Applicant,

New hires are to bring all available vaccine records to the post-offer/pre-placement screening. This may include: childhood vaccine records, school vaccine records or records from previous employment — especially if it was a health care facility.

Internal transfers please provide proof of any vaccines received outside of BJC. Otherwise, occupational health will already have your information. Employees transferring from a non-safety to a safety role require a drug screen.

Remote employees living outside Missouri and Illinois are not required to provide proof of immunizations or TB screening.

Vaccination or immunization records are to include:

- Measles, mumps, rubella or MMR vaccination
- Varicella or chickenpox (vaccination or physician documented proof of disease)
- Pertussis vaccine (Tdap)
- Hepatitis B vaccine series (recommended, not required)
- Hepatitis A vaccine series (2 shots, required for specific roles)
- Meningococcal vaccine (recommended, not required)
- Tuberculosis (TB) skin or blood test (if you have had a previous positive TB test, please bring records of medical treatment and chest x-ray results if available)
- Results of any blood testing for immunity to measles, mumps, rubella or chickenpox a previous employer may have
- Proof of current influenza vaccine (September through March)
- Proof of Covid-19 vaccination

Failure to provide proof of required immunizations will require blood testing and/or vaccination. All employees living in Missouri or Illinois require a TB blood test.

Immunization records may be requested from your physician, school, previous employer or state registry.

Missouri vaccine registry record request:
https://health.mo.gov/living/wellness/immunizations/pdf/ImmunizationRecordRequest.pdf

Illinois vaccine registry record request:
https://idphportal.illinois.gov/s/?language=en_US

Read and complete the following forms prior to attending your post-offer/pre-placement screening with occupational health:

1. Post-offer/pre-placement assessment
2. TB screening form
3. Authorization for release of information

BJC HealthCare

BJC HealthCare

Post-Offer/Pre-Placement Assessment

Confidential

Name: _____ Street Address: _____

City: _____ State: _____ Zip Code: _____ Phone #: _____

Birth date: _____ Age: _____ Department: _____

Facility: _____ Position: _____

Email: _____

Emergency Contact & Phone #: _____

Health History

Have you ever had:

1.	Allergies	No	Yes	16.	Glasses/Contacts	No	Yes
2.	Asthma	No	Yes	17.	Eye Problems	No	Yes
3.	Back/Neck Pain	No	Yes	18.	Head Trauma	No	Yes
4.	Broken Bones	No	Yes	19.	Heart Problems	No	Yes
5.	Carpal Tunnel Syndrome	No	Yes	20.	High Blood Pressure	No	Yes
6.	Injury from Motor Vehicle Accidents	No	Yes	21.	Implanted Automatic Defibrillator	No	Yes
7.	Joint Problems/Injuries	No	Yes	22.	Kidney Problems	No	Yes
8.	Numbness, Weakness or Tingling	No	Yes	23.	Steroid Therapy	No	Yes
9.	Problems Bending/Lifting	No	Yes	24.	An Organ Transplant	No	Yes
10.	Chronic Lung Problems	No	Yes	25.	Treatment for Alcohol/Drug Abuse	No	Yes
11.	Chronic Skin Problems	No	Yes	26.	Treatment for Mental Illness/Depression	No	Yes
12.	Convulsions/Seizures/Fainting	No	Yes	27.	A Work-Related Injury	No	Yes
13.	Diabetes	No	Yes	28.	Limitations, temp/perm, related to acute/chronic illness/disability	No	Yes
14.	Hearing Loss	No	Yes				
15.	Thyroid Problems	No	Yes	29.	Past Surgeries	No	Yes

Do you have any lifting restrictions? **No** **Yes** **If yes, what is the specific weight restriction?** _____

Required: If you answered "Yes" to any of the above, please note the number and a brief explanation, including dates, below:

Disease History

Have you ever had any of the following diseases?

Chicken Pox	No	Yes	Rubella	No	Yes	
Measles	No	Yes	Polio	No	Yes	
Mumps	No	Yes	Hepatitis	No	Yes	Type _____

Name: _____

Present Treatment

Do you currently have any medical conditions, receive any medical treatments or have any medical restrictions that may affect your ability to safely perform the essential functions of the position you have been offered, with or without reasonable accommodations? No Yes

If yes, please describe: _____

_____

Are you currently taking any medications that may impact your ability to safely perform the essential functions of your position with or without reasonable accommodation? No Yes

If yes, please list any such current medications, dose and frequency: _____

_____

Exposure History

Have you ever had any KNOWN UNPROTECTED WORK-RELATED exposures to the following?

Hazardous drugs*	No	Yes**	Pesticides	No	Yes
Asbestos/silicosis	No	Yes	Radiation	No	Yes
Formaldehyde	No	Yes	Glutaraldehyde (Cidex)	No	Yes
Loud noise	No	Yes	Anesthetic gas	No	Yes
Ethylene Oxide	No	Yes			

Latex Sensitivity

Have you ever had:

Skin rash with gloves (latex exam gloves)?	No	Yes†
Watery eyes after latex use?	No	Yes†
Respiratory difficulty after latex use?	No	Yes†

I certify the above information is correct and complete to the best of my knowledge. I realize that misrepresentation of the facts may be cause for and result in the revocation of my employment offer or termination of employment.

Employee Signature: _____ Date: _____

**Hazardous drugs: Those that exhibit one or more of the following characteristics in humans or animals - carcinogenicity, teratogenicity, or other developmental toxicity, reproductive toxocity, organ toxicity at low doses, genotoxicity structure and toxicity profiles of new drugs that mimic existing drugs determined hazardous by the above criteria (NIOSH Working Group on Hazardous Drugs).*

***If yes, complete the BJC HealthCare Initial/Periodic Medical Survey for Persons Who May Handle Hazardous Drugs.*

†If yes, complete the BJC Post-Offer/Pre-Employment Latex Sensitivity Questionnaire.

TO BE COMPLETED BY SCREENING EXAMINER

Immunization History: Documentation is required for proof of immunizations. Copy & attach documentation provided to OH.

Other

_____ Color Vision: _____ of _____ plates correct+ _____ Amsler grid°: ❑ nl ❑ abn ❑ N/A

+Add *Color Deficiency Score Sheet* if failed.

°Complete *Laser Initial or Post-Exposure Eye Medical Questionnaire and Exam Form*.

Visual Acuity (VA)

Distance 0U 20/_____ ❑ with correction

Near 0U 20/_____ ❑ without correction

Screening Examiner's Signature _____ Date _____

BJC HealthCare

Agreement to Submit to Pre-Employment Drug Test

I understand that all offers of employment with any facility or hospital/service that is a member of BJC HealthCare are conditional upon successful completion of a drug test. I further acknowledge that failing any part of the health screening — including the drug test — may result in withdrawal of the offer of employment. I further understand that my refusal to cooperate in any way with the drug testing procedure will also be grounds for withdrawal of the employment offer.

I authorize the release of the results to the Senior Human Resources Manager or his/her designee or any other person who needs to know the results for purposes of evaluating my suitability for employment and understand that these results will be kept confidential to the extent possible and will not be released to a third party.

I agree to hold BJC HealthCare and any affiliated or related facilities or hospitals/services and their respective officers, directors, employees, agents and servants harmless for their use of the results of these tests and the release thereof to any person or hospital/service within BJC HealthCare.

I acknowledge and agree that the sample given by me shall become the property of BJC HealthCare, any affiliated or related facilities or hospitals/services and I hereby relinquish all rights to ownership and procession thereof.

By placing my signature below, I attest to the accuracy of the foregoing, authorize management to contact my physician regarding any prescribed medication, and agree to be bound by the terms of this consent. I further certify that I have read and understand the foregoing, have had an opportunity to ask questions and agree to submit to the pre-employment drug test.

_____ _____

Date Applicant Name (printed)

_____ _____

Witness Signature of Applicant

_____

Co-Signature by Parent or Legal Guardian (if applicant is under 18 years of age)

BJC HealthCare

Tuberculosis Screening Form

Please print name: _____ Today's date: _____

Employee #: _____ Date of birth: _____

Phone #: _____ Work location: _____

Please check below the reason for testing/screening:

New employee/transfer Exposure baseline Exposure F/U Volunteer Employee request

Baseline Risk Assessment

Health care personnel should be considered at increased risk for TB if any of the following stements are marked "Yes":

- Temporary or permanent residence of more than one month in a country with a high TB rate *(any country other than the United States, Canada, Australia, New Zealand and those in Northern Europe or Western Europe)* — Yes No
- Current or planned immunosuppression *(including human immunodeficiency virus [HIV] infection, organ transplant recipient, treatment with a TNF-alpha antagonist [e.g., infliximab, etanercept or other], chronic steroids [equivalent of prednisone >15 mg/day for >1 month] or other immunosuppression medication)* — Yes No
- Close contact with someone who has had infectious TB disease since last TB test — Yes No

TB History:

1. Have you ever had a positive (raised area or "bump") TST? Yes No
   *If you have a history of a positive TB skin test (TST), do **NOT** have another skin test placed.*
2. Have you ever had a positive blood test for TB (IGRA)? Yes No
3. Have you had a vaccination within the past four weeks? Yes No
   What vaccine? _____

The following to be completed by test administrator

Interferon - Gamma Release Assay (IGRA) Testing Date drawn: _____

TB Skin Test

PURIFIED PROTEIN DERIVATIVE 0.1 ml ADMINISTERED INTRADERMALLY

Step 1: Manufacturer: _____ Lot #: _____ Exp. date: _____

Date test given: _____ Time given: _____ Site of injection: _____

Date TST test must be read: _____ am/pm _____

Test administrator signature

Results: Date: _____

_____ mm _____

Approved reader's signature

Step 2: Manufacturer: _____ Lot #: _____ Exp. date: _____

Date test given: _____ Time given: _____ Site of injection: _____

Date TST test must be read: _____ am/pm _____

Test administrator signature

Results: Date: _____

_____ mm _____

Approved reader's signature

BJC HealthCare

Information and Consent/Declination for Hepatitis B Vaccine

Employee Name: _____ Department: _____

Home Address: _____

City: _____ State: _____ Zip: _____

The Disease: Hepatitis B is an infection caused by Hepatitis B virus (HBV). Most people recover completely, but about 5-10% of otherwise healthy adults develop a chronic infection. Some develop cirrhosis, liver failure and liver cancer. People with chronic infections often have no symptoms, and HBV can spread to others regardless of whether the infection is acute or chronic. The infection causes death in 0.5-1% of cases reported to the Centers for Disease Control and Prevention. HBV is transmitted by exposure to body fluids, such as blood. The Hepatitis B virus can survive in dried blood outside the body for seven (7) days. Common risk factors for HBV infection include injection drug use and sexual contact with multiple partners. Health care workers occupational exposure accounts for less than 1% of new HBV infections.

The Vaccine: Immunization can prevent Hepatitis B infection and reduces sickness and death from cirrhosis and liver cancer. BJC HealthCare offers HBV vaccine at no cost to all employees within ten (10) days of initial assignment. This vaccine is a recombinant vaccine that does not use live virus and cannot give you hepatitis. The vaccine is administered in three (3) doses. The second dose is given one (1) month after the first, and the third dose six (6) months after the first. The vaccine is safe and effective. Possible side effects include soreness at the injection site and low-grade fever. A severe reaction occurs about one (1) time for every 1.1 million doses. You should not receive the vaccine if you are allergic to yeast or have had a serious allergic reaction to a past HBV vaccine dose. You can receive the vaccine if you are pregnant.

Hepatitis B Vaccine Consent

I have been informed of the benefits and risks of Hepatitis B vaccination and have had the opportunity to obtain answers to all my questions to my satisfaction. I understand that as part of my job, I may be exposed to HBV and that a vaccine to protect against infection has been offered to me at no cost. Although the vaccine most likely will protect me from HBV infection if I receive three (3) doses, I understand there is the potential that a properly administered vaccine will not confer immunity. Immunity will be confirmed with a blood test after completion of the vaccine series. I voluntarily request the injections of Hepatitis B vaccine be given to me.

Signature: _____ Date: _____

Hepatitis B Vaccine Declination

I understand that, due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine at no charge to myself. However, I decline Hepatitis B vaccination at this time. I understand that, by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If, in the future, I continue to have occupational exposure to blood and other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

_____ (initial) I received the Hepatitis B vaccine series (3 shots) in _____. (year of vaccination)
_____ (initial) I do not have the original documentation.
_____ (initial) Antibody testing has revealed I am immune to Hepatitis B.
_____ (initial) Other: _____.

Signature: _____ Date: _____

BJC HealthCare

BJC HealthCare Employee Information Authorization for Release of Information

Name: _____ Street Address: _____

City: _____ State: _____ Zip Code: _____ Phone #: _____

Birth Date: _____ Age: _____ Social Security #: _____

Department: _____ Facility: _____ Position: _____

E-mail: _____

I have received or I have been provided the opportunity to receive a copy of the "Notice of Privacy Practices" that explains when, where, and why my confidential health information may be used or shared. I acknowledge that (Name of hospital or service organization), the physicians, nurses, and other (Name of hospital or service organization) staff may use and share my confidential health information with others in order to treat me, in order to arrange for payment of my bill and for issues that concern (Name of hospital or service organization) operations and responsibilities.

Initial: _____ Date: _____

I hearby authorize the Occupational Health Department where I receive my mandatory post-offer and annual immunizations to release information to my Manager/Supervisor to confirm my receipt of the immunizations or that I am exempt from the immunization requirement in accordance with policies established by BJC HealthCare.

Additionally, I understand that once this information has been released pursuant to this Authorization, it may no longer be protected by Federal and/or State law/regulations. I may request a copy of my signed Authorization if desired.

I understand that neither BJC HealthCare nor any of its affiliated healthcare providers can make me sign this Authorization as a condition of getting treatment, making payments on any bills, or gaining enrollment or eligibility in any health insurance plan, unless the federal Privacy Regulations allow it.

I understand that I may revoke this authorization at any time except to the extent that prior action has been taken in reliance on this Authorization. This Authorization will expire when I am no longer employed by BJC HealthCare or any of its affiliated entities if I do not cancel it in writing prior to the expiration date. I understand that if I want to cancel/revoke this Authorization, I must mail, fax, or bring a letter in person to the Occupational Health Department where I received my mandatory post-offer and annual immunizations stating I want to cancel this Authorization.

Initial: _____ Date: _____

Signature: _____ Date: _____