Please Read This Page

These forms need to be opened in Adobe Reader or Adobe Acrobat to work properly. Do not open them in your internet browser. Failure to use Adobe may result in missing fields, missing signature blocks, or other issues.

Instructions:

Don't just click the file at the bottom of your browser (e.g. Google, Firefox, or Edge). This often opens the file inside the browser itself. The easiest way to ensure you are using Adobe is to browse to the download location on your computer and open the file from there.

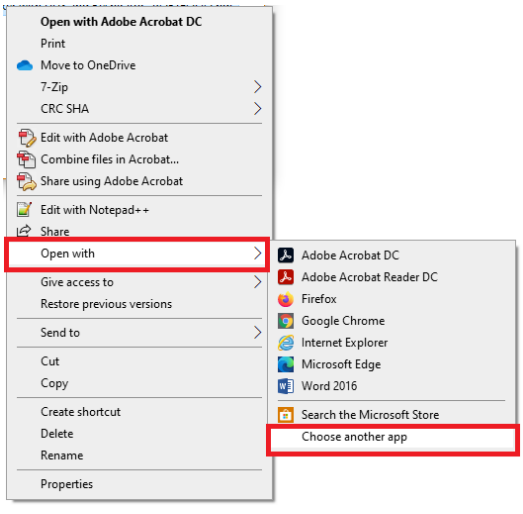
If you are using Windows, Adobe Reader is likely already installed on your computer. You can search for it in the start menu. If you don't have Adobe Reader or Acrobat, download Reader and install it. It's quick and free, and can be downloaded here: https://acrobat.adobe.com/us/en/acrobat/pdf-reader.html.

Also, please note that browsers often try to take over your default file types too. If you see something other than the Adobe symbol ( ) as your file's icon, it won't open in Adobe when you double-click it. You'll need to Right-Click the file and choose "Open with" and then select Adobe from the pop-up list. If Adobe isn't on the pop-up list, select "Choose another app" to find Adobe.

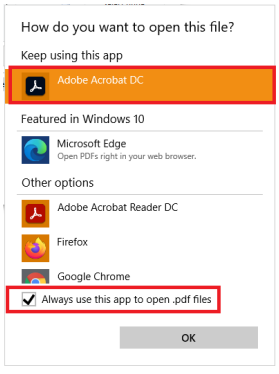
Optional: Setting the Default App for PDFs on Your Computer to Always Use Adobe

From your default download location on your computer, or wherever you saved the file, we can change the default app that will be used to open all PDFs on your computer. Here's how to do that:

1) Right-Click the PDF's file name
2) Choose "Open with"
3) Choose "Choose another app"



4) Make sure the "Always use this app to open .pdf files" box is checked **On**.
5) Select Adobe Reader or Adobe Acrobat from the list.
6) Press "OK". That's it! Your PDF icons will change to the Adobe symbol ( ) and Adobe will now be your default PDF app.



Employee Occupational Health Assessment- Initial Preplacement

The purpose of this evaluation is to screen for immunity to communicable diseases and to identify physical, mental, or emotional impairments that could affect your ability to perform the job that you have been offered. Whenever such impairment is present, we will assist you with the reasonable accommodation process (see www.access.duke.edu). This evaluation is not a comprehensive health review to identify hidden disease or to offer medical treatment.

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*	Duke Unique ID #: Birth date:
Address:	Cell/Home phone:
City, State, zip code:	Email:
Title of the job you have been offered:	Start Date:
Dept/work area:	
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 Contact**, or ☐ **No Patient Contact**
☐ **Blood Body Fluid Exposure** ☐ **Lab animals**

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

Do you have any lifting restrictions? ☐ Yes ☐ No
If yes, state restrictions: Use separate sheet if needed

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

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 disability? *(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 ☐ Any 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, provide comments:

_____
_____
_____
_____

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, provide comments:

_____
_____
_____
_____

4. Do you have physical problems (such as seizure disorder, diabetes, allergies) or mental/emotional problems (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 abuse/dependence problem?
Y ☐ N ☐ An alcohol abuse/dependency 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?

_____

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

I certify *that the information I have provided is true to the best of my knowledge. I understand and agree to authorize Duke Employee Occupational Health & Wellness to review any information (including, but not limited to, information relating to psychiatric/psychological and alcohol and substance abuse diagnosis and treatment, if any such information exists) at Duke or other health care providers for purposes related to my fitness for employment. I agree to any reasonable subsequent testing or evaluation deemed necessary to determine my fitness to perform this job, and I authorize the examining provider to forward pertinent information to those who would perform such testing or evaluation. I understand that Duke is relying upon my representations contained herein and they are substantial employment factors. I further 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