Duke | Employee Occupational Health & Wellness

Health Requirements

The placement health review is a required process for selected positions at Duke University and Health System based on federal, state, and Duke University regulations and policies. All information is maintained confidentially and separately from personnel and other Duke medical records. In addition to below items, a health review screening is required. Please upload documentation for each item below to our secure portal or fax to 919-385-7574.

Medical Record Requirements
Official Documentation of your Tuberculosis (TB) status: • Documentation of a negative TB skin test (mm induration) or TB blood test (IGRA) - within 1 year prior to start date at Duke. (*Note- Individuals who are 55 years or older, have previous equivocal TB testing results, have a history of BCG vaccine, or are from TB endemic areas will be required to show proof of a two-step skin test or a negative IGRA*), or • Documentation of previous positive result for the TB skin test or blood test   ○ **Those who have positive TB skin or blood test will need to provide documentation of chest x-rays, prior TB medication, and completed TB questionnaire form, described further in the FAQs.**
Official Documentation of your Measles immunity, either: • Two doses of Measles vaccine or 2 (MMR) vaccines or • A positive blood test (titer) for Measles (Rubeola) Antibody IGG
Official Documentation of your Mumps immunity, either: • Two doses of Mumps vaccine or 2 (MMR) vaccines or • A positive blood test for Mumps Antibody IGG
Official Documentation of your Rubella immunity, either: • One dose of Rubella vaccine or (MMR) vaccine or • A positive blood test for Rubella Antibody IGG
Official Documentation of your "chicken pox" Varicella (Vz) immunity, either: • Two doses of Varicella vaccine or • A positive blood test for Varicella surface Antibody IGG
Official Documentation of "whooping cough" Pertussis immunity is required for anyone who MAY provide care to children 18 months of age or younger as well as in certain designated work areas* • Tdap vaccination within past 10 years and must have and adult booster (after the age of 18).   * *For all others*, vaccination with acellular pertussis vaccine (Tdap) is strongly recommended.
Official Documentation of influenza immunity: • Documentation of Influenza vaccine during current flu season. Requests for medical exemptions must be made through Employee Occupational Health. Requests for religious exemptions must be made through Staff and Labor Relations. • Annual Influenza vaccination is required for your employment at Duke.

Official Documentation of Covid-19 immunity:
• Newly hired employees will be required, at a minimum, to have completed a primary series of World Health Organization (WHO) approved COVID-19 vaccination or have received a single dose of Novavax vaccine* or have a Duke-approved medical or religious exemption prior to their start of work date.
  ○ *Employees receiving their first Novavax vaccine will be expected to complete the initial series within 60 days from their initial dose.
• COVID website for updated information & resources:
  https://covidvaccine.duke.edu/ and https://covid-19.dukehealth.org/vaccine-information
- Requests for medical exemptions must be made through Employee Occupational Health. Requests for religious exemptions must be made through Staff and Labor Relations.

Documentation of polio immunity: • History of receiving childhood polio vaccine is acceptable.

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Medical Record Requirements (continued)

Documentation of respirator fit testing

- **Some groups of newly hired** healthcare workers will be required to have a respirator fit test.
  - Duke has walk-in fit testing available. If you come to EOHW during your placement process, your fit test can be done at that time.
  - If you are **fully cleared <u>remotely</u>** then you have 5 business days from your start date to visit a Duke OESO or EOHW site for your respirator fit test. Locations and times are detailed in the links below:
    1. Duke OESO location: Times vary. https://www.safety.duke.edu/occupational-hygiene-safety/personal-protective-equipment/respiratory-protection/upcoming-fit-test-sessions
    2. Duke Employee Occupational "Wellness" location. M-F 8am-4pm. Closed Wed from 12:30-2pm. https://hr.duke.edu/wellness/eohw/directions-eohw

Hepatitis B Vaccination and Post Vaccination Antibody Titer –Vaccine series is strongly recommended. Provide record of vaccination and/or Hepatitis B Antibody results.

Healthcare workers <u>without proof of Hepatitis B antibody titer</u> after vaccine series are encouraged to obtain a titer prior to placement appointment.

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Placement Health Assessment

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers 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.

Name (Print) *first name, middle initial, last name* Pronouns:	Duke Unique ID #:
Address:	Cell/Home phone:
City, State, zip code:	Preferred Email:
Title of the job you have been offered:	Birth date:
Dept/work area:	Start Date:
Supervisor/ Manager:	Work phone:

Check entity where you will be employed:

☐ Duke University Hospital ☐ Duke Regional ☐ Duke Raleigh ☐ University - SOM, SON, DCRI
☐ Ctr for Living – Health & Wellness ☐ Labco – DUHS Clinical Labs ☐ Duke Primary Care
☐ Private Diagnostic Clinic ☐ Duke HomeCare/Hospice ☐ Patient Revenue Mgmt Org.
☐ Assoc. Health Svc/Davis Ambulatory Surg Ctr ☐ DUHS - Company20, Corporate Services

Employment Information

Will you work with: ☐ **Patient Care Building**, or ☐ **Completely off site**
☐ **Blood and Body Fluids** ☐ **Lab animals**

Do you have any current disability or physical condition requiring restricted activity? ☐ Yes ☐ No

Do you have any lifting restrictions? ☐ Yes ☐ No

Do you have decreased ability to lift, carry, push/pull, and transfer patients and/or equipment/ materials as described in your employment interview and/or health assessment?
☐ Yes ☐ No

If yes, are these restrictions:
☐ Permanent ☐ Temporary until

If yes, to any above, please describe: Use separate sheet if needed

Have the physical demands of the job been described to you?
☐ Yes ☐ No ☐ Uncertain

Please state your understanding of the amount of weight and frequency of lifting required in this job:
_____ lbs. (*ex. Up to 10, 25, 30, 50, 75, or over 75 lbs.)*
_____ frequency *(ex. Up to 1/3, 2/3, or whole shift)*

Can you perform the essential functions of this job?
☐ Yes ☐ No ☐ Uncertain

If no, will you require a job modification to accommodate a disabling health condition? *(Speak with EOHW or see http://access.duke.edu for more information about making a request for an accommodation.)*
☐ Yes ☐ No ☐ Uncertain

Occupational History – List your last three positions, starting with the most recent.

	JOB TITLE/ Length of employment	BRIEF JOB DESCRIPTION	DUTIES PERFORMED
1			
2			
3			

List ALL current medications/treatments (including non-prescription), the condition treated, date begun.

Medication	Dosage	Condition	Start Date

Functional Self-Assessment

Duke ID _____

(*Check all that apply)*

1. Do you have any of the following?

Y ☐ **N** ☐ Loss of vision in either eye that cannot be corrected

Y ☐ **N** ☐ Loss of vision requiring correction
select type of correction needed (if applicable):

☐ Near Correction ☐ Far Correction
☐ Eyeglasses ☐ Contact Lenses

Y ☐ **N** ☐ Color vision deficiencies?

Y ☐ **N** ☐ Loss of hearing that is corrected
Y ☐ **N** ☐ Loss of hearing that is not corrected

2. Do you have decreased function in any of the following?

Y ☐ **N** ☐ Either arm/hand, including grip/reach, use of fingers

Y ☐ **N** ☐ Neck or lower back (such as arthritis, or pinched nerve)

Y ☐ **N** ☐ Hips, knees, ankles, or feet

If yes to any of the above, please describe:

3. Do you have decreased ability in any of the following?

Y ☐ **N** ☐ To stay awake or maintain consciousness (due to such causes as seizures, diabetes, or sleep disorder)

Y ☐ **N** ☐ To breathe or maintain endurance (due to such causes as asthma, emphysema, or angina)

Y ☐ **N** ☐ To fight off infection (due to such causes as immune deficiency, diabetes, HIV infection, drugs for rheumatoid arthritis, cancer, and other illnesses)

If yes to any of the above, please describe:

4. Do you have physical conditions (such as seizure disorder, diabetes, allergies) or mental/emotional conditions (such as anxiety, attention deficit disorder, or claustrophobia) that could interfere with any of the following?

Y ☐ **N** ☐ Managing multiple tasks at one time
Y ☐ **N** ☐ Focusing on job tasks
Y ☐ **N** ☐ Working rotating shifts (nights, evenings)
Y ☐ **N** ☐ Working with soaps, detergents
Y ☐ **N** ☐ Wearing gloves
Y ☐ **N** ☐ Using a respirator
Y ☐ **N** ☐ Working with radiation or chemotherapy agents
Y ☐ **N** ☐ Working with animals

If yes to any of the above, provide comments:

5. Have you ever experienced any of the following?

Y ☐ **N** ☐ A substance use/dependence problem?
Y ☐ **N** ☐ An alcohol use/dependence problem?

6. **Y** ☐ **N** ☐ Were you told by a health care professional that you have a latex allergy? If yes, check the symptoms you had related to latex exposure:

☐ Itching ☐ Runny or stuffy nose ☐ Shortness of breath
☐ Wheezing ☐ Sneezing ☐ Rash/skin irritation
☐ Anaphylaxis, intraoperative shock, or hives due to such causes as catheter or condom use?

7. **Y** ☐ **N** ☐ Have you experienced itching or swelling of the throat or lips while eating or during dental work?

8. **Y** ☐ **N** ☐ Were you born outside of the US?
9. **Y** ☐ **N** ☐ Have you had the BCG vaccine?
10. **Y** ☐ **N** ☐ Have you had the polio vaccine?
11. **Y** ☐ **N** ☐ Do you have questions regarding general health, reproductive health, or other safety issues at work that you would like to discuss with a provider?

If yes to any of the above, please describe:

I authorize *EOHW or its representative to access my record in the North Carolina Immunization Registry.* **Y** ☐ **N** ☐

I certify *that the information I have provided is true to the best of my knowledge. I understand that misrepresenting the facts may result in forfeiture of this employment opportunity. I understand that this information will become part of my confidential Employee Occupational Health record and is not shared with management.*

Applicant's Signature _____	Date _____ mm/dd/yy
Reviewer's Signature _____	Date _____ mm/dd/yy

OSHA QUESTIONNAIRE FOR RESPIRATOR USERS

Employees who need respiratory protection against M. Tuberculosis, SARS, Or other particulates found in clinical settings

The Occupational Safety and Health Administration (OSHA) requires that the following information be provided by every employee who has been selected to use any type of respirator (please print). If you have any questions regarding this form, you may call EOHW at 919-684-3136 Option #2. Some of the information has been completed for you, as it is the same for all Healthcare Workers at Duke Health.

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that in convenient to you. To maintain your confidentiality, your supervisor must not look at or review your answers to the medical portion of this questionnaire.

Can you read? ❑ Yes ❑ No

Today's Date:_____

Name:_____

Work Phone:_____

Duke ID: _____

Cell Phone :_____

Date of Birth: _____

Department:_____

Job Title:_____

Clinic Location:_____

Coordinator/Supervisor Name: _____

Sex: ❑ Male ❑ Female

Age: _____ **Weight**: _____ lbs.

Height: _____ ft. _____ in.

Check the type of respirator you will use in this job

Respirator types are pre checked for healthcare workers*

PAPR or N-95

☑ N, R, or P disposable respirator (filter-mask, non-cartridge type only). (<1lb)
❑ air-purifying, half mask (< 1 lb)
❑ air-purifying, full mask (1-3 lbs)
☑ powered air-purifying hood (<4 – 12 lbs)
❑ powered air-purifying, tight fitting (< 5 lbs)
❑ supplied air, hood (<3 lbs)
❑ supplied air, tight fitting (2 –4 lbs)
❑ Self-Contained Breathing Apparatus (SCBA) (24 lbs)
❑ Other:_____

Use is ☑ Required ❑ Voluntary

Please indicate your level of work effort while using the respirator, indicating the amount of time you would spend at each level in a day: *(Activity level pre-checked for the healthcare worker)*

Level of Effort		Examples
❑ light	____hours	Typing, operating a drill press.
☑ moderate	___hours	Nailing, assembly work, pushing a wheelbarrow on a level surface
❑ heavy	____hours	Heavy lifting, shoveling, climbing stairs with a heavy load

How often do you expect to use the respirator?

❑ Respiratory Isolation Patients
❑ Emergency only
❑ Less than 5 hours per week
❑ Daily, for less than 2 hours per day
❑ Daily, for 2 - 4 hours per day
❑ Daily, more than 4 hours per day

Have you worn a respirator in the past? ❑Yes ❑No

If yes, what type(s)? _____

Duke ID _____ Employee Name_____

On the list below, please check any types of personal protective equipment you will be wearing when using your respirator. (❑ None) *(PPE pre-checked for the healthcare worker)*

☑ Gloves ❑ Hearing protection ☑ Apron or lab coat
☑ Eye protection ❑ Hard hat ❑ Full body suit PPE
❑ Any other PPE that will be worn: (Please describe)_____

Will you be working under hot conditions? (above 85 deg. F): ❑ Yes ❑ No
Will you be working under humid conditions? ❑ Yes ❑ No

Describe the work you will be doing while using your respirator(s):
❑ Care of respiratory isolation patients ❑Other _____

Describe any special or hazardous conditions you might encounter when using your respirator(s) (for example, confined spaces, life-threatening gases):

_____N/A_____

Describe any special responsibilities you will have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue or security):

_____

Provide the following information, <u>if known</u>, for each potentially hazardous substance that you will be exposed to when using your respirator(s).

Name of potentially hazardous substance	Estimated Maximum Exposure Level	Duration of exposure (# hours/week)
Airborne M. Tuberculosis	Care of TB patient as necessary	Actual frequently not known
Airborne SARS pathogen		
Other airborne particulates		

Has your employer told you how to contact the health care professional who will review this questionnaire? (Call Employee Health at 684-3136 opt. 2.) ❑ **Yes** ❑ **No**

_____

For Employee Occupational Health Services (EOHS) use only:

Medically approved for ❑All air-purifying respirators ❑Supplied Air Respirators ❑SCBA
❑Other:_____

Restrictions: ❑Employee may decline respirator-requiring assignments for temporary health-related difficulties
❑Other: _____

Effective through_____ OR ❑ Complete brief questionnaire at time of annual training (Required users only)
Employee has been provided with a copy of this written recommendation: ❑Yes ❑No

Signature of Physician or Other Licensed Health Care Professional:_____

(Criteria: EE has health problems – Use medical judgment; No relevant health problems: indefinite clearance (20 years).)

Duke ID _____ Employee Name_____

Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please check "yes" or "no")**. Employee Occupational Health and Wellness (EOHW) at 684-3136 can assist you with this portion of the questionnaire.

	Yes	No
1. Do you <u>currently</u> smoke tobacco, or have you smoked tobacco in the last month?	❑	❑
2. Have you <u>ever had</u> any of the following conditions?		
a. Seizures (fits)	❑	❑
b. Diabetes (sugar disease)	❑	❑
c. Allergic reactions that interfere with your breathing	❑	❑
d. Claustrophobia (fear of closed-in places)	❑	❑
e. Trouble smelling odors	❑	❑
f. Heat stroke	❑	❑
3. Have you <u>ever had</u> any of the following pulmonary or lung problems?		
a. Asbestosis	❑	❑
b. Asthma	❑	❑
c. Chronic bronchitis	❑	❑
d. Emphysema	❑	❑
e. Pneumonia	❑	❑
f. Tuberculosis	❑	❑
g. Silicosis	❑	❑
h. Pneumothorax (collapsed lung)	❑	❑
i. Lung cancer	❑	❑
j. Broken ribs	❑	❑
k. Any chest injuries or surgeries	❑	❑
l. Any other lung problem that you've been told about	❑	❑
4. Have you <u>ever had</u> any of the following cardiovascular or heart problems?		
a. Heart attack	❑	❑
b. Stroke	❑	❑
c. Angina	❑	❑
d. Heart failure	❑	❑
e. Swelling in your legs or feet (not caused by walking)	❑	❑
f. Heart arrhythmia (heart beating irregularly)	❑	❑
g. High blood pressure	❑	❑
h. Any other heart problem that you've been told about.	❑	❑

	Yes	No
5. Do you <u>currently</u> have any of the following symptoms of pulmonary or lung illness?		
a. Shortness of breath	❑	❑
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline	❑	❑
c. Shortness of breath when walking with other people at an ordinary pace on level ground	❑	❑
d. Have to stop for breath when walking at your own pace on level ground	❑	❑
e. Shortness of breath when washing or dressing yourself	❑	❑
f. Shortness of breath that interferes with your job	❑	❑
g. Coughing that produces phlegm (thick sputum)	❑	❑
h. Coughing that wakes you early in the morning	❑	❑
i. Coughing that occurs mostly when you are lying down	❑	❑
j. Coughing up blood in the last month	❑	❑
k. Wheezing	❑	❑
l. Wheezing that interferes with your job	❑	❑
m. Chest pain when you breathe deeply	❑	❑
n. Any other symptoms that you think may be related to lung problems.	❑	❑

Duke ID _____ Employee Name_____

	Yes	No
6. Have you <u>ever had</u> any of the following cardiovascular or heart symptoms?		
a. Frequent pain or tightness in your chest	❑	❑
b. Pain or tightness in your chest during physical activity	❑	❑
c. Pain or tightness in your chest that interferes with your job	❑	❑
d. In the past two years, have you noticed your heart skipping or missing a beat	❑	❑
6 e. Heartburn or indigestion that is not related to eating	❑	❑
f. Any other symptoms that you think may be related to heart or circulation problems	❑	❑
7. Do you <u>currently</u> take medication for any of the following problems?		
a. Breathing or lung problems	❑	❑
b. Heart trouble	❑	❑
c. Blood pressure	❑	❑
d. Seizures (fits)	❑	❑

	Yes	No
8. If you've used a respirator, have you <u>ever had</u> any of the following problems? (If you've never used a respirator, check no on this line and go to question 9)		
a. Eye irritation	❑	❑
b. Skin allergies or rashes	❑	❑
c. Anxiety	❑	❑
d. General weakness or fatigue	❑	❑
e. Any other problem that interferes with your use of a respirator	❑	❑
9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?	❑	❑

****Briefly explain "Yes" answers:**

Duke UNIVERSITY

EMPLOYEE OCCUPATIONAL
HEALTH AND WELLNESS (EOHW)

Remote Color Vision Screening

Requirements

This screening requires an additional adult who is not color blind to witness the test and sign below.

Instructions

Please go to the color vision screening test. Follow the instructions on the site and complete all 12 pictures. Once all of the questions have been answered, report the percentage of correctly answered questions below.

On _____ (date) the Ishihara's Tests for Color-Blindness was administered remotely to the following individual and the test findings are indicated below:

Applicant Name: _____

Duke Unique ID: _____

Percent correct: _____

Applicant Signature (Required): _____

Witness Signature (required): _____