UNIVERSITY of ROCHESTER

Welcome to the University of Rochester!

Enclosed you will find details regarding your employment with the University of Rochester.
Directions to Strong Memorial Hospital Employee Health, and the Employment Center are included. Please complete the paperwork and bring all required documents to your pre-placement exam.

Strong Memorial Hospital (SMH) Room: G-6012

Your University appointment is contingent upon the satisfactory completion of a pre-placement health exam and drug test. **Per University policy 168, if a candidate fails to appear for their scheduled screen or refuses to take the test, the offer of employment will be rescinded. Appointments are not rescheduled for the candidates convenience.**
Please note that the information gathered at your exam will not be part of your personnel file but a separate medical record.
Please be advised that you will not be able to bring guests including children into the drug testing or exam area; our staff are unable to supervise children and cannot be held responsible for the safety or welfare of a minor during your exam or drug screening. Please plan accordingly so we are able to complete all elements of your visit.

PLEASE FAX, EMAIL OR BRING IMMUNIZATION RECORDS TO YOUR APPOINTMENT.
Fax: (585) 276-2365 E-Mail: SMH_EMPLOYEE_HEALTH@URMC.ROCHESTER.EDU

Bring to the pre-placement appointment:

1. Photo ID (i.e. License, Passport, School Photo ID, Work Photo ID).
   Electronic Photo ID's will not be accepted.

2. Immunization record (See "Immunization History Form" for required immunizations).

3. Bring the completed forms to your pre-placement appointment.

   a. Strong Immunization history form

   b. Medical History Form

   c. Strong Outpatient Registration Form

   d. Respiratory Fit Packet (if applicable)

4. Glasses/contact lenses.

What to expect at your pre-placement appointment:
Approximately 2-3 hour appointment; plan accordingly. You will be required to stay for the entire visit.
Do not bring any liquids or leave our clinic after check-in; you will be requested to provide a urine sample.
Possible blood draw and vaccines, if needed. Two PPD's are required for SMH pre-employment compliance. Negative Quantiferon is not accepted per policy.

UNIVERSITY of ROCHESTER MEDICAL CENTER

MEDICINE of THE HIGHEST ORDER

Strong Memorial Hospital (SMH) Employee Health

Immunization History Form

Name _____ Date of Birth: _____ Date _____

Please bring your immunization records to SMH Employee Health at the time of your appointment. **This form should be completed and signed by your provider if you are not able to obtain vaccination/titer records.** A PPD skin test will be provided at your visit.

REQUIRED PROTECTIONS AS A CONDITION OF EMPLOYMENT:

1. Rubeola (Measles) (**Attach vaccination record**)
   - ☐ If you were born on or after January 1, 1957, check which of the following apply:
   - ☐ I have received 2 measles vaccines after January 1, 1968. Dose 1 _____ Dose 2 _____
   - ☐ I have had a titer drawn.
     Date _____ Result _____ (**Attach copy of result**)
   - ☐ If you were born before January 1, 1957, have you had the measles (rubeola): Y __ N __

2. Rubella (German Measles) Check which of the following apply: (**Attach vaccination record**)
   - ☐ I have received the rubella vaccine after January 1, 1969. Date _____
   - ☐ I have had a titer drawn.
     Date _____ Result _____ (**Attach copy of result**)

3. Tuberculin PPD Skin Test within the last 12 months (Mantoux, not Tine)
   - ☐ Date of last skin test _____ Read date: _____ Result (mm): _____
   - ☐ If positive, did you receive a chest x-ray? Y ____ N ____
     If Yes, Date _____ Result _____ (**Attach copy of result**)

4. Influenza vaccine (Annually)
   - ☐ I have received the influenza vaccine. Date _____ (**Attach vaccination record**)
   - ☐ I have declined the influenza vaccine. Employee Signature: _____

RECOMMENDED PROTECTIONS:

6. Hepatitis B Vaccinations
   - ☐ I have received the Hepatitis B vaccination series. Note Dates:
     Dose 1 _____ Dose 2 _____ Dose 3 _____
   - ☐ I have had the Hepatitis B surface antibody titer drawn.
     Date _____ Result _____ (**Attach copy of result**)

7. Tetanus/Diphtheria or Tdap **(Please indicate)**
   - ☐ Date of last booster _____ (Tetanus toxoid only is not sufficient.)

8. Chicken Pox
   - ☐ I have had the chicken pox: Y ____ N ____ If yes, date _____
   - ☐ I have received the Varicella vaccine. Dates: _____, _____ (**Attach vaccination record**)
   - ☐ I had a titer drawn: Y ____ N _____ Result: Date _____ Negative ____ Positive ___
     (Attach copy of result)

9. Mumps
   - ☐ If you were born on or after January 1, 1957, check which of the following apply:
   - ☐ I have received the mumps vaccine after January 1, 1968. Date _____
   - ☐ I have had a titer drawn.
     Date _____ Result _____ **(Attach copy of result)**
   - ☐ If you were born before January 1, 1957, have you had the mumps: Y __ N __

10. COVID
    - ☐ I have received the COVID vaccine. Dates: _____, _____ (**Attach vaccination record**)

    Manufacturer/Brand Name: _____

_____
Provider Signature / Date

UNIVERSITY of ROCHESTER MEDICAL CENTER

MEDICINE of THE HIGHEST ORDER

For office use only
☐ **Pre-Health Assessment Screen**
☐ **Medical History**

Strong Memorial Hospital
SMH Employee Health (EH)

Name (print): _____ Today's date: _____

Age: _____ Date of Birth: _____

Gender: ☐ Female ☐ Male ☐ Non-Binary ☐ Trans Female ☐ Trans Male ☐ _____

Pronouns: ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Their/Theirs ☐ _____

Job title / type of work: _____

Medical History

1. List all medications that you take on a routine or periodic basis (include over-the-counter medications, vitamins, and supplements): _____
   _____

---

2. List all allergies (including drugs, environmental, & latex): _____
   _____

3. List all current or active medical problems for which you see a physician or other health care provider:
   _____
   _____

4. List all past hospitalizations and operations (includes dates):
   _____
   _____

5. Current restrictions:
   Has a health professional told you to limit your activities at home or work?
   Yes ☐ No ☐
   Do you have any permanent medical restrictions on your activities or any permanent impairments?
   Yes ☐ No ☐
   Do you need any accommodations to perform the job for which you are being evaluated?
   Yes ☐ No ☐

Social History

Do you use tobacco products? Yes ☐ No ☐
If yes, number of packs / dips per day _____ and number of years _____
Do you drink alcohol? Yes ☐ No ☐
If yes, how much do you drink on an average week _____

Occupational History

List past employment, providing the information requested below:

	Company name	Job / Position	Dates	Workplace Exposures
1.				
2.				
3.				
4.				

OVER ⟶

Review of systems: Have you ever had or do you currently have any of the following (check [x] for each item)

Past = past medical problem

Current = current medical problem

Please explain any "Yes" answers (Past or Current) in the space provided below. ↓

		If Yes:	
	No	**Past**	**Current**
1. Frequent / severe fatigue	☐	☐	☐
2. Arthritis / bursitis / tendonitis	☐	☐	☐
3. Carpal tunnel syndrome	☐	☐	☐
4. Back / spine trouble	☐	☐	☐
5. Amputations / bone – joint problem	☐	☐	☐
6. Cancer	☐	☐	☐
7. Diabetes / sugar problems	☐	☐	☐
8. Skin problems	☐	☐	☐
9. High / low blood pressure	☐	☐	☐
10. Chest pains / palpitations	☐	☐	☐
11. Heart trouble	☐	☐	☐
12. Anemia	☐	☐	☐
13. Difficulty breathing	☐	☐	☐
14. Chronic cough or sputum	☐	☐	☐
15. Asthma or emphysema	☐	☐	☐
16. Pneumonia	☐	☐	☐
17. Tuberculosis	☐	☐	☐
18. Past positive test for TB	☐	☐	☐
19. Abdominal pain	☐	☐	☐
20. Bowel / stomach problems	☐	☐	☐
21. Stomach / duodenal ulcers	☐	☐	☐
22. Liver / gallbladder disease	☐	☐	☐
23. Jaundice (turning yellow)	☐	☐	☐
24. Hernias or ruptures	☐	☐	☐
25. Urinary problems	☐	☐	☐
26. Menstrual problems	☐	☐	☐
27. Infertility	☐	☐	☐
28. Fainting episodes	☐	☐	☐
29. Convulsions / epilepsy	☐	☐	☐
30. Severe head injuries	☐	☐	☐
31. Dizziness / lightheadedness	☐	☐	☐
32. Severe headaches	☐	☐	☐
33. Change in vision	☐	☐	☐
34. Change in hearing	☐	☐	☐
35. Psychiatric conditions	☐	☐	☐

The Genetic Information Nondiscrimination Act *(GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.*

Patient/Examinee Signature: _____ Date: _____

Nurse Reviewer Signature: _____ Date: _____

☐ Review Completed by EH nurse.
☐ N/A Scheduled for Physical.
☐ Deferred to EH Provider for Focused Exam.

Provider Signature: _____ Date: _____

UNIVERSITY of ROCHESTER MEDICAL CENTER

MEDICINE of THE HIGHEST ORDER

SMH Employee Health (EH)

Outpatient Registration

Welcome to SMH Employee Health! Please complete the following information for identification purposes:

Date _____

Name _____ **Maiden Name**_____

Date of Birth _____ **Race** _____ Marital **Status** _____

Gender: ☐ **Female** ☐ **Male** ☐ **Trans Female** ☐ **Trans Male** ☐ **Non-Binary** ☐ _____

Address, Apt # _____

City, State, Zip Code _____

Home Phone _____ **Other Phone**_____

Family Physician _____

Address _____

City, State, Zip Code _____

Employer _____

(Affiliated with as Applicant or Employee)

Address _____

City, State, Zip Code _____

Employment: **F/T** ___ **or P/T** ___ **Work Phone** _____ **Ext**. _____

Emergency Contact _____ **Relationship** _____

(Messages can be left with)

Home Phone _____ **Work Phone** _____ **Other** _____

**** *IF INFORMATION IS UNKNOWN, PLEASE INDICATE SO IN THE DESIGNATED AREA.* ****

SMH Employee Health (EH)

Medical Clearance/Certification for Respirator Use

Employee Name_____ **Job Title** _____

********* DO NOT WRITE BELOW THIS LINE – FOR EH OFFICE USE ONLY *******

Physician Certification

☐ 1 - Medically certified to use a N95/CAPR/PAPR respirator
☐ 2 - Medically certified to use the following respirator(s) with restrictions or accommodations:
  ☐ N95
  ☐ CAPR/PAPR
☐ 3 - Not medically certified for respirator use under any circumstances
  ☐ 3a-Temporary condition_____ ☐ 3b – Permanent Condition _____
☐ 4 – Employee needs to contact Employee Health regarding question #9.

Restrictions/Accommodations

☐ 1 - No restrictions/accommodations needed
☐ 2 - Corrective lens required
☐ 3 - No mask/CAPR/PAPR use during exacerbation of pre-existing
☐ condition 4 - Not medically cleared pending respirator exam
☐ 5 - Call 275-9300 to schedule mask fit
☐ 6 - Call 275-9300 to schedule CAPR/PAPR training
☐ 7 - Other _____

Recommendations

☐ 1 - Annual examination recommended
☐ 2 - Annual PFT to assess for adequate reserve for respirator use
☐ 3 - Follow up with personal physician
☐ Other _____

I certify that the above named employee has been evaluated to wear a respirator in accordance with OSHA Respiratory Protection Standard (29 CFR 1910.134), and that my findings are summarized above.

_____ _____

Provider Signature **Date**

University of Rochester
Employee Respirator Fit Test Record

Employee Name (print):_____ Date of Birth:_____ Job Title:_____

Company (if non-UR employee): _____

Respirator: ☐ Dust/Mist ☐ ½ Face APR ☐ Full Face APR ☐ CAPR/PAPR ☐ Air Supplied ☐ SCBA

Manufacturer:	Manufacturer:	Manufacturer:
Model No. &/or Name:	Model No. &/or Name:	Model No. &/or Name:
Size:	Size:	Size:

Positive Pressure Check: ☐ Pass ☐ Fail Negative Pressure Check: ☐ Pass ☐ Fail

Qualitative: ☐ Pass ☐ Fail Test Agent: ☐ Saccharin ☐ Bittrex ☐ Isoamyl Acetate_____Sensitivity Level

Qualitative Fit Test Elements (1 minute each):

1. Normal Breathing	☐ Pass	☐ Fail	5. Speaking	☐ Pass	☐ Fail
2. Deep Breathing	☐ Pass	☐ Fail	6. Forward Bend	☐ Pass	☐ Fail
3. Side to Side	☐ Pass	☐ Fail	7. Normal Breathing	☐ Pass	☐ Fail
4. Up and Down	☐ Pass	☐ Fail			

Quantitative: Quantitative Fit Test: ☐ Pass ☐ Fail Overall Fit Factor: _____

(Attach quantitative test results to this form)

Limitations: ☐ Facial Hair ☐ Dentures ☐ Eyeglasses ☐ None

Comments: _____

I have been successfully medically evaluated, fit tested, and instructed on the proper uses and limitations of the respirator(s) indicated above. I understand how to perform both positive and negative pressure checks and I have been instructed to, and will perform them each time I wear a respirator. I will also inspect the parts of my respirator before each use for wear, cracks, tears, and other damage and will report any damage to my supervisor.

I reviewed the respirator training and had the opportunity to ask questions regarding it. I have been given the guidance document for the respirator(s) indicated above, and understand I can still ask questions or seek additional information.

I have taken the Respirator Fit Test Quiz and reviewed my answers with my fit test provider.

I will follow all respirator use procedures as appropriate, and seek guidance from my supervisor on any usage I am unsure of.

Employee Signature_____ Date _____

The above-named employee has successfully passed fit testing and is cleared to wear the respirator indicated above.

Performed by (print name):_____Fit Test Date _____

Fit Test Provider's Signature: _____

UNIVERSITY OF ROCHESTER RESPIRATOR FIT QUIZ

Employee Name (print):_____ Date of Birth:_____ Job Title:_____

Company (if non-UR employee): _____

Choose the correct answer for the following questions **Check One**

1. If you are told to wear a respirator in a designated area, you should wear it whenever you:
   A. enter the area
   B. will be in the area for 10 minutes or longer
   C. can see, smell, or taste the hazard
   D. begin to feel sick as you work in the area
   ☐A ☐C ☐B ☐D

2. If you have a full face beard, the face mask style respirator will not fit properly. ☐T ☐F

3. When caring for suspected TB patients, you are required to wear a PAPR if you have a beard. ☐T ☐F

4. You must wear a respirator when you are seeing a patient with suspected or known TB. ☐T ☐F

5. You should throw away your old N95 respirator and get a new one if:
   A. the respirator looks worn or damaged
   B. the respirator has gotten wet
   C. the respirator does not seem to fit like it used to
   D. all of the above are correct
   ☐A ☐C ☐B ☐D

6. You must be properly trained and fit tested before wearing a respirator. ☐T ☐F

7. It is up to you to make sure that your respirator is in good condition before you wear it. ☐T ☐F

8. Wearing a respirator means that you do not need to be careful about what you are exposed to. ☐T ☐F

9. A respirator can only protect you if it:
   A. is worn properly
   B. is in good condition
   C. fits you well
   D. all of the above are correct
   ☐A ☐C ☐B ☐D

10. An N95 respirator will protect you from:
    A. dust
    B. mist
    C. tuberculosis
    D. all of the above are correct
    ☐A ☐C ☐B ☐D

11. To check the fit of your respirator, you must perform both positive and negative pressure checks. ☐T ☐F

12. If your respirator becomes damaged or malfunctions you should:
    A. take off the respirator and inspect it
    B. leave the area if you feel ill
    C. immediately leave the contaminated area
    D. finish your work and then go get a new one
    ☐A ☐C ☐B ☐D

13. If your respirator malfunctions, you should leave the contaminated area immediately. ☐T ☐F

SMH Employee Health (EH)

Appendix C to Sec. 1910.134: OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

Name: _____

Occupation/Department: _____

To the Employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical exam

To the Employee: Can you read: (check one) Yes ☐ No ☐

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

PART A. SECTION 1 (MANDATORY)

Every employee who has been selected to use any type of respirator must provide the following information. (Please Print)

1. Today's date: _____
2. Your age (to nearest year) _____
3. Gender: Female ☐ Male ☐ Non-Binary ☐ Trans female ☐ Trans Male ☐ ☐ _____
4. Your height _____ft _____in
5. Your weight _____lbs
6. Your job title _____
7. Phone number where you can be reached by the health care professional who reviews this questionnaire (include area code) _____
8. The best time to reach you at this number _____
9. Has your employer told you how to contact the health care professional who will review this questionnaire: (check one) Yes ☐ No ☐
10. 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 type (for example: half or full-face piece type, controlled/powered-air purifying, supplied-air, self-contained breathing apparatus)
11. Have you worn a respirator (check one) Yes ☐ No ☐

    If "yes", what type(s) _____

PART A. SECTION 2 (MANDATORY)

Questions 1 through 9 must be answered by every employee who has been selected to use any type of respirator (please check "yes" or "no"), **PLEASE EXPLAIN ANY"YES" RESPONSES**.

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?

a. Seizures (fits) Yes ☐ No ☐
b. Diabetes (sugar disease) Yes ☐ No ☐
c. Allergic reactions that interfere with breathing Yes ☐ No ☐
d. Claustrophobia (fear of closed-in places) Yes ☐ No ☐
e. Trouble smelling odors Yes ☐ No ☐

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

a. Asbestosis Yes ☐ No ☐
b. Asthma Yes ☐ No ☐
c. Chronic bronchitis Yes ☐ No ☐
d. Emphysema Yes ☐ No ☐
e. Pneumonia Yes ☐ No ☐
f. Tuberculosis Yes ☐ No ☐
g. Silicosis Yes ☐ No ☐
h. Pneumothorax (collapsed lung) Yes ☐ No ☐
i. Lung cancer Yes ☐ No ☐
j. Broken ribs Yes ☐ No ☐
k. Any chest injuries or surgeries Yes ☐ No ☐
l. Any other lung problems you've been told of Yes ☐ No ☐

4. **Do you currently have any of the following symptoms of pulmonary or lung disease:

a. Shortness of breath Yes ☐ No ☐
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline Yes ☐ No ☐
c. Shortness of breath when walking with other people at an ordinary pace on level ground Yes ☐ No ☐
d. Have to stop for breath when walking at your own pace on level ground Yes ☐ No ☐
e. Shortness of breath when washing or dressing yourself Yes ☐ No ☐
f. Shortness of breath that interferes with your job Yes ☐ No ☐
g. Coughing that produces phlegm (thick sputum) Yes ☐ No ☐
h. Coughing that wakes you early in the morning Yes ☐ No ☐
i. Coughing that occurs mostly when you are lying down Yes ☐ No ☐
j. Coughing up blood in the last month Yes ☐ No ☐
k. Wheezing Yes ☐ No ☐
l. Wheezing that interferes with your job Yes ☐ No ☐
m. Chest pain when you breathe deeply Yes ☐ No ☐
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	Yes ☐	No ☐
b. Stroke	Yes ☐	No ☐
c. Angina	Yes ☐	No ☐
d. Heart failure	Yes ☐	No ☐
e. Swelling in legs or feet (not caused by walking)	Yes ☐	No ☐
f. Heart arrhythmia (heart beating irregularly)	Yes ☐	No ☐
g. High blood pressure	Yes ☐	No ☐
h. Any other heart problem that you've been told	Yes ☐	No ☐

6. **Have you ever had any of the following cardiovascular or heart symptoms

a. Frequent pain or tightness in your chest	**Yes ☐**	**No ☐**
b. Pain or tightness in chest interfering with job	**Yes ☐**	**No ☐**
c. Pain or tightness in chest during physical activity	**Yes ☐**	**No ☐**
d. In the past two years, have you noticed your heart skipping or missing a beat	**Yes ☐**	**No ☐**
e. Heartburn or indigestion that is not related to eating	**Yes ☐**	**No ☐**
f. Any other symptoms that you think may be related to heart or circulation problems	**Yes ☐**	**No ☐**

7. **Do you currently take medication for any of the following problems:

a. Breathing or lung problems	**Yes ☐**	**No ☐**
b. Heart trouble	**Yes ☐**	**No ☐**
c. Blood pressure	**Yes ☐**	**No ☐**
d. Seizures (fits)	**Yes ☐**	**No ☐**

8. If you've used a respirator, have you ever had any of the following problems?
(If you've never used a respirator, check the following box and go to question 9) ☐

a. Eye irritation	Yes ☐	No ☐
b. Skin allergies or rashes	Yes ☐	No ☐
c. Anxiety	Yes ☐	No ☐
d. General weakness or fatigue	Yes ☐	No ☐
e. Any other problem that interferes with your use of a respirator	Yes ☐	No ☐

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? Yes ☐ No ☐

Employee Signature:_____ **Date:** _____

Finding your way to Strong Memorial Hospital .....

YOU MAY PARK IN

SAUNDERS RESEARCH BUILDING VISITOR PARKING LOT #14:
Cross Crittenden Blvd. From the Mental Health & Wellness entrance, enter the sliding glass doors, walk past the front desk and enter the door to the right. Turn right and continue straight. Employee Health (G-6012) will be on your left.

PARKING GARAGE: Use the Hospital Drive entrance off Elmwood Avenue – Please note the color code and level number of your parking location. From the ground floor of the parking garage, enter main hospital and turn right, walk straight past the red elevators. Turn left following signs to the Post Office. Turn right at the Post Office intersection. Employee Health (G-6012) will be on your right.

Link to Maps: Directions to Employee Health

NEED MORE INFORMATION?
Please feel free to contact Employee Health at (585) 275-9300