which may subpoena your records.

I have read and understand the employment substance abuse consent form and consent to the above stated testing and reporting process. Except for those items required by law to be disclosed, I understand that consent to release my records or information contained therein shall remain in effect for one (1) year from the date of the most recent test, and releases the Hopkins organizations identified above from any and all liability arising out of the release of any such information or records.

_____	_____	_____
Signature	**Social Security #**	**Date**
_____		_____
Witness		**Date**

Name:	
Social Security Number:	

I am taking the following medications: (Reporting of birth control medication and doctor's diagnoses are not required.)

Name of Medication(s)	Doctor issuing Medication(s)
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.

**************************DO NOT WRITE BELOW THIS LINE**************************

Date:		Time:		Temp:		Signature:	

HEPATITIS B VACCINE

I have read the attached information concerning Hepatitis B and the Hepatitis B vaccine, and have had an opportunity to have my questions answered. I know that the vaccine requires ***three*** injections to induce good immunity, and will present myself for the second and third injections.

Adverse reactions are uncommon, but any suspected adverse reaction should be reported to 550-0477.

_____ _____

Witness Date Signature Date

DECLINATION FOR HEPATITIS

I understand that due to my occupational exposure to blood or other potentially infectious materials 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 other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

_____

Signature Date

MMR VACCINE

I have read the information sheet about measles, mumps and rubella (MMR). I understand that hospital workers cannot be protected from exposure to patients who have MMR, and that I am likely to acquire those infections if I am exposed. I also understand if I do acquire MMR, I will be infectious to others for several days before the diagnosis of MMR can be made, and could infect patients. I understand that if I was vaccinated against MMR in infancy, that I cannot rely on being protected against MMR as an adult. I understand that a first vaccination with MMR carries a low risk of complications, and that the complications of the vaccine are far less serious than the complications of the natural diseases. Re-vaccination with MMR in a person who received MMR as a child almost never causes complications.

□ I was	□ I was not	vaccinated against MMR as a child
□ I have	□ I have not	been re-vaccinated with MMR within 10 years
□ I am	□ I am not	pregnant

Reason_____

_____

YOU SHOULD NOT RECEIVE THE VACCINE IF:

□	You are pregnant	□	Receiving Immunosuppressive therapy for 2 weeks or longer
□	Allergic to Neomycin	□	Have blood Dyscrasia, Leukemia, or Lymphoma
□	Allergic to gelatin	□	Moderately or severely ill at present time
□	Allergic to previous dose of MMR	□	Family or individual history of immunodeficiency
□	Recently given blood products (transfusion)		

Pregnancy should not be planned for **four weeks** after receiving the vaccine. Any adverse reactions should be reported to Occupational Health at 550-0477. I have read the information and agree to receive MMR.

_____ _____

Witness Date Signature Date

TETANUS & DIPHTHERIA

I have read the information sheet about Tetanus and Diphtheria. I understand that it is important to be re-vaccinated every ten years. I understand that the vaccine carries a low risk of complications. I am interested in being re-vaccinated.

_____ _____

Witness Date Signature Date

HOWARD COUNTY GENERAL HOSPITAL
STANDARD PRECAUTIONS

Standard precautions are designed to reduce the risk of transmission of pathogens from blood or any other body fluids. These precautions apply to ALL patients.

Standard precautions apply to blood; all body fluids, secretions and excretions except sweat, regardless of whether or not they contain visible blood; non-intact skin; and mucous membranes. Standard precautions are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection.

Standard precautions focus on the use of barriers to prevent contact with blood and all other body substances. Standard precautions do not rely on a diagnosis of infection to be made before precautions are instituted. Rather, by assuming that all blood and body fluids are potentially infectious, measures are taken to safely handle these body substances. In addition to handwashing, the consistent use of barriers, particularly gloves, by staff protects patients from the organisms that can be transmitted from patient-to-patient by personnel.

GENERAL GUIDELINES

+**Handwashing** is the single most important measure to reduce the transmission of microorganisms. Hands will be washed for 15 seconds after touching blood, body fluids, secretions, excretions and contaminated items, whether or not gloves are worn. Hands will also be washed immediately after glove removal, and between patient contacts (before and after each patient contact), and when otherwise indicated. It may be necessary to wash hands between tasks and procedures on the same patient to prevent cross-contamination of different body sites. Use plain soap for routine handwashing. Use an antimicrobial soap for specific circumstances (i.e. control of outbreaks, resistant organisms, ICU's, etc.).

+**Gloves** will be worn (sterile or non-sterile, depending on the purpose for which they are to be used) when touching blood, body fluids, secretions, excretions and contaminated items. In addition, gloves will be worn for touching mucous membranes and non-intact skin. Gloves will be changed between tasks and procedures on the same patient. Gloves will be removed promptly and discarded after use, before touch uncontaminated items and environmental surfaces, and before going to another patient. Hands should be washed immediately thereafter. Using gloves is not a substitute for good handwashing before and after each patient contact.

+**Masks, Eye Protection, Face Shields** will be worn to protect mucous membranes of the eyes, nose and mouth during procedures and patient care activities likely to generate splashes or sprays of blood, body fluids, secretions and excretions.

+**Gowns** will be worn (clean, non-sterile) to protect and to prevent soiling of clothing during procedures and patient care activities likely to generate splashes or sprays of blood, body fluids, secretions or excretions. Select a gown that is appropriate for the activity and amount of fluid likely to be encountered. Remove gown barrier prior to leaving a patient's room and place in appropriate receptacle. Wash hands to avoid transfer of microorganisms to other patients or environment.

+**Patient Care Equipment** will be handled in a manner to prevent skin and mucous membrane exposures, contamination of clothing, and the transfer of microorganisms to other patients and environments. Reusable equipment will be cleaned and reprocessed appropriately before use of another patient. Single-use items will be discarded.

+**Environmental Control** procedures are in place for routine care, cleaning and disinfection of environmental surfaces and patient furniture. Gloves will be worn when cleaning up spills containing blood, body fluids, secretions or excretions. The spilled substance should be thoroughly wiped up using a disposable absorbent material (i.e. paper towels) which is then discarded as infectious waste. A hospital approved disinfectant or a sodium hypochlorite solution (1 part bleach to 9 parts water) should be applied to the area contaminated by the spill. The area should then be rinsed with tap water and dried. Use general purpose utility gloves (i.e. household rubber gloves) for non-patient contact (i.e. housekeeping) and for tasks that involve potential blood and body fluid contact but where a high level of manual dexterity is not required. Utility gloves may be decontaminated and reused but should be discarded if they are peeling, cracked or discolored, or if they have punctures, tears or other evidence of deterioration. Hands will not be used to pick up broken glass, sharp objects, etc.

+**Linen** is treated as if contaminated with blood or body fluids and therefore does not require additional labeling or color-coding. Wet linen should first be placed in a plastic bag and then placed in a linen bag. Soiled linen will be handled in a manner to prevent skin and mucous membrane exposures, contamination of clothing, and transfer of microorganisms to other patients and environments.

+**Handling Specimens** of blood or other potentially infectious materials shall be placed in a container such as a vacutainer, which prevents leakage during collection, handling, processing, storage, transport or shipping. If specimen containers become contaminated on the outside they must be thoroughly wiped of visible contamination with a disinfectant agent (e.g. alcohol swab) and placed in a plastic bag with a biohazard symbol prior to further handling or transport. Specimens that could puncture the primary container shall be placed in a secondary puncture-resistant container that is labeled with a biohazard symbol, or placed in a plastic bag prior to transport. Specimens being transported to an outside laboratory or institution must have either a biohazard label prominently affixed to the outside container or be placed in a red bag.

+**Occupational Health and Bloodborne Pathogens** care should be exercised with needles, scalpels, and other sharp instruments or devices to prevent personnel from accidentally injuring themselves or coworkers. Needles WILL NOT BE RECAPPED, BENT OR CUT AFTER USE. Needles will never be removed from a syringe or a vacutainer holder, but they will be disposed of as a unit in a puncture-resistant container. However, if the department head can demonstrate that no alternative is feasible or that such action is required by a specific medical procedure, recapping or needle removal must be accomplished using a mechanical device present on the top of needle containers or using a one-handed technique. Needles should never be placed in the patient's bed, or on environmental surfaces in the patient's room, or be left attached to the administration set and hung over the IV pole. Puncture-resistant containers are located in each patient's room and in other patient care areas (i.e. outpatient clinics). The puncture-resistant containers should be securely closed and placed in red bags when 2/3 full and replaced with a new container. DO NOT OVERFILL CONTAINERS. To minimize the need for emergency mouth-to-mouth ventilation, disposable resuscitation masks shall be readily accessible in areas where the need can be reasonably anticipated.

+ **Post-exposure follow-up** includes timely testing, counseling and chemoprophylaxis (when indicated) and is provided at no charge to all JHBMC employees who sustain an exposure to blood or body fluids. Employees must report exposure incidents immediately to their supervisor who will refer them to Employee Health Service (EHS), or in the event that EHS is closed, to the Shift Coordinator on duty. Refer to Needlestick/Exposure policy in the Infection Control Manual or Red Envelope. Hepatitis B vaccine is offered free of charge to all HCGH healthcare workers with the potential risk of blood/ body fluid exposures.

I have read, understood, and received a copy of the above information. I understand that additional protective equipment and/or procedures may be required by my department and that my compliance to Standard Precautions procedures will be monitored by my supervisor and will be a component of my personal evaluation. I will attend the required education session on Standard Precautions. If I have any questions at any time, I should contact Infection Control, Occupational Health Services, or my supervisor.

PRINT NAME:_____ DATE:_____

SIGNATURE:_____ DEPT:_____