

Post-Offer Screening Patient Contact Form

UF Residency / Fellowship

February 1, 2019

Dear New University of Florida Medical or Dental Resident/Fellow:

Welcome to the University of Florida. I hope that you will find your training experience here challenging and profoundly worthwhile.

As Interim Director of the UF Student Health Care Center (SHCC), it is my role to oversee the Occupational Medicine Program for the University. It is our goal at this program to tailor the Post-Offer Health Assessment Evaluations of new employees to the individual job description and duties. As Medical and Dental Residents or Fellows, your patient care duties make a post-offer screening process both advisable and necessary. Via this evaluation, we hope to minimize any occupational risks to you and to ensure that you can safely perform the essential functions of your new job. Please make sure you print your name and UF ID number legibly on each page.

Please complete the Post-Offer Screening Patient Contact Forms

(www.ehs.ufl.edu/programs/occmed/healthassess/residents)

and return them to the UF Occupational Medicine Program via email (occmedclinic-riskassessment@ahc.ufl.edu) by

May 1, 2019.

- **Section I: Medical History** – Includes completing questions on pages 1-2. Please complete your contact information should we need to contact you if more information is needed prior to beginning your Residency/Fellowship Program.
- **Section II: Immunization History** – Must be completed and signed by a physician or authorized health professional certifying the accuracy of your immunization data. Go to your university or college's student health services or your hospital's occupational health service for completion of this information. **Your immunization history will not be accepted if you complete the form and sign it yourself. Please take the time to collect all specific immunization and/or titer dates and any X-ray results and submit these together. You will not proceed through the medical clearance process to official hire until all records are received, reviewed and approved.**
- **Medical History Questionnaire for N-95 Filtering Face Respirator** – Complete the form, as you may be required to be fitted for this piece of protective equipment.

Please note that the specific medical history information you supply will be kept confidential and will not be shared with your Residency/Fellowship director or program. The Occupational Medicine provider will determine if additional medical information, testing or a physical examination is needed based on the medical information you provide. Occupational Medicine personnel may notify you if additional information is needed. Should additional vaccinations or titers be necessary, it is your responsibility to get these before you start your residency and to submit to the Occupational Medicine program prior to your start date. If a physical examination, immunizations, or additional testing are required you should obtain them through your current medical provider.

Once all needed documentation is completed, the UF Occupational Medicine personnel will either recommend you for duty with certain specified restrictions or modifications to your job duties or you will be recommended for full duty without limitations.

If you have any questions regarding the UF's Post-Offer Screening and Medical Monitoring Programs for Medical and Dental Residents/Fellows, please send all correspondence to occmedclinic-riskassessment@ahc.ufl.edu . Once again, welcome to the University of Florida.

Sincerely,

Ronald Berry, MD

Interim Director, UF Student Health Care Center (<http://shcc.ufl.edu>)

RB/bac

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The information requested on these pages is necessary in order to minimize any occupational risks to you and to insure that you can safely perform the essential functions of your new job. Medical History information on this form will be kept in a confidential file at the SHCC, and will not be shared with your Employer, Program or Director without your written permission/consent. Immunization Documentation may be shared with your Program and the Occupational Medicine Department of your work site.

Must complete ALL sections. Please print legibly.

Name: _____ **Date of Birth:** _____
(Last, First, Middle Initial) (Mm / dd / yy)

UF ID #: _____ **Gender at Birth: Male** _____ **Female** _____

Email Address: _____ **Cell number:** _____

Address: _____

City, State Zip: _____

Work Site - Gainesville: _____ **Jacksonville:** _____ **Other:** _____

Department: _____ **Supervisor/Program Director:** _____

Job Title: Resident Fellow (MUST circle one)

Section I - Medical History

Do you have now, have you ever had, or have you received treatment for the following:

Yes	No		If YES use as many lines below as needed to explain with dates.
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol abuse/alcoholism	_____
<input type="checkbox"/>	<input type="checkbox"/>	Allergies to medications/foods	_____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	_____
<input type="checkbox"/>	<input type="checkbox"/>	Back or neck injury	_____
<input type="checkbox"/>	<input type="checkbox"/>	Carpal Tunnel syndrome	_____
<input type="checkbox"/>	<input type="checkbox"/>	Chronic back pain	_____
<input type="checkbox"/>	<input type="checkbox"/>	Current Medications: doses and Frequency	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (type)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty hearing/hearing aides	_____
<input type="checkbox"/>	<input type="checkbox"/>	Drug abuse/addiction	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hospitalizations/Surgeries	_____
<input type="checkbox"/>	<input type="checkbox"/>	Immunosuppression	_____
<input type="checkbox"/>	<input type="checkbox"/>	Infectious Disease	_____

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UF Residency / Fellowship

Yes	No		If YES use as many lines below as needed to explain
<input type="checkbox"/>	<input type="checkbox"/>	Latex allergy or other skin sensitivities	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other hand/wrist problems	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other liver disease (type)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	_____
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Visual loss (one or both eyes)	_____

Have you ever had a work-related illness or injury? Yes ___ No ___

If yes, explain: _____

Have you been cleared by a medical provider to return to full duty without restrictions? Yes ___ No ___

Date: _____

Are you currently recovering from any significant illness, surgery or injury? Yes ___ No ___

If yes, explain: _____

Have you been cleared by a medical provider to return to full duty without restrictions? Yes ___ No ___

Date: _____

Do you have any medical or psychological conditions that you feel may prevent you from completely and safely performing the duties outlined in your job description, or do you require/request any modifications to your job duties? Yes ___ No ___ If yes, explain: _____

Would you like to speak to a UF Occupational Medicine clinician about any of the information you have given above? Yes ___ No ___ If yes, daytime phone (_____) _____

The Genetic Information Nondiscrimination Act of 2008 (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.

Print Name: _____ **UFID#:** _____

Signature: _____ **Date:** _____

Post-Offer Screening Patient Contact Form UF Residency / Fellowship

Name: _____ DOB: _____ UFID: _____

Required Immunizations				
Positive titer for immunity will substitute for shots on numbers 1-4. Titers must have lab attached				
	Mo/Day/Year	Mo/Day/Year	Mo/Day/Year	Titer Date & Result*
1. Measles (2 doses after 1 st birthday)				
2. Mumps (2 doses after 1 st birthday)				
3. Rubella (2 doses after 1 st birthday)				
4. Varicella (Chicken Pox 2 doses after 1 st birthday)				
5. Hepatitis B (vaccination dates required)				Titer does not substitute
6. Tdap (adult booster within 10 years)				

Required Tuberculosis Screening				
Tuberculosis screening completed within 12 months prior to start date must be either: Two negative TST's** (PPD's) or a negative Interferon Assay <u>BCG is not a substitute for a previous positive screening for TB.</u> If there is a history of a prior positive TB screening result then see below.				
PPD** #1 Skin Test (Tuberculosis Screening)	Date Placed	Date Read	MM	Neg or Pos
PPD** #1 Skin Test (Tuberculosis Screening)	Date Placed	Date Read	MM	Neg or Pos
Interferon-based Assay* (instead of PPD's)		Date	Result	

(OR)

If past positive PPD or positive Interferon Assay you must submit documentation: 1.) Original report of positive TST, (BCG is not a substitute for a previous positive screening for TB), 2.) Chest x-ray within 12 months prior to start date (record below), and 3.) UF TB surveillance form. All 3 items must be submitted.				
Past Positive PPD skin Test	Date Placed	Date Read	MM	Neg or Pos
Interferon-based Assay* (attach copy of lab)		Date	Result	
CXR* (only if past positive PPD)		Date	Result	

***All titers, assays, and chest x-rays must have results attached**

**TST's (PPD) placements must be at least 7 days apart and cannot be placed within 28 days after a live virus immunization like measles, mumps, rubella, or varicella. TST's (PPD's) must be read within 48-72 hours after placement.

Official Office Stamp Here	Authorized Signature	Date
An official stamp from a doctor's office, clinic, or health department AND an authorized signature must appear here or this form will not be approved. You or a family member may not be the authorized signator of your own form.		

University of Florida
Occupational Medicine Program
Email: occmedclinic-riskassessment@ahc.ufl.edu