

Ottumwa Regional Health Center New Employee Report

Employee Name _____ SS# _____ Dept _____

TETANUS STATUS _____ Yrs. Ago / Given if over 10 years Y or N Date _____ Declined _____

TUBERCULOSIS

Have you ever had tuberculosis? Y or N _____ If yes, where were you treated? _____
Have you ever had a TB test before? Y or N _____ If yes, was it ever positive? _____
If it was positive how long ago and where were you tested? _____
Have you ever been inoculated with BCG? Y or N Don't know _____
If yes how long ago and where did you receive this inoculation? _____
Are you pregnant? _____
Have you had a TB test in the last year? _____ If yes, do you have proof with you? _____

I understand the risks of exposure to tuberculosis in my employment setting. This is recommended by the American lung Associate as an aid in the detection of infection with Mycobacterium tuberculosis. I am aware of potential adverse reactions or side effects that may occur from the test, including but not limited to vesiculation (blistering), ulceration (shallow sore) or necrosis (deeper sore with temporary skin loss) at the site. I hereby consent to allow the Ottumwa Regional Health Center Occupational Health Service to perform this test on me today. I agree to return to the clinic or another health facility in 48-72 hrs so that staff can read the test results and offer me further counseling as needed.

Signature _____ Date _____

1st TB TEST-Date/Time given _____ RFA/LFA _____ Given by _____
1st TB READ-Date/Time read _____ Results _____ mm _____ Read by _____

*****Schedule Date for Second TB Test*****

IF NO PROOF OF PREVIOUS TB TEST WITHIN THE LAST 12 MONTHS IT IS MANDATORY THAT ALL EMPLOYEEES HAVE A 2ND TB TEST 10-14 DAYS FROM THE FIRST ONE.

2nd TB TEST-Date/Time given _____ RFA/LFA _____ Given By _____
2nd TB READ-Date/Time read _____ Results _____ mm _____ Read by _____

MMR

Proof of two MMRs Y or N _____
No Proof of two MMRs Y or N _____
If no proof rubella titer drawn Y or N _____
If no proof rubeola titer drawn Y or N _____
Rubella titer drawn Y or N _____
Rubeola titer drawn Y or N _____

Have you had the Chicken Pox? Y or N _____
Have you had the Chicken Pox Vaccine? Y or N _____

Hepatitis B

Has had the series of 3 -Y or N _____ Antibody drawn- Y or N _____ Results- Pos or Neg _____

Vaccine offered if Associate works in any of the following areas: *Emergency, Environmental Services, Nursing, Laundry, Plant Operations, Dietary, Patient Family Services, Family Recovery, Radiology, SIROC, or Central Supply.*
Offered Series Y or N _____ Started Series- Y or N Date _____ Associate signed declination - Y or N _____

• **I have answered all the above questions to the best of my knowledge.**

Signature _____ Date _____

Respiratory Fit Testing

If an associate works in the following areas: Radiology, Home Health Care, Emergency, OR, Procedures, or Respiratory therapy fit testing must be completed.

Associate fitted _____ Size of mask _____ Department _____