Dear Candidate,

We look forward to you joining the Inova team! Inova is committed to the safety and wellbeing of all our team members, patients and community. Your health assessment is an important step in your onboarding process as your job offer is contingent upon its completion. Team Member Health works closely with our Talent Acquisition and Human Resource Partners. If you have any questions related to the steps outlined below please contact us.

Prior to arriving to your scheduled Team Member Health appointment you will need to:

- ***You must bring a photo valid ID with you to our appointment in order to conduct your drug screen*.**
- Download, print and complete all Team Member Health forms. These forms are located in the link emailed to you by your recruiter in your Inova Offer Letter or by accessing your Candidate Portal. Contact your recruiter immediately if you are unable to print forms as these completed forms are required for your appointment.
- Eat and hydrate well the morning of your appointment in preparation for lab work.
- **Arrive 30 minutes prior** to your scheduled appointment time to complete additional paperwork before meeting with the Nurse Consultant.

Required Documentation:

- Bring all completed documents found in this packet.
- Bring all availiable immunization records (MMR, Varicella, Tdap, HepB, Flu, COVID-19), titers, tuberculosis (TB) screening and/or chest x-ray results and TB treatment history with you.
- Team Member Health will offer Flu, COVID-19 and Tdap vaccines during your new hire health assessment if needed.
- All newly hired team members **must have received their FLU vaccine (during flu season) or have an approved exemption from the flu vaccine by their start date**.
- All newly hired team members **must have received at least the 1st dose of COVID-19 vaccine or have an approved exemption by their start date.**
- For information on Inova's Exemption Request policy please email Exemptionrequests@Inova.org

BE ADVISED:

- Late arrivals and/or failure to complete required paperwork may result in a need to reschedule your Team Member Health appointment. This should be handled by your recruiter. This may delay your start date with Inova.

- For the safety of our team members we do not allow children to be present during your health assessment. If children accompany you to your appointment you will be referred back to your recruiter to reschedule your Team Member Health appointment which may delay your start date with Inova.

If you have any questions, feel free to contact Team Member Health. Our contact information is on the last page of this packet.

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE (MANDATORY)

To the employer: *Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do* ***not*** *require a medical examination.*

To the team member:

Can you read (check one): ❑ Yes ❑ No

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the healthcare professional who will review it.

PART A. SECTION 1. (MANDATORY)

The following information must be provided by every team member who has been selected to use any type of respirator (please print).

1. Today's date: _____

2. **PRINT** your name: _____ Social Security # _____

3. Your age (to nearest year): _____

4. Sex (check one): ❑ Male ❑ Female

5. Your height: _____ ft., _____ in.

6. Your weight: _____ lbs.

7. Your job title: _____

8. A phone number where you can be reached by the healthcare professional who reviews this questionnaire (include the Area Code): _____

9. The best time to phone you at this number: _____

10. Has your employer told you how to contact the healthcare professional who will review this questionnaire (check one): ❑ Yes ❑ No

11. Check the type of respirator you will use (you can check more than one category):

    θ N, R, or P disposable respirator (filter-mask, non-cartridge type only).

    θ Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

12. Have you worn a respirator (check one): ❑ Yes ❑ No

    a. If yes", what type(s): _____

Do you have a history of an allergy or sensitivity to SACCHARIN or BITREX? ❑ Yes ❑ No

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FOR OFFICE USE ONLY:

This Team Member is: ❑ Cleared to be fit tested ❑ Not cleared to be fit tested

Team Member was notified of the results of this evaluation by: _____

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE (MANDATORY) (continued)

Date Fit Test Completed:_____/____/____

PART A. SECTION 2. (MANDATORY)

Questions 1 through 9 below must be answered by every team member who has been selected to use any type of respirator (please check "yes" or "no").

1.	Do you *currently* smoke tobacco, or have you smoked tobacco in the last month:	❑ Yes	❑ No
2.	Have you *ever had* any of the following conditions?		
	a. Seizures (fits):	❑ Yes	❑ No
	b. Diabetes (sugar disease):	❑ Yes	❑ No
	c. Allergic reactions that interfere with your breathing:	❑ Yes	❑ No
	d. Claustrophobia (fear of closed-in places):	❑ Yes	❑ No
	e. Trouble smelling odors:	❑ Yes	❑ No
3.	Have you *ever had* any of the following pulmonary or lung problems?		
	a. Asbestosis:	❑ Yes	❑ No
	b. Asthma:	❑ Yes	❑ No
	c. Chronic bronchitis:	❑ Yes	❑ No
	d. Emphysema:	❑ Yes	❑ No
	e. Pneumonia:	❑ Yes	❑ No
	f. Tuberculosis:	❑ Yes	❑ No
	g. Silicosis:	❑ Yes	❑ No
	h. Pneumothorax (collapsed lung):	❑ Yes	❑ No
	i. Lung cancer:	❑ Yes	❑ No
	j. Broken ribs:	❑ Yes	❑ No
	k. Any chest injuries or surgeries:	❑ Yes	❑ No
	l. Any other lung problem that you have been told about:	❑ Yes	❑ No
4.	Do you *currently* have any of the following symptoms of pulmonary or lung illness?		
	a. Shortness of breath:	❑ Yes	❑ No
	b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline:	❑ Yes	❑ No
	c. Shortness of breath when walking with other people at an ordinary pace on level ground:	❑ Yes	❑ No
	d. Have to stop for breath when walking at your own pace on level ground:	❑ Yes	❑ No
	e. Shortness of breath when washing or dressing yourself:	❑ Yes	❑ No
	f. Shortness of breath that interferes with your job:	❑ Yes	❑ No
	g. Coughing that produces phlegm (thick sputum):	❑ Yes	❑ No
	h. Coughing that wakes you early in the morning:	❑ Yes	❑ No
	i. Coughing that occurs mostly when you are lying down:	❑ Yes	❑ No
	j. Coughing up blood in the last month:	❑ Yes	❑ No
	k. Wheezing:	❑ Yes	❑ No
	l. Wheezing that interferes with your job:	❑ Yes	❑ No
	m. Chest pain when you breathe deeply:	❑ Yes	❑ No
	n. Any other symptoms that you think may be related to lung problems:	❑ Yes	❑ No

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE (MANDATORY) (continued)

5. Have you ever had any of the following cardiovascular or heart problems?

a.	Heart attack:	❑ Yes	❑ No
b.	Stroke:	❑ Yes	❑ No
c.	Angina:	❑ Yes	❑ No
d.	Heart failure:	❑ Yes	❑ No
e.	Swelling in your legs or feet (not caused by walking):	❑ Yes	❑ No
f.	Heart arrhythmia (heart beating irregularly):	❑ Yes	❑ No
g.	High blood pressure:	❑ Yes	❑ No
h.	Any other heart problem that you have been told about:	❑ Yes	❑ No

6. Have you ever had any of the following cardiovascular or heart symptoms?

a.	Frequent pain or tightness in your chest:	❑ Yes	❑ No
b.	Pain or tightness in your chest during physical activity:	❑ Yes	❑ No
c.	Pain or tightness in your chest that interferes with your job:	❑ Yes	❑ No
d.	In the past two years, have you noticed your heart skipping or missing a beat:	❑ Yes	❑ No
e.	Heartburn or indigestion that is not related to eating:	❑ Yes	❑ No
f.	Any other symptoms that you think may be related to heart or circulation problems:	❑ Yes	❑ No

7. Do you *currently* take medication for any of the following problems?

a.	Breathing or lung problems:	❑ Yes	❑ No
b.	Heart trouble:	❑ Yes	❑ No
c.	Blood pressure:	❑ Yes	❑ No
d.	Seizures (fits):	❑ Yes	❑ No

8. If you have used a respirator, have you ever had any of the following problems?
(If you have never used a respirator, check the following box and go to question 9:) ❑

a.	Eye irritation:	❑ Yes	❑ No
b.	Skin allergies or rashes:	❑ Yes	❑ No
c.	Anxiety:	❑ Yes	❑ No
d.	General weakness or fatigue:	❑ Yes	❑ No
e.	Any other problem that interferes with your use of a respirator:	❑ Yes	❑ No

9. Would you like to talk to the healthcare professional who will review this questionnaire about your answers to this questionnaire: ❑ Yes ❑ No

INOVA

REPORTABLE CONDITIONS AND OCCURRENCES FOR TEAM MEMBERS

In compliance with established policies governing Team Member Health, and in the best interest of other staff and patients, you must report the following conditions to your supervisor:

1. Diagnosed with:
    - Streptococcal (Group A) throat.
    - Pneumonia – viral, bacterial or walking.
    - Conjunctivitis
    - Meningitis
    - Influenza
2. **Any** exposure to the following, or development of an active infection with:
    - Hepatitis A, Hepatitis B, or Hepatitis C
    - Measles, Mumps, Rubella (if you are not immune)
    - Chickenpox or shingles
    - Herpes Simplex Virus
    - Tuberculosis
    - Pertussis
    - Bacterial Meningitis (N. meningitidis)
3. Needlesticks/sharps accident, mucous membrane or non-intact skin exposure to patient's blood or body fluids containing visible blood.

All exposures should be reported as soon as the exposure or incident occurred with appropriate forms filled out.

I understand that it is my responsibility to notify my supervisor of any exposure I have had to a communicable disease. I also understand that I am to notify them of any illness/disease which I contract that may pose a threat to other team members or patients. I understand that this notification is to protect myself, patients, and other staff members.

I have received a copy of this document, understand its content and was made aware that this will be placed in my medical record.

Printed Name: _____

Signature: _____ Date: _____

INOVA HEALTH SYSTEM
TEAM MEMBER HEALTH
__IAH____IAS____IFMC__IFOH____ILH____IMVH___ISO

PRE-PLACEMENT HEALTH HISTORY QUESTIONNAIRE AND ASSESSMENT

PLEASE PRINT ***DATE COMPLETED:*** **/ /**

NAME	BIRTHDATE	BIRTHPLACE	PRIMARY LANGUAGE SPOKEN	
ADDRESS	CITY-STATE-ZIP CODE			SEX
SOCIAL SECURITY NUMBER	HOME PHONE		MOBILE PHONE	

IN CASE OF EMERGENCY--NOTIFY

NAME	RELATIONSHIP	PHONE
ADDRESS	CITY-STATE-ZIP CODE	

WORK ASSIGNMENT INFORMATION

JOB POSITION	DEPARTMENT / FACILITY	ORIENTATION DATE

Have you ever worked at an Inova Health System facility? No / Yes If yes, please list:

To determine whether accommodations are appropriate or required, and to enhance wellness, the information obtained in this form is designed to assist in assessing your ability to perform the essential functions of the job position for which you have been offered employment. Some job classifications may require additional information and examination. This information is CONFIDENTIAL and will be released only when necessary to those who have a need to know for work related reasons and/or in the event of a medical emergency. It will be part of your Team Member Health record, separate from your Human Resource Record and will be maintained in the Team Member Health office.

Circle the appropriate response—No or Yes—Provide comments as indicated

ALLERGY HISTORY—Do you have any medication or drug allergies? No / Yes If Yes – Describe Reaction

Have you ever had an allergic reaction or sensitivity to Latex? No / Yes If Yes – Describe Reaction

MEDICATIONS—List all medications you are currently taking, including over-the-counter medications.

TUBERCULOSIS ASSESSMENT

1. Have you ever had a TB skin test?	**Yes**	**No**
2. What was the result?	**POSITIVE**	**NEGATIVE**
If positive, do you have documentation?	**Yes**	**No**
3. Did you have a chest X-ray after your skin test?	**Yes**	**No**
If yes, when?	____/____/_____	
4. Have you ever been told that you have TB?	**Yes**	**No**
5. Have you ever been treated for TB infection or TB disease?	**Yes**	**No**

MEDICAL HISTORY			
HAVE YOU EVER HAD:	**NO**	**YES**	**If Yes or Unsure—Please give dates Describe/Comment**
Respiratory conditions/Asthma/Emphysema			
Seizures/Epilepsy			
Dizzy or Fainting Spells			
Migraines/Headaches/Head Injury			
Blood disease/Sickle cell			
Diabetes/Hypoglycemia			
Heart/Circulatory Conditions			
Arthritis/Auto Immune Disease			
Neck, Back or Joint Pain/Problems/Injury			
Skin Disease/Problem			
Cancer/Tumors			
Fibromyalgia/Chronic Fatigue Syndrome			
Mental Health Disorders			
Anxiety/Panic Attacks			
PTSD			
Depression			
Other			
Narcotic/Drug/Alcohol Problems/Dependency			
Do you wear Hearing aid(s)			Left / Right / Both
Do you wear corrective eyewear for? Near / Far /Both			Glasses/Contacts/Laser eye surgery
Other illness, conditions or symptoms not previously listed			

I have….	**NO**	**YES**	**If Yes or Unsure—Please give dates Describe/Comment**
Been treated for a serious medical condition (accident, illness, or surgery) within the past five (5) years			
Experienced sensitivity or acute allergic reaction, hives or life-threatening reaction to any substance such as latex, dust or chemicals			
Worked with cytotoxic chemotherapy agents			
Had laser or radiation treatment or exposure in a medical facility			
A condition or medication use that affects the immune system such as chemotherapy, steroid use or other			
Been prescribed or taking over-the-counter medication that could affect balance, judgement, alertness or other function			
Presently or in past: any limitations, disability or restriction that requires assistance and/or change in essential functions of my job			

BASED ON A ROUTINE WORK DAY, I AM ABLE TO:	NO	YES	IF NO OR UNSURE- PLEASE DESCRIBE/COMMENT
Sit and/or walk for up to 8 hours/day (with routine breaks)			
Stand 4-7 hours/day			
Squat, stoop or kneel without difficulty			
Use both hands to do fine motor activities without difficulty			
Lift up to 50 pounds without difficulty			
Push or pull items without difficulty			

I am aware of the essential functions of the job position offered to me. ____Yes ____No

Describe any condition that could affect or limit your ability to perform the essential functions of the job offered to you. ***If none, please state "None".***

This Preplacement Health History Questionnaire and Assessment was completed by:
_____Myself_____Other (List name)_____

APPLICANT'S CERTIFICATION AND AGREEMENT

I understand that the intent of this questionnaire and screening process is to assemble an employment health file with documentation to indicate my fitness-for-duty; and, to determine my qualifications for performing the assigned duties of the job position for which I have been made an offer of employment. It is not to be considered a replacement for any examination performed by a physician. I understand that my offer of employment is conditioned upon successful completion of a preplacement health assessment and drug screen and that continued employment may be subject to subsequent fitness-for-duty examinations or screens.

I am aware that this employment could place me at some risk for exposure to infectious disease or injury. I understand it will be my responsibility to adopt and use safe work habits, which will include taking advantage of those safety policies, equipment and practices which Inova Health System has established for my protection and to insure a safe and healthy work environment. In addition, I understand that I am responsible for my own health and safety and that I must report any acute infectious or contagious illness to my supervisor, and that the presence of an acute infectious illness may result in my removal from duty for a period of time until cleared by a medical provider.

I also understand that medical information on this form is confidential. I give my consent for Inova Health System to contact my medical care provider(s) and obtain any additional information/records and perform any health screens that are deemed necessary to complete this screening process. In the event I transfer my employment to another Inova site/facility; I hereby give my permission for my confidential health record to be transferred to this facility, as deemed indicated by Inova. Furthermore, I acknowledge that the information provided herein is current, correct and complete to the best of my knowledge and that any omission or falsification of any part of my medical history would be cause for dismissal.

Team Member Signature_____ Date_____

Print Name_____

Parent/Guardian Signature (for applicant under 18):_____

Nurse Consultant Notes:

INOVA

Team Member Health Clinic Locations

FACILITY	OFFICE HOURS	WALK IN CLINIC HOURS	FAX
Inova Fairfax Medical Campus 3300 Gallows Road Falls Church, VA 22042 **703-776-3271**	**Monday—Friday** 7 a.m. – 4 p.m.	**Monday—Wednesday and Friday** 7 – 8:30 a.m. 2 – 3:30 p.m.	**703-776-3598**
Inova Alexandria Hospital ***(Including HealthPlex/Springfield)*** 4320 Seminary Road Alexandria, VA 22304 **703-504-3033**	**Monday—Friday** 7:30 a.m. – 4 p.m.	**Monday—Wednesday and Friday** 7:30 – 9 a.m. 2 – 3:30 p.m.	**703-504-3060**
Inova Fair Oaks Hospital 3600 Joseph Siewick Drive Fairfax, VA 22033 **703-391-3373**	**Monday—Friday** 7:30 a.m. – 4 p.m.	**Monday—Wednesday and Friday** 7:30 – 9 a.m. 2 – 3:30 p.m.	**703-391-3751**
Inova Loudoun Hospital 44045 Riverside Parkway Leesburg, VA 20176 **703-858-6424**	**Monday—Friday** 7:30 a.m. – 4 p.m.	**Monday, Wednesday and Friday** 7:30 – 8:30 a.m. 2 – 3:30 p.m.	**703-858-6015**
Inova Mt. Vernon Hospital ***(Including HealthPlex/Lorton)*** 2501 Parkers Lane Alexandria, VA 22306 **703-664-7110**	**Monday—Friday** 7:30 a.m. – 4 p.m.	**Monday—Wednesday and Friday** 7:30 – 9 a.m. 2 – 3:30 p.m.	**703-664-8299**
Team Members of: **Inova System Office** **Ambulatory Services** **ICPH**	**Services provided at Inova Fairfax Medical Campus**		