THE QUEEN ELIZABETH HOSPITAL BOARD
MARTINDALES ROAD, ST. MICHAEL, BB 11155, BARBADOS, W.I.

PRE-EMPLOYMENT HEALTH SCREENING FORM
(INSTRUCTIONS FOR COMPLETION)

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 have received a conditional offer and/or are being considered.

Your answers to this questionnaire will be *strictly confidential* to the officers assigned to the Occupational, Safety, Health and Wellness Section (OSHWS) of the Human Resources 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 about 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 various sections of this form, you are reminded that the PHSF MUST BE completed and validated by your physician following your medical appointment and physical examination.

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

Immunisations 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 VII

Mask Fit Testing – In order to minimize your exposure to airborne pathogens employees are expected to be fit 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 Control Unit.**

Submission of Form

Any queries regarding completion of this form may be discussed with the officer attached to the OSHWS of the Human Resources Department.

Please forward thoroughly completed PHSF confidentially through the OSHW Section of the Human Resources Department for submission to the QEH Staff Wellness Centre.

Immediately following processing of the PHSF you will be advised further by the Human Resources Department.

PRE-EMPLOYMENT HEALTH SCREENING FORM

Important

- This Pre-employment Health Screening form MUST be thoroughly completed by ALL employees *prior to the assumption of duty*.

Please forward confidentially through the OSHWS of the Human Resources 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:**	
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)*

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.

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

Date .....

SECTION IV (FOR OFFICIAL USE ONLY)

I hereby certify that I have examined the applicant .....

and confirm that he/she:

☐ is fit for employment at The Queen Elizabeth Hospital

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

_____ _____

Signature of Medical Referee/Physician Print name

Date: .....

SECTION V - IMMUNIZATION RECORD FOR EMPLOYEES

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.

If possible, 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**: Employees 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 on Infection Control/ 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

Employee and trainees are expected to seek appropriate medical care when ill. In addition, employees and trainees MUST follow the appropriate infection control practices and MUST notify the Hospital Infection Control Unit/Clinical Risk Management Unit/Staff Wellness Centre of the QEH following needle stick injuries or **unprotected** contact with patients with communicable diseases.

Documentary proof of current immunization for items 1-4 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 trainee/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**

I. HEPATITIS B immunization:

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

Date of 1st shot _____ Date of 2nd shot: _____ Date of 3rd shot: _____

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

Date: _____

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

HBsAg: Positive ☐ Negative ☐ Date: _____

If HBsAg positive: HBeAg: Positive ☐ Negative ☐

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

Date: _____

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

Date: _____

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

Date: _____

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

Date: _____

V. **CHICKEN POX** Known History? No ☐ Yes ☐ If Yes, VZV antibody: _____

Date: _____

If VZV antibody negative, varicella vaccine dates: 1st shot _____ 2nd shot: _____

VI. **DIPHTHERIA, TETANUS, ACELLULAR PERTUSSIS and POLIO** immunizations:

☐ DIPHTHERIA Date: _____ ☐ TETANUS Date: _____

☐ POLIO Date: _____ ☐ ACELLULAR PERTUSSIS Date: _____

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 Employee/Student: Print name

_____

Date

QEH STAFF WELLNESS CENTRE AUTHORIZATION:

I certify that the above information is <u>complete</u> and <u>accurate</u>

_____ _____

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

SECTION VI - MEDICAL ASSESSMENT RECOMMENDATION

For Official Use by the QEH Staff Wellness Centre 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 reasond 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 Medical Practitioner/Nurse Print Name

_____

Date

SECTION VII - MASK 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 N95 mask use.

Please complete the attached form. Mask fitting can be arranged via the Hospital Infection Control Unit. (To schedule an appointment please contact the HICU at Ext. 6115)

Please refer to the Exemption Form for mask fitting testing exemption.

RESPIRATOR/MASK FIT FORM

Name of Employee/Trainee: _____

Instructions:

- Respirator/mask fit data are valid for 2 years
- Please complete this form or forward copies of your respirator/mask fit cards to Human Resources Department.

RESPIRATOR/MASK FIT DATA:

Date Fitted: _____ Brand: _____ Size: _____

Quality of Fit: _____ Expiration Date: _____

(Pass/Fail) (Default = 2 years)

Hospital/Site of 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 form completed)

_____ _____

Signature of Healthcare Professional **Printed Name**

Date: _____

Date for Review: .....

N95/RESPIRATOR MASK FIT TESTING EXEMPTION FORM

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

Occupation: _____

I am aware that I am not mask fit tested and will not be permitted to participate in any rotation/training that requires the use of N95/Respirator masks 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 and report the incident to the Occupational Health Section/Staff Clinic.

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.

Review due for: _____

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 Candidate/Employee 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

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.