THE QUEEN ELIZABETH HOSPITAL BOARD

MARTINDALES ROAD, ST. MICHAEL, BB 11155, BARBADOS, W.I.

PRE-EMPLOYMENT HEALTH SCREENING FORM

The Queen Elizabeth Hospital (QEH) Board is firmly obligated to the promotion and maintenance of the health of its employees in a safe and secure working environment. As such, the purpose of the QEH Pre-employment Health Screening form (PHSF) is to determine your fitness to fully and efficiently undertake the duties of the position for which you are being considered and/or have received a conditional offer.

Your answers to this questionnaire will be *strictly confidential* to the officers assigned to the Occupational, Safety, Health and Wellness (OSHW) Department and the QEH Wellness Centre. *Absolutely NO* information provided will be disclosed or given to anyone other than the relevant stated persons, without your written permission. Specific guidance on each section of the PHSF form is given below.

Please ensure that clear, legible responses are provided in all relevant sections to avoid return of the form for completion and the unnecessary delay of this process.

While you are required to provide your own responses on section I of this form, you are reminded that the PHSF MUST BE completed and validated by your physician following your medical appointment and physical examination. Copies of your immunization documents and ALL completed tests must be provided.

Section I

Personal Data - All sections must be completed and where applicable, responses **PRINTED** in the spaces provided. Kindly only provide accurate contact details that we are authorized to use as part of your work health assessment and for any subsequent communication.

Section II

Personal Medical History - These questions have been designed to allow an assessment of your health and well-being in relation to the work tasks and functions of the proposed job. If you have an illness, impairment or disability that may affect your work and requires some adjustments or special support to be provided please indicate same. In particular, health problems that may

affect work tasks or be affected by work patterns such as night work or working environments, should be disclosed.

Section III

Family History - The responses to these questions provide information on your family's medical health record and any conditions/illnesses to which you may be pre-disposed so that any necessary work considerations and/or adjustments can be made accordingly.

Section V

Immunizations and Blood Tests - If you will be involved in direct patient care (as defined below for health care workers) or body fluid and sample handling, please ensure that you provide full details and documented evidence of any and all previous immunisations and blood tests.

Guidelines for completion of this Section by your Physician are enclosed on pg. 16.

Section VIII

Respirator Fit Testing – In order to minimize your exposure to airborne pathogens employees are expected to be fit tested for a respirator. Persons who have completed this fit within the last two years can document their data. **This section is filled out by the Hospital Infection Prevention & Control Department.**

Submission of Form

Any queries regarding the completion of this form may be discussed with the Occupational Safety, Health and Wellness Officer.

Please forward thoroughly completed PHSF and copies of your immunization documents confidentially to the Occupational Safety, Health and Wellness Officer for submission to the QEH Staff Wellness Centre.

Immediately following processing of the PHSF you will be advised further by the Occupational Safety, Health and Wellness Department and the Human Resources Department.

PRE-EMPLOYMENT HEALTH SCREENING FORM

Important

- This Pre-employment Health Screening form MUST be thoroughly completed by ALL applicants/ potential employees ***prior to the assumption of duty*****.**
- Please forward confidentially through the OSHW Department for submission to the QEH Staff Wellness Centre.

N.B. All sections of this form must be completed. Incomplete forms will be returned.

SECTION I - PERSONAL DATA

SURNAME: (*block letters***)**		**OTHER NAMES:**	
NATIONAL REGISTRATION NUMBER:			
TELEPHONE NUMBER: **MOBILE**		**HOME**	
HOME ADDRESS:			
EMAIL ADDRESS:			
POSITION:		**AGE:** (years)	**SEX:**
Mass in kg:	Height in cm	Date of last consultation with a doctor: (approximate)	State nature of illness or reason for consultation

Section II - PERSONAL MEDICAL HISTORY (*tick ✓ the appropriate boxes below and give details where necessary. To be filled by your medical practitioner)*

2. Have you ever had or been treated for any of the following conditions?				
Condition	***Diagnosis***		***Date/period of illness***	***Explain Nature of Condition and/or Treatment Prescribed***
a) Disorders of the eyes or vision problems which would affect your ability to:	Yes	No		
i. distinguish colours	☐	☐		
ii. Read or see objects clearly	☐	☐		
iii. See at a distance	☐	☐		
iv. Work at a computer monitor	☐	☐		
If "yes" to any questions please explain in space provided				
(b) Disorders of the ears or hearing problems which would affect your ability to:	Yes	No		
i. Hear normal speaking voice(s)	☐	☐		
ii. Hear in noisy situations	☐	☐		
(c) Speech disorders which could affect your ability to:	Yes	No		
i. Communicate verbally to others	☐	☐		
(d) Disorder of the back or problems which would affect your ability to:	Yes	No		
i. Sit for prolonged periods of time	☐	☐		
ii. Stand/walk for prolonged periods	☐	☐		
iii. Bend your back frequently	☐	☐		
iv. Lift or carry 1-10 pounds	☐	☐		
v. Lift or carry 10 - 20 pounds	☐	☐		
vi. Lift or carry in excess of 20 pounds	☐	☐		

Condition	***Diagnosis***	***Date/period of illness***	***Explain Nature of Condition and/or Treatment Prescribed***
(e) Disorders of the ears or hearing problems which would affect your ability to: i. Hear normal speaking voice(s) ii. Hear in noisy situations	Yes ☐ No ☐ Yes ☐ No ☐		
(f) Dizziness, fainting, convulsions, headaches, speech defects, paralysis or stroke?	Yes ☐ No ☐		
(g) Anxiety, depression, psychiatric or nervous Disorder(s)	Yes ☐ No ☐		
(h) Shortness of breath, persistent hoarseness or coughing, spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder?	Yes ☐ No ☐		
(i) Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessel?	Yes ☐ No ☐		
(j) Jaundice, intestinal; bleeding, stomach ulcer, hernia, appendicitis, hemorrhoids, recurrent indigestion or other disorders of the stomach, intestines, liver or gallbladder?	Yes ☐ No ☐		
(k) Albumen, blood or pus in urine, venereal disease, stone or other disorder of the kidney, bladder, prostate or reproductive organs?	Yes ☐ No ☐		
(l) Diabetes, thyroid or other endocrine disorders?	Yes ☐ No ☐		
(m) Neuritis, sciatica, rheumatism, arthritis, gout, or other disorder of the muscles, bones or joints?	Yes ☐ No ☐		
(n) Deformity, lameness or amputation?	Yes ☐ No ☐		
(o) Disorder of skin or lymph glands, cyst, tumor or cancer?	Yes ☐ No ☐		
(p) Skin conditions or allergies? This includes allergies to any general cleansing/skin cleansing products, latex gloves or other glove intolerances?	Yes ☐ No ☐		

Section II - PERSONAL MEDICAL HISTORY (*continued)*

1. Have you ever had or been treated for any of the following conditions

Condition	***Diagnosis***	***Date/period of illness***	***Explain Nature of Condition and/or Treatment Prescribed***
(m) Anemia or other blood disorders?	*Yes* ☐ *No* ☐		
(n) Excessive use of alcohol, tobacco or any habit forming drugs?	*Yes* ☐ *No* ☐		
2. Are you taking any regular prescribed medication or treatment? If yes, please clearly list medication and/or treatment plan and reason(s)	*Yes* ☐ *No* ☐		
3. Other than above, have you had any illness, accident operation, cause for hospitalization or routine or other diagnostic test?	*Yes* ☐ *No* ☐		
4. Females only: (a) Have you ever had any disorder of menstruation, pregnancy, or of the female organs or breast?	*Yes* ☐ *No* ☐		
(b) To the best of your knowledge and belief, are you now pregnant?	*Yes* ☐ *No* ☐		

SECTION III - FAMILY HISTORY

Relationship	Living		Deceased	
	Ages	**State of health**	**Age at Death**	**Cause of Death**
Father				
Mother				
Brother(s)				
Sister(s)				
Wife / Husband				

DECLARATION

I hereby declare that the foregoing information provided is true and complete. I understand that should any required information be proven to be deliberately omitted or any statement shown to be false within my knowledge, I may be liable to disqualification or, if appointed, to disciplinary action, and that I may forfeit my right to certain superannuation benefits. I agree to comply with all required immunization checks and/or health screening directly related to placement in a high-risk area or involvement with direct patient care/clinical specimens.

Employee Signature: ..... Print Name: .....

Date .....

SECTION IV - OCCUPATIONAL SAFETY AND HEALTH AUTHORIZATION:

The Queen Elizabeth Hospital Occupational Safety, Health and Wellness Department provides you, the Independent Health Care Practitioner, authorization to sign the relevant document having examined the above applicant. Kindly affix your professional stamp to the below after signing.

I certify that the above applicant was assessed and the information provided is <u>complete</u> and <u>accurate.</u>

_____ _____

Signature of Independent Health Care Professional: **Date:**

_____

Stamp

SECTION V - IMMUNIZATION RECORD FOR APPLICANTS

IMMUNIZATION POLICY

Documentary evidence of current immunization against specific diseases must be provided to the Queen Elizabeth Hospital Board prior to confirmation of employment, particularly if you have been assigned to a clinical area and will be working with clinical materials.

Please enclose copies of all immunization records and relevant laboratory reports. Failure to supply these will require you to undertake these tests/vaccinations again.

N.B. All sections of this form must be completed. Incomplete forms will be returned.

The specific immunization requirements are:

1. **Tuberculosis**: Applicants must have an initial baseline two-step Mantoux skin test if their last documented skin test is negative. Employees determine their TB status through gamma interferon assay, which is done with a blood test and bypasses the affects of the BCG vaccination. (Please note: the assay is not widely available and TB skin tests are the standard in Barbados).

2. **Previous BCG vaccination(s) does not preclude TB skin testing**. You may **not** provide chest x-ray as an alternative to TB skin test.

3. A **chest x-ray** is required if the TB skin test is positive. Positive skin test should be documented in millimeters.

   Note: Annual TB (skin or assay) testing is a requirement for individuals who have previously tested negative. A negative TB test result is valid for one year only. This is required for all employees in patient care areas.

4. **Hepatitis B**: Immunization is a series of 3 injections. Lab evidence of immunity (immune or non-immune) must be provided after the vaccine series is complete (Section V).

   Individuals who are non-immune (i.e. do not have antibodies against HBs Ag or no prior history of immunization) must be screened for the surface antigen (HBs Ag). If the BHsAg result is positive, a further screen for e-antigen (HBeAg) must be performed (Section B). Those who are non-immune and HBsAg negative must undergo a second series of HB immunization, and subsequent lab results recorded (Section V). ***Employment status for HBV Carriers remains CONDITIONAL until the Expert Panel of Occupational Health, Infection Control and Human Resources reviews their case.***

5. **Measles, Mumps, Rubella**: Date of receipt of **two** live MMR vaccine dates or positive titre results for antibodies with date.

6. **Chicken pox**: History of infection (chicken pox or shingles) or VZV titre results or 2 varicella vaccines.

7. **Diphtheria, Tetanus, Acellular Pertussis, and Polio**

   - Immunization against **diphtheria** and **tetanus** is generally valid for ten years. Maintenance of up to date immunization status is strongly recommended.

   - Vaccination with **acellular pertussis** as an adolescent or adult is recommended. A single dose of Tdap (tetanus, diphtheria and acellular pertussis) is sufficient and can be taken without waiting for the usual 10 years between diphtheria/tetanus boosters.

   - Primary immunization against **polio** is sufficient

8. **Malaria, Typhoid Fever and Yellow Fever:** Declaration of a diagnosis of malaria, typhoid or yellow fever within the last three (3) months prior to entering the country.

   Employees will be screened and appropriate treatment provided for contagious infectious diseases which may be endemic to the country when the employee arrives to Barbados, inclusive of malaria, typhoid fever and yellow fever; once symptomatic.

9. **Coronavirus Disease 2019 (COVID-19) Vaccination:** Date of receipt of COVID-19 vaccine(s) and proof of a negative Polymerase Chain Reaction (PCR) Test.

Employees are expected to seek appropriate medical care when ill and MUST follow the appropriate infection prevention and control practices. Employees MUST notify the Occupational Safety & Health Department/Clinical Risk Management Unit/Staff Wellness Centre/Infection Prevention & Control Unit following needle stick injuries or **unprotected** contact with patients with communicable diseases.

Documentary proof of current immunization for items 1-9 noted above is MANDATORY for ALL employees assigned to a clinical area or directly involved in patient care.

All associated documentation fees are the responsibility of the employee.

1. **TUBERCULIN TEST**

Negative: ☐ Positive: ☐

Date of Test # 1: _____ (Must be within the last 12months, if previously negative) Reading # 1 (mm) _____ (Induration)

Date of Test # 2: _____ (2-step required at initial registration) Reading # 1 (mm) _____ (Induration)

Last known negative: _____ BCG Vaccination: No ☐ Yes ☐ Date: _____

Previous Treatment for TB: No ☐ Yes ☐

Previous Treatment for Latent TB: No ☐ Yes ☐

CHEST X-RAY: Required, if TB test is positive or previously positive (positive TB skin test ≥10 mm in duration)

2. **IMMUNIZATIONS**

Section A: (ALL of Section A must be completed)

HEPATITIS B: Immunization Date: _____ 2nd Date: _____ 3rd Date: _____

Lab Evidence of Immunity against Hep B. (anti-H-Bs/HBsAB)

Test Date: _____ ☐ Immune ☐ Non-Immune (-)

Section B: If non-immune in Section A, please provide:

HBsAg: Positive ☐ Negative ☐ Date: _____

If HBsAg positive: HBeAg: Positive ☐ Negative ☐

II MEASLES: Immunization Date: _____ 2nd Date: _____ OR Titre _____

III MUMPS: Immunization Date: _____ 2nd Date: _____ OR Titre _____

IV RUBELLA: Immunization Date: _____ 2nd Date: _____ OR Titre _____

V CHICKEN POX: Immunization Date: _____ 2nd Date: _____

If history of previous disease, VZV Titre _____ Date: _____

VI DIPHTHERIA, TETANUS, ACELLULAR PERTUSSIS and POLIO immunizations:

☐ DIPHTHERIA Date: _____ ☐ TETANUS Date: _____

☐ POLIO Date: _____ ☐ ACELLULAR PERTUSSIS Date: _____

VII MALARIA, TYPHOID FEVER and YELLOW FEVER immunizations:

☐ MALARIA Date: _____ ☐ TYPHOID Date: _____

☐ YELLOW FEVER Date: _____

VIII CORONAVIRUS DISEASE 2019 (COVID-19) Vaccination(s):

Name of Vaccine: _____

Vaccination Date: 1st Date _____ 2nd Date: _____ Booster: _____

Polymerase Chain Reaction (PCR) Test Date: _____ Result: _____

I declare that the above information provided in the Immunization Record is true and complete and give my consent that the information on this form may be shared with hospital staff as deemed appropriate.

_____	_____	_____
Signature of Applicant	Print name	Date

OCCUPATIONAL SAFETY AND HEALTH AUTHORIZATION:

The Queen Elizabeth Hospital Occupational Safety, Health and Wellness Department provides you, the Independent Health Care Practitioner, authorization to sign the relevant document. Kindly affix your professional stamp to the below after signing.

I certify that the above information provided is complete and accurate.

_____ _____

Signature of Independent Health Care Professional: **Date:**

_____

Stamp

SECTION VI (FOR OFFICIAL USE BY THE QEH ONLY)

I hereby certify that I have examined the applicant and confirm that: _____
(Name)

☐ is fit for employment at The Queen Elizabeth Hospital.

☐ should undergo a further medical examination for reasons stated separately.

_____	_____
Signature of Physician	Print name
Date:	Stamp:
_____	_____
Signature of Occupational Safety & Health Officer	Print name
Date:	Stamp:

SECTION VII - MEDICAL ASSESSMENT RECOMMENDATION

For Official Use by the QEH ONLY:

Having reviewed the attached pre-employment health screening form this department concludes that this individual is:

☐ Fit to assume duties in the recommended position of

☐ Fit pending resolution of the following restrictions

☐ Awaiting further medical assessment

☐ Unfit to assume duty in the recommended position

EMPLOYMENT RESTRICTIONS

☐ Pre-employment Health Screening form deemed incomplete. Insufficient information provided to facilitate medical QEHB clearance and individual is restricted from performing exposure prone procedures and/or working in exposure prone areas.

☐ No evidence of Chicken pox/MMR/TB immunity provided. Individual MUST avoid high risk occupational areas and contact with known or suspected cases.

☐ Not approved "fit to work" with respiratory sensitizers, except latex. Recommended for further screening.

☐ Other:

_____

APPOINTMENT REFERRAL

This individual has been recommended for further medical assessment/vaccination as follows:

☐ Appointment with Dr._____, Department of _____

☐ Appointment with Nurse, _____, Department of _____

☐ Appointment with the HICU/Staff Wellness Centre for a vaccination check during the first four (4) weeks of employment. The individual will be notified of the appointment details and the Manager informed if the person fails to attend the appointment. Based on the reason for non-attendance another appointment may be arranged within a two to four-week period.

☐ Other: _____

APPOINTMENT REASON

☐ Mantoux test ☐ BCBG vaccination/ scar check ☐ Varicella update

☐ Hepatitis B update ☐ MMR update ☐ Vision screening ☐ Skin assessment

☐ Blood bourne virus screening ☐ Lung function test ☐ Laboratory vac update

☐ Review appointment ☐ Other:_____

MEDICAL ADVICE TO MANAGER

☐ Individual has already assumed duty/established in position of _____
Department/unit reassignment may be required.

☐ Individual must be provided with latex free (sterile) gloves.

☐ Medical condition declared and currently well controlled but periods of exacerbation possible.

☐ Other: _____

_____ _____

Signature of Physician Print name

Date: _____ Stamp:

_____ _____

Signature of Occupational Safety & Health Officer Print name

Date: _____ Stamp:

SECTION VIII – RESPIRATOR FIT TESTING

IMPORTANT

Medical staff MUST have respiratory protection when at risk of exposure to airborne infectious agents, specifically tuberculosis.

To protect the health and safety of our staff and trainees all persons MUST comply with the Queen Elizabeth Hospital Board airborne policies/guidelines on respirator use.

Please complete the attached form. Respirator Fit Testing can be arranged via the Hospital Infection Prevention & Control Unit. To schedule an appointment please contact the HICO at Ext. 6115.

Please refer to the Exemption Form for respirator fit testing exemption.

RESPIRATOR FIT TEST FORM

Name of Applicant/Employee: _____

Instructions:

• Respirator fit testing record is valid for 2 years
• Please complete this form or forward copies of your respirator fit test card to the Occupational Safety, Health and Wellness Department.

RESPIRATOR FIT TESTING RECORD:

Date Fitted: _____ Brand: _____ Size: _____

Quality of Fit: _____ Expiration Date: _____

(Pass/Fail) (Default = 2 years)

Hospital/Site of Respirator Fit Test: _____

Comments: _____

Clinic/Health Centre Authorization:

I certify that the above information is complete and accurate.

_____

(Name, address and phone number of centre where the form was completed)

_____ _____

Signature of Healthcare Professional **Printed Name**

Date: _____ Stamp: _____

Date for Review: _____

RESPIRATOR FIT TESTING EXEMPTION FORM

CANDIDATE'S NAME: _____
Please Print (Surname) (First name)

Occupation: _____

I am aware that I am not face fit tested and will not be permitted to participate in any work/training that requires the use of respirators in the hospital or community setting, for the following reason(s):

☐ Religious/ Cultural

☐ Medical Condition

☐ Other, please specify: _____

If for any reason I am exposed to airborne infectious agents, I will seek immediate medical attention at the Staff Wellness Clinic and report the incident to the Occupational Safety, Health and Wellness Department.

In the event of a pandemic, I understand that I am restricted from participating in any clinical activity and from being present in any hospital setting that may expose me to any airborne contaminants.

If there is any change to my status, I will notify the Queen Elizabeth Hospital Board to facilitate the update of my mask fit exemption status.

Date of next review: _____

I hereby declare that the foregoing is true and I understand that should any statement be shown to be false within my knowledge, I may be liable to disqualification or, if appointed, to disciplinary action, and that I may forfeit my right to certain superannuation benefits.

_____ _____
Signature of Applicant Print Name

Date: _____

Instructions to Physician Completing Employment Immunization Form

IMPORTANT

Administrative or non-clinical staff is exempt from Sections 1 and 2 as wide spread testing is not recommended.

The applicant's immunization record MUST NOT be authorized without evidence of immunity or written documentation as defined below:

TUBERCULOSIS (condition for employment)

- A 2-step Mantoux must be done at the time of initial registration if lasted documentation TB skin test is negative
- Please note: BCG vaccination (s) does not preclude TB skin testing and chest x-rays are not alternative to TB skin test
- Chest x-ray results are required with positive TB skin test or assay
- Gamma interferon assay (not widely available) may be done as an alternative to skin test.

HEPATITIS B:

- Lab evidence of immunity (anti-HBs) is required with provision of the date
- HBsAg (antigen) must be screened if no prior history of immunization or if lab evidence of immunity is negative
- If HBsAg is positive, HBeAg (e-antigen) must be screened
- Immunization dates along with lab evidence of non-immunity are required for those who have not developed antibodies after the 2nd immunization series

MEASLES:

- Lab evidence of immunity with date, or
- Documentation of receipt of **two (2)** live mumps containing vaccine on or after their first birthday
- **Born before 1970.**

MUMPS:

- Lab evidence of immunity with date, or
- Documentation of receipt of **two** live mumps containing vaccine on or after their first birthday

RUBELLA:

- Lab evidence of immunity with date or
- **Documentation** of receipt of live rubella virus containing vaccine on or after their first birthday

VARICELLA/SHINGLES

- **Documentation** of definite disease history, or
- Lab evidence of immunity (VZV antibody) with date, or
- **Documentation** of receipt of 2 varicella vaccines with dates

Immunization against the following are STRONGLY RECOMMENDED:

- **Diphtheria and Tetanus – boosters every ten (10) years**
- **Acellular Pertussis** – single dose as an adolescent or adult
- Tdap (tetanus, diphtheria and acellular pertussis) is safe to give before the usual ten (10) years diphtheria/tetanus boosters
- Primary immunization against polio is sufficient

MALARIA, TYPHOID FEVER AND YELLOW FEVER:

- Declaration of a diagnosis of malaria, typhoid or yellow fever within the last three (3) months prior to entering the country.
- Employees will be screened and appropriate treatment provided for contagious infectious diseases which may be endemic to the country when the employee arrives to Barbados, inclusive of malaria, typhoid fever and yellow fever; once symptomatic.
- Documentation of receipt of vaccines with dates

CORONAVIRUS DISEASE 2019 (COVID-19)

- **Documentation** of receipt of COVID-19 vaccine(s) with dates
- Proof of a negative Polymerase Chain Reaction (PCR) Test.

Immunization against the FLU is STRONGLY RECOMMENDED:

An annual flu vaccination provided through the QEH/Ministry of Health will be made available. Persons employed in clinical areas and having direct contact with patients are strongly advised to obtain yearly vaccination against the flu.