UNIVERSITY of MARYLAND MEDICAL SYSTEM

UMMC Urine Drug Collection

I understand that the urine drug test collection process may take up to three hours to complete and thus I understand that I might need to remain in Employee Health Services for up to three hours once the urine drug testing collection process begins.

I understand that if I am not able to remain in employee health services for up to three hours once my urine collection has started, then I should not start the urine collection process and I should make an appointment to schedule the urine collection for another day when I know that I can remain in the clinic for up to three hours.

I understand that if I do start the urine collection process and then leave the testing site prior to providing an adequate specimen and prior to the completion of the three hour time frame, then the outcome of my collection will be deemed a "refusal to test" and my job offer will be rescinded.

_____ _____

Applicant Signature Date

_____ _____

EHS Staff Signature Date

8/31/15

UNIVERSITY of MARYLAND MEDICAL SYSTEM

	Baltimore Washington Medical Center	**X**	**University of Maryland Medical Center**
	Capital Regional Health		Rehabilitation and Orthopaedic Institute
	Charles Regional Medical Center		Shore Regional Health
	Midtown Campus		St. Joseph Medical Center

EMPLOYEE HEALTH SERVICES

Rubeola (German Measles), Mumps, Rubella and Varicella (Chickenpox)

Statement of Understanding

UMMC requires employee's to provide evidence of immunity to Rubeola (German Measles), Mumps, Rubella and Varicella (Chickenpox).

Measles and Rubella immunity is a requirement of the State of Maryland Health Department. In order to safeguard the health of employees and patients and prevent the spread of disease, UMMC is also requiring immunity to Mumps and Varicella. There have been some occurrences of Mumps outbreaks in the United States. There have been frequent occurrences of patients admitted to the hospital with Varicella (chickenpox) and Shingles.

Acceptable proof of immunity:

Measles – evidence of 2 vaccinations or blood test indicating sufficient antibody levels.

Mumps - evidence of 2 vaccinations or blood test indicating sufficient antibody levels.

Rubella - evidence of 1 vaccination or blood test indicating sufficient antibody levels.

Varicella - evidence of 2 vaccinations or blood test indicating sufficient antibody levels

If you are found to be not immune to any of these diseases prior to starting work, your start date may be delayed if you cannot accept vaccination.

If you have a medical contraindication or sincere religious objection to vaccination, you must communicate this to EHS and follow processes to submit documentation to decline vaccination.

_____ _____

Employee Print/ Sign Date

_____ _____

EHS Witness Print/Sign Date

Revised 2/16/18

UNIVERSITY of MARYLAND MEDICAL SYSTEM

	UM Baltimore Washington Medical Center		UM Rehabilitation and Orthopaedic Institute
	UM Capital Region Medical Center		UM Shore Regional Health
	UM Charles Regional Medical Center		UM St. Joseph Medical Center
	UMMC Downtown Campus/UMMS Corporate		UM Upper Chesapeake Health
	UMMC Midtown Campus		

Applicant and Employee Consent to Alcohol and Drug Testing

_____

Applicant/Employee Name (Print)

I understand that the University of Maryland has a Drug-Free Work Place Policy against the manufacture, use, possession, distribution or sale of illegal drugs and the abuse of legal drugs or alcohol by its employees on hospital property or while conducting business for the hospital. I further understand that the University of Maryland is committed to a drug-free workplace and has adopted a drug and alcohol testing program as one method of implementing that policy. I also understand that in the event that I become an employee of the University of Maryland, I may be subject to reasonable cause testing in accordance with policy.

I hereby voluntarily consent to provide samples of my blood and/or urine to a laboratory designated by the University of Maryland to determine the presence or use of alcohol or drugs, I understand that all screening tests for drugs and alcohol will be subject to careful testing procedures. If the test result is positive, I can request a retest of the same sample, I understand that I must pay for the second test. I further understand that if my test indicates positive for illegal drugs, abuse of legal drugs or alcohol, as an applicant I will not be considered for employment, or as an employee, I may be subject to discipline including termination. I release and discharge the University of Maryland as well as the laboratory, officers, employees, agents and representatives from any claim or liability arising from such tests, including the testing process and procedures, analysis and disclosure of results.

If you are licensed by a professional licensing board including, but not limited to, the Maryland Board of Nursing, Board of Physicians or Board of Pharmacy, and you have a positive urine drug screen result, your results may be reported to the licensing board as required by statute or regulation.

I voluntarily authorize the release of medical information concerning the results of my drug and/or alcohol test(s) to company representatives who will use it to determine if I am in compliance with hospital work rules and policies on drug and/or alcohol. I also understand that I am entitled to a copy of this authorization. I understand that refusal by me to sign this consent will be cause for termination or ineligibility for employment.

_____ _____

Applicant/Employee Signature Date

_____ _____

Witness Date

UNIVERSITY of MARYLAND MEDICAL SYSTEM

	Baltimore Washington Medical Center	X	**University of Maryland Medical Center**
	Capital Regional Health		Rehabilitation and Orthopaedic Institute
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Tetanus, Diphtheria and Pertussis (Tdap) Vaccine Declination

I understand that Tetanus, Diphtheria and Pertussis are vaccine-preventable diseases, and that susceptible health care workers can acquire and transmit diphtheria and pertussis to patients. These diseases may result in serious morbidity or even death in health care workers and in patients. In addition, I understand that pertussis in particular is associated with hospital outbreaks and serious morbidity or even death in patients.

I decline to receive the Tdap vaccine free of charge at this time. I am aware that Vaccine Information Sheets are available in Employee Health Services should I have any questions. I acknowledge that it is my responsibility to contact Employee Health Services should I change my mind in the future and decide to be vaccinated, or if I am exposed to a person in the contagious state of the disease and did not wear the appropriate personal protective equipment. I understand that if I am exposed to a case of Diphtheria or Pertussis, I may automatically be relieved from all direct patient contact throughout the incubation period following my exposure.

	I am interested in receiving the Tdap vaccine

I am declining due to:

	Medical reasons
	Non - medical reasons
	I have already received the vaccine on _____ (please submit proof of vaccination)

Printed name:	Signature:
Date:	ID #

Respirator Fit Testing / PAPR Training Form

PLEASE WRITE CLEARLY

Name:	Date:
Employee Number:	Department/Unit/Location:

Has Employee been medically cleared to wear a respirator? YES NO

FIT TESTING RESULTS:

Sensitivity test to Bitrex: PASS FAIL

Fit Test: PASS FAIL

CIRCLE TYPE/SIZE OF MASK:

***DISPOSABLE N95*:**

3M 1870 PLUS 3M 1860 Small 3M 1860 Regular

KC 46727 Regular KC 46827 Small AlphaProTech

***REUSABLE MASK*:**

7501(Small) 7502(Medium) 7503(Large)

Instruction given for:
___ Donning and doffing mask
___ Seal Check
___ Sticker (to be placed on badge)
___ Storage and replacement
___ Cleaning and maintenance

PAPR

_____ If employee cannot be fit tested for a Disposable N95 or Reusable Mask (or employee works in a department that requires PAPR training), instructions have been given and demonstrated on how to use an Air-Mate PAPR.

_____ Facial Hair _____ Failed Disposable Masks

_____ _____

Employee Signature Date

_____

Fit Tester/Trainer

UNIVERSITY of MARYLAND MEDICAL SYSTEM

	Baltimore Washington Medical Center	**X**	University of Maryland Medical Center
	Capital Regional Health		Rehabilitation and Orthopaedic Institute
	Charles Regional Medical Center		Shore Regional Health
	Midtown Campus		St. Joseph Medical Center

Hepatitis B Information and Declination Form

Information:

The University of Maryland Medical System is offering recombinant Hepatitis B vaccine to all at risk UMMS employees free of charge. Immunization against Hepatitis B can prevent acute Hepatitis B as well as reduce illness and death from chronic active Hepatitis, cirrhosis and liver cancer.

Hepatitis B is a viral infection caused by the Hepatitis B virus (HBV). One of the leading occupational hazards to healthcare workers is exposure to Hepatitis B. This risk comes from a significant exposure to blood and body fluids after a needle stick or mucous membrane exposure. The Hepatitis B vaccine is available to healthcare workers to prevent Hepatitis B infection. This is a genetically engineered vaccine and is free of any association with human blood or blood products. The vaccine consists of three intramuscular injections given over a six month period of time after which your blood is tested for immunity. Over 90% of those vaccinated will become immune to the disease and will be protected in the event of an exposure.

Declination:

I understand that I could acquire Hepatitis B Virus (HBV) infection due to my occupational risk of exposure to blood and other potentially infectious material. I have been given the opportunity to be vaccinated with Hepatitis B Vaccine, at no charge to myself. 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 blood disease. If in the future I continue to have the risk of occupational exposure to blood or other potentially infectious material and I want to be vaccinated, I can receive the Hepatitis B vaccine at no charge to me.

	I have already received all three (3) doses of the Hepatitis B vaccine
	I do NOT desire vaccination against Hepatitis B
	I am not in patient care and I do NOT desire vaccination against Hepatitis B
	I am willing to complete the vaccination series

Signature	Printed Name
Department	Date
Employee ID Number	SSN for non-employee

UNIVERSITY of MARYLAND MEDICAL SYSTEM

University of Maryland Medical Center
Employee Pre-Placement Medical Clearance Record

Print Name:				**DOB:**		**Today Date:**	
Social Security:				**Job Title:**			
Vital Signs							
B/P indications for MD note: Systolic 160 , Diastolic 100				***Vision indications for MD Note, glasses or contacts: (20/50 acceptable)***			
Blood Pressure /	Pulse	Manual Blood Pressure /		Visual Acuity: n W/Correction **glasses contacts** n W/O Correction R Eye: 20/ L Eye: 20/ Both Eyes: 20/			
Weight:	Height: ' "	Body Mass Index:		***Color Vision Screening*** n Normal n Abnormal How many missing:			
Immunization Record	**Date Given**	**Date Given**	**Date Given**	**Date of Titer**	**Titer Result**	**Hx of Disease Date**	**Complete / Comments (√)**
MMR	#1	#2	#3				
Measles	#1	#2	#3				
Mumps	#1	#2	#3				
Rubella	#1	#2	#3				
Varicella	#1	#2	#3				
**COVID-19 VAC	#1	#2	MANUFACTURER:				Proof Submitted
Comments:							
Hepatitis B Status (Personnel who may perform tasks that may involve exposure to blood/body fluids)							
Date of Hep B #1							
Date of Hep B #2		n Non Patient Care					
Date of Hep B #3							
Date of Hep B Ab		Hep B Ab result:		Action taken:			
Date of Hep B Vaccine Declination		n Reports Receipt of all (3) dosesn		Does not desire Vaccination			
		nDesires vaccination if titer negative					
Date of Hep B #4							
Date of Hep B #5							
Date of Hep B #6							
Date of Hep B Ab		Hep B Ab result:		Action taken:			
Date of Hep B Ag		Hep B Ag result:		Action taken:			
Tetanus Diphtheria (Td) Tetanus, Diphtheria and Pertussis (Tdap)							
Td (Every 10 years)							
Tdap (1-time dose)	n Previously Received			n Does not desire Vaccination		Declination Reason: Medical or Non Medical	
Tdap	Date:	Lot #		Exp:	Site:		
Influenza							
Date of Seasonal		Date of Declination					
TB Screening	**Date placed**	**Date read**	**TST result**				
TST #1							
TST #2							
Hx of +TST							
Quantiferon Gold, T-Spot #1	Date completed:	Result:					
Quantiferon Gold, T-Spot #2	Date completed:	Result:					
TB Screening Form	Date completed:	Comments:					
CXR	Date of referral:	Date of CXR:	Result:				
Comments:							
Respiratory Questionnaire Clearance for N95/3M Reusable/PAPR							
Date Completed:		Cleared: n Yes n No		Mask type & size:		n N/A for position	
Urine Drug Screen							
nCollected n Negative		n MRO negative	n MRO Positive	n N/A for position	Comments:		
Additional information requested and or MD note(s).							
nRequested #Amount of note(s)				Date Received By EHS:			
Chart Cleared to Start Working				**Chart Not Cleared (refer to notes)**			

****TB testing (Skin/IGRA) can be performed prior to COVID-19 vaccination but should be delayed ≥ 4 weeks after completion of mRNA vaccinations. In addition, there should be a 14-day interval between COVID-19 and Non-COVID-19 vaccines.**

UNIVERSITY of MARYLAND MEDICAL SYSTEM

	Baltimore Washington Medical Center	X	University of Maryland Medical Center
	Capital Regional Health		Rehabilitation and Orthopaedic Institute
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Distance and Color Vision Screening Form

Applicant's Name:	Date:
Glasses: ☐ Yes ☐ No	Contact Lenses: ☐ Yes ☐ No

		1	2	3	4	5	6	7
2	Both Eyes	☐	☐	☐	☐	☐	☐	☐
3	Right Eye	☐	☐	☐	☐	☐	☐	☐
4	Left Eye	☐	☐	☐	☐	☐	☐	☐
	Snellen Equivalents	20/200	20/100	20/70	20/50	20/40	20/30	20/20
6	Color Vision	A 12	B 5	C 26	D 6	E 16	F 0	

Applicant's Signature: _____ EHS Provider Signature: _____

If Titmus color vision screening fails use Ishihara Color Test book and table below.

Number of Plate	Normal Plate	Person with Red Green Deficiencies				Person with Total Color Blindness and Weakness
1	12	12				12
2	8	3				X
3	5	2				X
4	29	70				X
5	74	21				X
6	7	X				X
7	45	X				X
8	2	X				X
9	X	2				X
10	16	X				X
11	**traceable**	X				X
		Protan		**Deutan**		
		Strong	**Mild**	**Strong**	**Mild**	
12	**35**	5	(3) 5	3	3 (5)	
13	**96**	6	(9) 6	9	9 (6)	
14	**Can trace two lines**	**Purple**	**Purple (red)**	**Red**	**Red (purple)**	X

If the applicant fails the Ishihara Color Deficiency Test. (4 or more plates read incorrectly is considered deficient) Complete the following…

- Release of Records for Color Deficiency located in the nurses' office.
- Identify the following color items in the exam room
  - Three (3) red items: ☐ yes ☐ no; missed _____
  - Three (3) blue items: ☐ yes ☐ no; missed _____
  - Three (3) green items: ☐ yes ☐ no; missed _____
- Identify the color of the blood tubes: ☐ yes ☐ no; missed _____

UNIVERSITY of MARYLAND MEDICAL SYSTEM

step UP to employee health

Satisfaction Survey

*** *Providing extraordinary care for extraordinary people* ***

Directions: Please rate your level of satisfaction on the following items. Return survey to the box provided on the Employee Health Counter. **Thank you for helping us improve our services for you and other employees.**

SECTION 1: Feedback on our performance using the 1-5 scale. **If you select options 1 or 2, please comment in Section 2**	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
Scheduling an appointment with Employee Health was not difficult	1	2	3	4	5
Appointment times were convenient	1	2	3	4	5
Waiting time at the clinic was minimal	1	2	3	4	5
Questionnaire was appropriate	1	2	3	4	5
Employee health care provider and staff were welcoming and caring	1	2	3	4	5
Employee health care provider and staff were knowledgeable	1	2	3	4	5
The suite and examining room were clean	1	2	3	4	5

SECTION 2: More of your thoughts.

Was there anyone who particularly provided great service to you here today? (if yes, who?)

Also, please comment on questions you rated 1 or 2, and tell us how could we improve our service to you?

Your Department/Job Title: _____ **Date:**_____

____Yes ____No I have included my name and phone number and would like someone to call me about my survey response.

Name:_____ Phone #:_____

Thanks for your feedback,

Regina Hogan, RN, MS, Manager, Employee Health Services
Melissa Frisch, MD, MPH, Medical Director, Employee Health and Safety

UNIVERSITY of MARYLAND MEDICAL SYSTEM

Employee Health Services
920 Elkridge Landing Road Linthicum, MD 21090
Phone Fax 410-684-3353

Dear _____ Date _____

We hope that your experience in Employee Health Services was a good one. In order to fully complete your pre-placement physical there are some items that must be completed **BEFORE** you attend orientation. **Please be sure that we are in receipt of the item(s) checked off below no later than the Wednesday before your scheduled orientation date**. ***Please note, if you do not provide the required information by this deadline, it is likely your start date may need to be postponed.***

- You'll need your tuberculin skin test read on _____ or _____ . Our clinic staff, any physician, or any Registered Nurse may read your skin test. You may **not** read your own TB test. **If your Tuberculin Skin Test appears to have any skin reaction such as redness, swelling, or itching, you must return to Employee Health Services the next business day for our clinical staff to evaluate your reaction. Employee Health must receive your test results no later than two business days before your start date.**
- Forward copies of your most recent (must be within the last 12 months) Tuberculin Skin Test(s) as soon as possible. If you are not able to provide this documentation, please return to Employee Health to have a Tuberculin Skin Test placed.
- If your 1st Tuberculin Skin Test reading is negative, please **return to the Employee Health Suite in 1-3 weeks for the placement of your 2nd TST skin test.** This will complete the 2 step Tuberculin skin test performed on new hires only. Please return on or after _____.
- Please make sure that we receive any requested doctor's note(s), **no later than the Wednesday before your start date.**
- Complete your chest x-ray as soon as possible.
- Forward a copy of your most recent chest x ray (from time of conversion or later). If one is not available, please return to Employee Health Services for a radiology referral, which will allow you to have a chest x-ray done here in the main hospital free of charge.
- Forward your Immunization records or blood test results.

  □ MMR
  □ Measles (Rubeola)
  □ Mumps
  □ Rubella (German Measles)
  □ Hepatitis B
  □ Varicella (Chicken Pox)
  □ Td/Tdap (Tetanus, Diphtheria, Pertussis)
  □ Influenza vaccination

- Go to www.flu-freezone.com/?p=e9de379697e645c66c8d647c0fbab5f to decline the flu vaccine and fax proof to (410) 630-7460.

_____

_____

For your convenience, Employee Health Services is open from 7am -4pm, Monday through Friday (except holidays).

By signing this statement, I am acknowledging that the items checked above are outstanding. I understand that it is my responsibility to ensure that Employee Health Services receives this documentation no later than the Wednesday prior to my start date. Failure to complete the outstanding item(s) can result in a delay in hire.

Signature: _____ Date: _____