Welcome to the University of Rochester!

Enclosed you will find details regarding your employment with the University of Rochester. You will find directions to University Health Services (UHS) (for your physical) and directions to the Employment Center (to complete paperwork).

INFORMATION REGARDING YOUR UHS PHYSICAL VISIT University Health Service, River Campus, 738 Library Road, 2nd Floor, Rochester, NY 14627

***Please refer back to the e-mail that you have received from your HR Liaison/Recruiter for the date and time of your appointment.**

Your University appointment is contingent upon the satisfactory completion of a pre-placement physical and a drug test with a negative result. **Per University policy 168, this appointment will not be rescheduled for the convenience of the applicant. If this appointment is missed for any reason, the offer of employment will be rescinded.** Please note that the information gathered at your physical will not be a part of your personnel file but a separate medical record.

Please be prompt! You will also be required to return two days later to have your PPD (Tuberculin Skin Test) read. For Friday appointments, Monday morning is acceptable. You should schedule a follow-up appointment on the day of your UHS pre-placement physical.

➢ Failure to return for the PPD Read after your pre-placement physical will defer your start date and may rescind your employment offer.

➢ The documents listed below are enclosed and must be completed and brought with you when you report for your UHS physical:

1. Pre-placement Communicable Disease Form
2. University Health Services Baseline History Form

➢ It is necessary to bring your original immunization records (this information is often obtained from your doctor, high school, college; or your blood will be drawn for testing). Candidates not providing written immunization records will be vaccinated. The following exceptions will be considered: (1) Candidates who are pregnant or planning pregnancy within the next three months; or (2) Candidates currently on immunosuppressive medications. Refusal of immunization will result in rescinding of the employment offer. In addition, please be sure to bring any prescribed medication(s) that you are currently taking.

➢Please note that information disclosed or discovered in the pre-placement exams which may reveal a conviction for a crime will be reported to the HR Office for review. Discovery of a conviction for a crime will not automatically disqualify an applicant for consideration of employment. However, omission or failure to disclose any conviction may be grounds for disqualification due to falsification of information.

INFORMATION REGARDING YOUR EMPLOYMENT CENTER VISIT: You will also need to report to the Office of Human Resources, 910 Genesee Street, Suite 100, to complete necessary pre-employment forms. You will be scheduled an appointment to come to the Employment Center. Please try to only come at the time you are scheduled. If you are going to be early or late, or cannot make it on your scheduled date please contact your liaison. In order to complete the I-9 Form, please refer to the documentation listing on the reverse side of this letter. You will need to provide one (1) document from List A OR one (1) document from List B and one (1) document from List C.

If you have any questions or concerns, your HR Liaison/Recruiter will be happy to assist you.

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
1. U.S. Passport or U.S. Passport Card		**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		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**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		**2.** Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (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.		**5.** U.S. Military card or draft record		**5.** Native American tribal document
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		**6.** Military dependent's ID card		**6.** U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		8. Native American tribal document		**8.** Employment authorization document issued by the Department of Homeland Security
		9. Driver's license issued by a Canadian government authority		
		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		

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.

Occupational Health Program
(585) 275-4955, Fax (585) 461-9636

UNIVERSITY of ROCHESTER

Director, University Health Service:
Ralph Manchester, MD Vice Provost & Director, UHS

Occupational Health Program Clinical Staff:
Ralph Manchester, MD Director UHS Occupational Health Programs

We are looking forward to serving you in a timely and efficient manner when you come for your pre-placement health evaluation. Proof of immunization is **REQUIRED** prior to beginning work. This can be accomplished in several ways:

1. You may take the enclosed immunization form to your doctor's office and have the form completed. If you choose to use the form provided- Please note that the form **MUST** be signed by your physician or health care provider. We will also accept immunizations without the need for signature printed on official letterhead.

2. If you are from out of town or out of state, you may call your doctor's office and request that your immunization record be faxed to us at (585) 461-9636, attention: Occupational Health Office, **PRIOR** to the day of your appointment.

3. If you are bringing your own immunization record with you, please make sure that it has been signed by your physician or health care provider.

4. If you have had any former affiliation with the University of Rochester as an employee, student, or volunteer, YOU MUST inform Human Resources, or Strong Staffing of such affiliation- otherwise, your records will not be obtained.

5. If your immunization record is not available, we will give you the necessary immunizations, or your blood will be drawn for testing.

Please arrive on time for your appointment. If you have any questions, please feel free to call us at (585) 275-4955, Monday- Friday, 8:00am-4:30pm.

UNIVERSITY OF ROCHESTER
UNIVERSITY HEALTH SERVICE
OCCUPATIONAL HEALTH PROGRAM

PRE-EMPLOYMENT DRUG TESTING QUESTIONS and ANSWERS

- **What is a drug screen?**

A drug screen is a series of tests done on a urine specimen to check for the presence of some commonly abused drugs. The drug screen is processed by the Strong Memorial Hospital (SMH) certified regional toxicology lab.

- **Is there anything I need to know ahead of time?**

✓ You will be required to show photo identification.
✓ Drink no more than 8 ounces of fluid prior to testing to avoid retaking; you will remain in the area until you are able to produce a sufficient specimen.
✓ Have a full bladder as you will remain in the area until you are able to produce a sufficient specimen.
✓ Avoid poppy seed baked goods before testing. Some poppy seeds contain a small amount of morphine which if eaten before a drug test may result in a positive test. One should not eat foods containing poppy seeds for at least 3 days prior to a drug test.

- **Are test results confidential?**

The collector does not know the results. Laboratory staff do not know the identity of the donor since an ID number, not name, is used for specimen identification. The SMH lab reports the results to the UHS physician. UHS tells Human Resources/Residency Program Director whether the individual passed or failed the drug screen.

- **What if my specimen is positive?**

If the initial screening result is positive, it will be confirmed by a second test on the same specimen. Drugs that may be abused are confirmed by a special procedure called gas chromatography-mass spectrometry (GCMS). The procedure eliminates false positives by breaking the drug molecule into fragments. The pattern of fragments is a "finger print" unique to that drug. This procedure ensures the test is accurate. Only results confirmed by GCMS are reported as positive to UHS. The UHS physician will review the test results and you may be asked to provide certification that a particular medication is authorized under a prescribing provider. If further clarification is needed you will need to discuss the results with our Certified Medical Review Officer at Strong Memorial Hospital.

- **How long does it take to get results?**

Normally 24-48 hours. However, results may take as long as 5 days.

- **What is chain of custody?**

Collection, handling and storage of every specimen has to be documented to show that the specimen tested is the specimen given by the donor and tampering with the specimen has not taken place.

The chain of custody system is carefully designed to account for each specimen at all times. The laboratory has a specific protocol followed by all individuals who handle specimens. Complete documentation of a specimen begins with the collection of the specimen and ends when the specimen is discarded. If there is any break in the chain you will be asked to provide another specimen.

Office/Department: ____________________

Name: ____________________ DOB: __/__/__

Immunization Record

NEW YORK STATE MANDATORY REQUIREMENTS:

Measles requirement: Two (2) doses of live vaccine. The vaccine **must** have been given on or after the first birthday, in 1968 or later, and without immune globulin.
A second dose of measles vaccine must meet the same requirement, but should be given no sooner than 30 days after the first dose. Serologic evidence of measles immunity is acceptable, or a history of physician diagnosed measles is acceptable for establishing immunity.
Rubella requirement: One (1) dose of live vaccine given on or after the first birthday AND on or after 1/1/69. Serologic evidence of immunity is acceptable

MEASLES (RUBEOLA)	RUBELLA	*OR MMR*	
1st Immunization: ________ mo/day/yr AND 2nd Immunization: ________ mo/day/yr OR Date of Disease: ________ year OR Serologic Test: ________ mo/day/yr AND Titer Result: ________	Immunization: : ________ mo/day/yr OR Serologic Test: ________ mo/day/yr AND Titer Result: ________	1st Immunization: ________ mo/day/yr AND 2nd Immunization: ________ mo/day/yr	

UNIVERSITY OF ROCHESTER/STRONG MEMORIAL HOSPITAL MANDATORY REQUIREMENTS:

Tetanus/Diphtheria (Td), OR Tetanus/Diphtheria/Pertussis (Tdap) vaccination within 9 years. Tetanus alone does not meet the requirement.
Tuberculin Skin Test: Two PPD (Mantoux intradermal skin test) tests and interpretations are **required, the first within one year of the second and the second within 3 months of the start of appointment.** unless history of past positive skin test is reported.
Chest x-ray: A chest x-ray report within the past 12 months is required only if the PPD is positive.

Td/Tdap	TUBERCULIN SKIN TESTS		CHEST X-RAY
Td Immunization: ________ mo/yr OR Tdap Immunization: ________ mo/yr	Manufacturer: ________ #1 Date Placed: ________ mo/day/yr Date Read: ________ mo/day/yr Results: ________ mm of induration: ________	Manufacturer: ________ #2 Date Placed: ________ mo/day/yr Date Read: ________ mo/day/yr Results: ________ mm of induration: ________	(only when PPD is positive) Date: ________ Result: ________ Attach copy of x-ray report. DO NOT SEND X-RAY FILM

RECOMMENDED IMMUNIZATIONS AND TESTS:

Hepatitis B vaccine: The Centers for Disease Control and Prevention strongly recommend vaccination with hepatitis B vaccine for health care professionals.
Varicella Vaccine: When there is no history of chicken pox disease and susceptibility is verified by a titer, vaccination with varicella vaccine may be beneficial.

HEPATITIS B	VARICELLA (CHICKEN POX)	
Immunization #1 ________ mo/day/yr Immunization #2 ________ mo/day/yr Immunization #3 ________ mo/day/yr Serologic Test: ________ Result: ________ mo/day/yr	Disease History ________ year OR Serologic Test: ________ mo/day/yr Result: ________ OR (if negative titer) Immunization #1 ________ mo/day/yr Immunization #2 ________ mo/day/yr	

Print name and address of certifying physician or official:	Phone No:

I certify that the above is complete and accurate to the best of my knowledge.

SIGNATURE OF CERTIFYING PHYSICIAN or OFFICIAL: ____________________ DATE: ________

Revised 2/24/10
OHPP-11V-Adult Comm Dis Form

UNIVERSITY OF ROCHESTER -- University Health Service
Pre-placement Health Questionnaire

Today's Date	Last Name	First Name	MI

XXXXXXXXXXXXXXXXXXXXX	Date of Birth	Phone

Address	(Street)	(City)	State	Zip

For All University Employees:

- The information obtained from this preplacement health assessment will be used solely to determine whether you have a condition which would presently interfere with performance of job duties. The information obtained in this health assessment will be kept with your occupational health records at the University Health Service, which is separate from employee records in Human Resources.

For Employees working in Healthcare areas:

- **New York State Title 10 Health Code 405.3 (b) (10) (11) requires:**
  The provision for a physical examination and recorded medical history for all personnel and members of the medical staff. The examination shall be sufficient scope to ensure that no person shall assume his/her duties unless he/she is free from a health impairment which is potential risk to the patient or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior.

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.*

Please complete pages 1 – 3 before your UHS appointment.

Do you need help completing this form? YES ❒ NO ❒

JOB TITLE/TYPE OF WORK: ______________________________

Potential work-related exposure to human blood and body fluids? YES ❒ NO ❒

List all current or active medical problems for which you see a physician or other healthcare provider:

____

____

List all medications that you take on a routine or occasional basis (including prescription medications, over- the counter drugs such as aspirin, vitamins, herbs or other supplements):

____

____

List all allergies (including allergies to drugs, latex, food, and environmental sources such as to dust, chemicals, or **animals**):

____

____

ACCOMODATION:

Has a health care professional told you to limit your activities at work or home?	YES ❒	NO ❒
Do you have any permanent medical restrictions on your activities or any permanent impairment?	YES ❒	NO ❒
Do you need any accommodations to perform the job for which you are being evaluated?	YES ❒	NO ❒

If yes to any of the questions above, explain

____

____

Name: ________________________________ **DOB:** ________________

List all hospital admissions/ surgeries (operations) excluding childbirth. If none, check here ❐

	YEAR	REASON FOR HOSPITALIZATION
1.	________	____
2.	________	____
3.	________	____

Check (✔) if your previous work has involved any of the following:												
WORK HISTORY Start with most recent job including military	Number of Years	**A** Asbestos	**B** Chemicals or solvents	**C** Insecticides	**D** Vapors Or fumes (chemical, metall)	**E** Mist (spray paints)	**F** Mineral Dust (coal, rock, silica)	**G** Other Dust (cotton, grain, wood pulp)	**H** X-rays or other radiation	**I** Infectious Agents (hepatitis, TB)	**J** Biologics (blood, sera, etc)	**k** Work with Animals
1												
2												
3												
4												

Have you ever had or do you currently have any of the following: Past = Past Medical History:

Current = current medical problem **(within past 1-2 years)**.

	NO	**PAST**	**CURRENT**	**COMMENTS**
1. Loss or impaired vision in either eye uncorrected by Glasses/contacts?	❐	❐	❐	
2. Do you have difficulty hearing, hearing loss, or use of hearing aids?	❐	❐	❐	
3. Any stomach or intestinal problems?	❐	❐	❐	
4. High blood pressure?	❐	❐	❐	
5. Hepatitis or liver disease, jaundice (turning yellow) ?	❐	❐	❐	
6. Heart problem, heart disease, heart attack, palpitations, chest pain?	❐	❐	❐	
7. Arthritis, joint problems, or amputations?	❐	❐	❐	
8. Back pain or back injury? If yes, how many episodes and length of illness___________.	❐	❐	❐	
9. Serious injury to muscle, bursa or tendon (ex: tendinitis, bursitis or carpal tunnel syndrome)? If yes, 4 all that apply: a. ❐ shoulder b. ❐ arm/hand c. ❐ leg	❐	❐	❐	
10. Seizure, epilepsy or convulsions?	❐	❐	❐	
11. History of stroke, a head injury or other neurologic problems?	❐	❐	❐	
12. Fainting, dizzy spells, lightheadedness, vertigo, Meniere's disease,?	❐	❐	❐	

Name: ______________________________ DOB: _______________

	NO	PAST	CURRENT	COMMENTS
13. Headaches- severe, frequent, interferes with activities?	❒	❒	❒	
14. Any breathing difficulty (asthma, emphysema, frequent wheezing, chronic cough or shortness of breath)? If yes, any treatment?	❒	❒	❒	
15. Tuberculosis (TB) or past positive skin test for TB?	❒	❒	❒	
16. Skin rash, eczema/dermatitis, dry/cracking skin, or other skin conditions?	❒	❒	❒	
17. Problems wearing latex or other gloves?	❒	❒	❒	
18. Problems with alcohol or drug use?	❒	❒	❒	
19. Have you used illegal drugs (ex: marijuana, cocaine, heroin, crack) or abused alcohol.	❒	❒	❒	
20. Have you had treatment for drug or alcohol problems? When? ____________________________	❒	❒	❒	
21. Smoke? Type:____________Amount: _______________	❒	❒	❒	
22. Psychological or emotional problems?	❒	❒	❒	
23. Hernia?	❒	❒	❒	
24. Fatigue that frequently interferes with activity/fibromyalgia?	❒	❒	❒	
25. Cancer?	❒	❒	❒	
26. Diabetes/ sugar problems?	❒	❒	❒	
27. Anemia or blood problems?	❒	❒	❒	
28. Learning disability?	❒	❒	❒	
29. Any other illness not mentioned?	❒	❒	❒	
30. Do you have any diseases that affect your immune system's ability to fight infection (e.g., cancer, leukemia, lymphoma, myeloma, sickle cell anemia, HIV/AIDS)?	❒	❒	❒	
31. Are you taking (or in the past year have you taken) any medication that affect your immune system's ability to fight infection (e.g., chemotherapy, steroids, disease-modifying drugs for arthritis, psoriasis or inflammatory bowel disease)?	❒	❒	❒	
32. Have you had a bone marrow transplant or stem cell transplant?	❒	❒	❒	
33. Has your spleen been removed?	❒	❒	❒	

I hereby certify that the information herein is correct, and I understand that misrepresentation on my part may result in dismissal if I am employed.

Signed____ **Date**_______________

Name/address of physician or health care facility where you are currently receiving your medical care:

Name ____ Phone _______________

Address ____

____

PROVIDER COMMENTS: ____

____

____

Name: ______________________________ DOB: _______________

FOR UHS USE ONLY

❒ **Physical Examination not required**

❒ **Physical Examination REQUIRED**

VITAL SIGNS

Height____ft____in **Weight________lbs** **Temperature__________°C** **Blood Pressure________/________**

VISION

❒ With correction	Near R ________	Far R _________	Peripheral ______	Date of last eye
❒ Without correction	L ________	L _________	Color _________	exam:___/___/___

PHYSICAL EXAMINATION

Normal	Abnormal		Comments
❒	❒	Skin	____________________
❒	❒	HEENT	____________________
❒	❒	Nodes	____________________
❒	❒	Lungs	____________________
❒	❒	Heart	____________________
❒	❒	Abdomen	____________________
❒	❒	Musculoskeletal	____________________
❒	❒	Reflexes	____________________
❒	❒	Other (based on history)	____________________

ASSESSMENT and PLAN

❒ Placement as indicated, ***PENDING*** compliance with immunization requirements. (No health factors preclude placement.)

❒ ***ACCOMMODATIONS*** necessary. (See Preplacement Data Form for details)

❒ ***DEFER*** placement until health factors resolved.

❒ **Statement** requested from treating physician. Comment: ______________________________

❒ **Consult** with OH MD Comment: ______________________________

❒ **Examination** by UHS physician needed. Appointment date/time: ______________________________

EXAMINER SIGNATURE:________________________________ RN / NP / MD ______Date: ___/____/____

FINDING YOUR WAY......

Directions to University Health Service
River Campus
Library Lot

- Stop at the Information Booth on Wilson Boulevard, corner of Elmwood Avenue
- The Information Booth Attendant will give you a Dash Pass to put on your dashboard while parking in a designated UHS parking spot in the Library Lot
- Proceed straight on Wilson Boulevard
- Turn right on Library Road
- Continue to the top of the road
- At the 2nd stop sign, turn left onto Intercampus Drive
- Proceed a few yards, turn left into the Library Lot parking lot
- Scan the barcode from the dash pass when you approach the parking lot gate
- There will be a short delay before the gate opens
- If you experience a problem, hit the “i” button on the keypad. You will be connected, via intercom, to the Parking Attendant who will assist you
- You must park in a UHS designated spot. The designated spots are located on the right side of the Library Road Lot, next to the UHS Building
- Place the dash pass on your dashboard before coming into the UHS Building
- • The Dash Pass authorizes you to park in a UHS parking spot for up to 2 hours. If the pass is not on your dashboard, or if you are parked longer than 2 hours, you run the risk of receiving a parking ticket

NEED MORE INFORMATION?

Please feel free to contact our Information Hotline Number at 275-2275