Internal Occupational Health
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To: Incoming Housestaff
From: Internal Occupational Health Project Manager
Date: March 2022
Re: MCWAH Mandatory Health Requirements

Welcome to Froedtert & Medical College of Wisconsin. We look forward to working with you beginning this July.

As part of your onboarding, please complete the attached forms and submit all documentation in one completed packet to Medical College of Wisconsin Affiliated Hospitals Administration by ***May 16, 2022.*** For your convenience, a self-addressed, stamped envelope is enclosed for this purpose.

- ***Forms to complete if you are a Medical College of Wisconsin graduate*:**

  - ❑ **Health and Communicable Disease Record-** please have this completed by a physician, NP, or PA, dated within 90 days prior to start (after April 1, 2022).
  - ❑ **Authorization to Release Medical Records**
  - ❑ **Respirator Medical Evaluation Questionnaire**
  - ❑ **Please send a copy of your Castlebranch records** to determine if your immunizations and TB surveillance are up to date

- ***Forms to complete if you graduated from another medical college system:***

  - ❑ **Immunization and Tuberculosis (TB) Surveillance Form** with copies of indicated documentation
  - ❑ **Health and Communicable Disease Record** completed by a physician, NP, or PA, dated within 90 days prior to start (after April 1, 2022)
  - ❑ **Authorization to Release Medical Records**
  - ❑ **Respirator Medical Evaluation Questionnaire**

If you need assistance with meeting these health requirements, or have any questions, please call our office at 805-7997.

Immunization and Tuberculosis (TB) Surveillance Form

Froedtert & Medical College of Wisconsin

****Supporting documentation must accompany this form****

Please print legibly

Last Name:	First Name:	Middle Initial:
Address:		
Phone:	Primary Email:	
Date of Birth:	Last 4 SS#:	

MMR (Measles, Mumps, Rubella) – *2 doses of MMR vaccine or two (2) doses of Measles, two (2) doses of Mumps and one (1)dose of Rubella; OR serologic proof of immunity for Measles, Mumps, and/or Rubella*

Option 1	**Vaccine**	**Date**	**Please Attach Copies**
MMR 2 doses of MMR vaccine	MMR Dose #1	____/____/____	❑ Copy Attached
	MMR Dose #2	____/____/____	❑ Copy Attached
Option 2	**Vaccine or Test**	**Date**	
Measles 2 doses of vaccine or positive serology	Measles Vaccine Dose #1	____/____/____	❑ Copy Attached
	Measles Vaccine Dose #2	____/____/____	❑ Copy Attached
	Serologic Immunity (IgG, antibodies, titer)	____/____/____	❑ Copy Attached
Mumps 2 doses of vaccine or positive serology	Mumps Vaccine Dose #1	____/____/____	❑ Copy Attached
	Mumps Vaccine Dose #2	____/____/____	❑ Copy Attached
	Serologic Immunity (IgG, antibodies, titer)	____/____/____	❑ Copy Attached
Rubella 1 dose of vaccine or positive serology	Rubella vaccine	____/____/____	❑ Copy Attached
	Serologic Immunity (IgG, antibodies, titer)	____/____/____	❑ Copy Attached

Hepatitis B Vaccination – 3 doses of vaccine follow by a QUANTITATIVE Hepatitis B Surface Antibody (titer) preferably drawn 4-8 weeks after 3rd dose. If negative, give 4th (booster vaccine) and recheck Hepatitis B Surface Antibody (titer). If titer continues to be negative, complete second series (doses 5 and 6), and recheck Hepatitis B Surface Antibody (titer) again. If Hepatitis B Surface Antibody is negative after completing a second series (total of 6 doses of vaccine), considered as non-responder.

		Date	
Primary Hepatitis B Series	Hepatitis B Vaccine Dose #1	____/____/____	❑ Copy Attached
	Hepatitis B Vaccine Dose #1	____/____/____	❑ Copy Attached
	Hepatitis B Vaccine Dose #1	____/____/____	❑ Copy Attached
	QUANTITATIVE Hepatitis B Surface Antibody	____/____/____	Result: ____ mIU/ml ❑ Copy Attached
Booster Dose of Vaccine (if no response to primary series)	Hepatitis B Vaccine Dose #4	____/____/____	❑ Copy Attached
	QUANTITATIVE Hepatitis B Surface Antibody	____/____/____	Result: ____ mIU/ml ❑ Copy Attached
Completion of Second Series (if no response to Booster Dose)	Hepatitis B Vaccine Dose #5	____/____/____	❑ Copy Attached
	Hepatitis B Vaccine Dose #6	____/____/____	❑ Copy Attached
	QUANTITATIVE Hepatitis B Surface Antibody	____/____/____	Result: ____ mIU/ml ❑ Copy Attached

Tetanus diphtheria pertussis (Tdap) vaccine – 1 (one) dose of adult Tdap. If last Tdap is more than 10 years ago, also provide date of last Tetanus diphtheria vaccine (Td)			
		Date	
	Tetanus diphtheria pertussis (Tdap) Vaccine	____/____/____	❑ Copy Attached
	Tetanus diphtheria vaccine (Td) - if Tdap given more than 10 years ago	____/____/____	❑ Copy Attached
Varicella Vaccination – 2 doses of vaccine or positive serology			
		Date	
Option 1	Varicella Vaccine #1	____/____/____	❑ Copy Attached
	Varicella Vaccine #2	____/____/____	❑ Copy Attached
Option 2	Serologic Immunity (IgG, antibodies, titer)	____/____/____	❑ Copy Attached
Covid Vaccination- Recommended			
		Date	
Option 1 Pfizer/Moderna	Dose 1	____/____/____	❑ Copy Attached
	Dose 2	____/____/____	❑ Copy Attached
Option 2 Single Dose	Manufacturer:	____/____/____	❑ Copy Attached
Covid Vaccine Booster	Manufacturer:	____/____/____	❑ Copy Attached

Tuberculosis Surveillance – Complete Section A, B, OR C				
SECTION A: Negative Skin or Blood Test History - Last two skin tests or one IGRA required				
Option 1	Tuberculin Skin Test #1 (dated within 12 months of program start)	Date Placed	Date Read	Result: _____ mm ❑ Copy Attached
	Tuberculin Skin Test #2 (dated within 90 days of program start)	Date Placed	Date Read	Result: _____ mm ❑ Copy Attached
Option 2	Interferon gamma releasing assay (IGRA) Blood Test (dated within 90 days of program start)	Date		Result: _____ ❑ Copy Attached
SECTION B: History of Latent Tuberculosis, Positive Skin Test or Positive Blood Test				
Option 1	Positive Tuberculin Skin Test	Date Placed	Date Read	Result: _____ mm
Option 2	Positive IGRA Blood Test	Date: ____/____/____		Result: _____ ❑ Copy Attached
	Chest X-ray (dated within 6 months of program start)	Date: ____/____/____		Result: _____ ❑ Copy Attached
	Written symptoms questionnaire (dated within 90 days of program start) – Form may be obtained from Internal Occupational Health	Date: ____/____/____		❑ Copy Attached
	Was prophylactic medication taken for latent TB?			❑ Yes ❑ No
	If prophylactic medication was taken, total duration of prophylaxis			_____ Months
SECTION C: History of Active Tuberculosis				
	Date of Diagnosis:			
	Date Treatment Completed:			
	Chest X-ray (dated within 6 months of program start)	Date: ____/____/____		Result: _____ ❑ Copy Attached

History of Active Tuberculosis continued:	Written symptoms questionnaire (dated within 90 days of program start) – Form may be obtained from Internal Occupational Health	Date: ____ / ____ / ____	❑ Copy Attached

I hereby declare that all statements included in this Surveillance Form are true and correct to the best of my knowledge.

Signature of Patient	**Date**

HEALTH AND COMMUNICABLE DISEASE RECORD

The information you are being asked to provide is being requested for two purposes. It will assist in evaluating your physical and mental capacity to perform healthcare worker functions and to ascertain whether you are free from communicable disease.

This information will be maintained in your health record and is **confidential** unless Internal Occupational Health is authorized to disclose it.

This review, with signed health practitioner statement, must be done within 90 days of program and/or employment start.

Name: _____ Date of Birth: _____

Home Address: _____ Gender: _____

City: _____ State: _____ Social Security Number: _____

Zip Code: _____ Phone (Cell): _____ Phone (Home): _____

Have you ever worked or volunteered at a Froedtert or Medical College of Wisconsin facility? Yes ☐ No ☐

If yes, please indicate when and where: _____

PERSONAL HISTORY
(To be completed by patient)

Allergies

Drug(s): _____ Reaction(s): _____

Food: _____ Reaction(s): _____

Latex: _____ Reaction(s): _____

Environmental: _____ Reaction(s): _____

Medications

Please list all nonprescription (over – the – counter) medications that you regularly use, including vitamins, herbal supplements, laxatives, aspirins, and weight-reducing aids:

Please list all prescription medicines that you are currently taking:

Hospitalizations / Surgeries / Childbirth Within the Last Five Years

Year	Reason(s)

Have you had or do you now have: (Please comment on "yes" answers as needed.)					
	Yes	No		Yes	No
Heart / Blood			**Musculoskeletal**		
High Blood Pressure	☐	☐	Neck Pain / Neck Injury	☐	☐
Low Blood Pressure	☐	☐	Back Pain / Back Injury	☐	☐
Stroke	☐	☐	Spine or Joint Surgery	☐	☐
Heart Attack	☐	☐	Inability to Lift / Lifting Restrictions	☐	☐
Comments:			Dislocation of Any Joint	☐	☐
			Bone, Joint, or Other Deformity	☐	☐
Respiratory / Lungs			Fractured / Broken Bones	☐	☐
Breathing Problems	☐	☐	Joints That "Lock" or Give Out	☐	☐
Coughed Up Blood	☐	☐	Swollen / Painful Joint(s)	☐	☐
Cough Over 2 weeks Duration	☐	☐	Arthritis	☐	☐
Night Sweats	☐	☐	Fibromyalgia	☐	☐
Tuberculosis	☐	☐	Tendonitis	☐	☐
Positive TB Skin Test	☐	☐	Bursitis	☐	☐
Year:	☐	☐	Carpal Tunnel Syndrome	☐	☐
Date of Chest X-ray:			Hernia	☐	☐
INH Treatment?	☐	☐	Need to use a mobility aid (i.e., walker, cane, wheelchair, scooter)	☐	☐
Comments:			***Comments:***		
Head			**Nerve / Muscle**		
Head Injury	☐	☐	Muscular Dystrophy	☐	☐
Dizziness / Fainting	☐	☐	Parkinson's Disease	☐	☐
Headaches, Frequent or Severe	☐	☐	Paralysis	☐	☐
Comments:			Multiple Sclerosis	☐	☐
			Unusual Weakness	☐	☐
Skin			Numbness / Tingling	☐	☐
Skin Problems	☐	☐	Seizures / Epilepsy	☐	☐
Comments:			***Comments:***		
	Yes	No		Yes	No
Eyes / Ears / Nose / Throat			**Gastrointestinal**		
Wear Glasses	☐	☐	Stomach or Bowel Problems	☐	☐
Contacts (type):	☐	☐	***Comments:***		
Vision: Nearsighted	☐	☐			
Farsighted	☐	☐	**Immune System**		
Eye Problems	☐	☐	Lymph Gland Swelling	☐	☐
Hearing Problems	☐	☐	Lupus	☐	☐
Hearing Aid	☐	☐	Organ Transplant	☐	☐
Comments:			Immunocompromised	☐	☐
			Comments:		
Mental Health					
Anxiety / Panic Attacks	☐	☐	**Other Health Problems**		
Depression	☐	☐	Cancer:	☐	☐
Eating Disorder	☐	☐	Chemotherapy	☐	☐
Alcohol / Substance Abuse	☐	☐	Radiation	☐	☐
Other:	☐	☐	Diabetes	☐	☐
Comments:			***Comments:***		
Any other physical or psychological problem(s) not listed above:					

Have you lived or traveled outside of the United States for longer than a month? Yes ☐ No ☐ If yes, when and where?

Have you had an injury to the eye involving metallic fragments, an implanted device placed (i.e., aneurysm clips, cochlear implants, pace maker, spinal cord stimulator, etc.), an injury by a metallic object (i.e., bullet, BB, shrapnel, etc.), or any other implanted metallic object? Yes ☐ No ☐ If yes, please comment:

Do you have any permanent physical, mental, or learning disabilities? Yes ☐ No ☐ If yes, what are they? _____

I hereby declare that all statements included in this Health and Communicable Disease Record are true and correct to the best of my knowledge.

Signature of Patient **Date**

HEALTHCARE PRACTITIONER STATEMENT

☐ **This patient is free of clinically apparent communicable disease.**

This patient may participate in direct patient care:

- ☐ **Without restrictions.**
- ☐ **With the following restrictions:** _____
- ☐ **May not participate at this time**

Physician, Nurse Practitioner, or Physician Assistant's name (Please print.) **Street Address**

City, State, Zip **Telephone**

Signature of Physician, Nurse Practitioner, or Physician Assistant **Date**

Authorization to Release Medical Records

For the Purpose of Occupational Health Information Requirements Only

I hereby authorize and request Froedtert & the Medical College of Wisconsin Internal Occupational Health Services to release the following occupational health records to any healthcare facilities I may rotate through as a student of the Medical College of Wisconsin and/or employee of Medical College of Wisconsin Affiliated Hospitals.

- ✓ Immunization records including Influenza; Varicella; Hepatitis B; Measles, Mumps, Rubella (MMR); Tetanus diphtheria (Td); Tetanus diphtheria pertussis (Tdap); Polio; Yellow Fever; Hepatitis A; Typhoid; Meningococcal; Japanese Encephalitis; Rabies
- ✓ Tuberculosis surveillance records including Mantoux tuberculin skin testing, interferon-gamma release assay (IGRA) testing and / or chest X-ray results
- ✓ Laboratory reports including Rubeola (Measles), Mumps, Rubella, Varicella, Hepatitis B titers
- ✓ Any other medical documentation needed to meet the occupational health requirements of the healthcare organization

This authorization for disclosure is effective until completion of my training with the Medical College of Wisconsin and/or termination of employment with Medical College of Wisconsin Affiliated Hospitals.

This information is for use by the recipient named above only. Records may not be released to any other individual or agency without written authorization. The party signing this release is entitled to receive a copy upon request. I understand that I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present my written revocation to the Froedtert & Medical College of Wisconsin Internal Occupational Health Department. I understand that the revocation will not apply to information that has already been released. I understand that if the persons or organizations I authorize to receive and/or use the protected health information described in this form are not health plans, covered health care providers or health care clearinghouses subject to the federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health law. I understand that I may refuse to sign this authorization, and that my refusal will not affect my ability to practice. I understand that my health information may be transmitted electronically.

Name (please print legibly):		Signature:
Date:	Birth month and day:	Last four digits of SS number:

Froedtert & Medical College of Wisconsin

Respirator Medical Evaluation Questionnaire

Can you read? Yes ❑ No ❑

Would you like assistance in completing this questionnaire? 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 health care professional who will review it.

Part A. Section 1. (Mandatory) The following information must be provided by every person who has been selected to use any type of respirator (please print).

1.	Today's date:	2.	Your name:
3.	Your age (to nearest year):	4.	Sex (circle one): Male Female
5.	Your height: _____ feet ____ inches	6.	Your weight: _____ lbs.
7.	Do you have a full facial beard? Yes ❑ No ❑		
8.	Your department and job title:		
9.	A phone number where you can be reached by the health care professional who reviews this questionnaire (include the area code):		
10.	The best time to phone you at this number:		
11.	Has your employer told you how to contact the health care professional who will review this questionnaire? Yes ❑ No ❑		
12.	Check the type of respirator you will use. (You may check more than one category.) a. ► N (Non-Oil), R (Oil Resistant), or P (Oil Proof) disposable respirator (i.e., filter-mask/N95, non-cartridge type only.) b. ❑ Other type (i.e., half or full-face piece type, powered-air purifying, supplied-air, self- contained breathing apparatus.) ❑ Powered Air Purifying Respirator (PAPR) ❑ Half Face Piece ❑ Other: _____ *(This question is answered for you since N95 respirators are those commonly worn in isolation rooms.)*		
13.	Have you worn a respirator? Yes ❑ No ❑ If "yes", what type(s): _____		

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every person who has been selected to use any type of respirator (please indicate "yes" or "no").

		Yes	***No***
1.	Do you ***currently*** smoke tobacco, or have you smoked tobacco in the last month? If yes: At what age did you start smoking? _____ How long ago did you quit smoking? _____ How many packs per day did or do you smoke? _____	❑	❑
2.	Have you ***ever had*** any of the following conditions?	***Yes***	***No***
	a. Seizures (fits) Type _____ Date of last seizure _____	❑	❑
	b. Diabetes (sugar disease)	❑	❑
	Have you ever lost consciousness or had a change in level of consciousness? If yes, when? _____	❑	❑
	c. Allergic reactions that interfere with your breathing?		

If yes, when? _____ ❑ ❑
If yes, describe: _____

d. Claustrophobia (fear of closed-in places) ❑ ❑

e. Trouble smelling odor ❑ ❑

3. Have you ***ever had*** any of the following pulmonary or lung problems?	***Yes***	***No***
a. Asbestosis	❑	❑
b. Asthma	❑	❑
c. Chronic bronchitis	❑	❑
d. Emphysema	❑	❑
e. Pneumonia	❑	❑
f. Tuberculosis	❑	❑
g. Silicosis	❑	❑
h. Pneumothorax	❑	❑
i. Lung cancer	❑	❑
j. Broken rib	❑	❑
k. Any chest injuries or surgeries	❑	❑
l. Any other lung problem that you've been told about?	❑	❑

If yes to any of the above, please describe, including when: _____

_____

4. Do you ***currently*** have any of the following symptoms of pulmonary or lung illness?	***Yes***	***No***
a. Shortness of breath	❑	❑
b. Shortness of breath when walking fast on level ground or up a slight hill or incline	❑	❑
c. Shortness of breath when walking with others at an ordinary pace on level ground	❑	❑
d. Have to stop for breath when walking at your own pace on level ground	❑	❑
e. Shortness of breath when washing or dressing yourself	❑	❑
f. Shortness of breath that interferes with your job	❑	❑
g. Coughing that produces phlegm (thick sputum)	❑	❑
h. Coughing that wakes you early in the morning	❑	❑
i. Coughing that occurs mostly when you are lying down	❑	❑
j. Coughing up blood in the last month	❑	❑
k. Wheezing	❑	❑
l. Wheezing that interferes with your job	❑	❑
m. Chest pain when you breathe deeply	❑	❑

	Yes	No
n. Any other symptoms that you think may be related to lung problems	❑	❑

If yes to any of the above, please describe: _____

_____

_____

5. Have you ***ever had*** any of the following cardiovascular or heart problems?	Yes	No
a. Heart attack	❑	❑
b. Stroke	❑	❑
c. Angina	❑	❑
d. Heart failure	❑	❑
e. Swelling in your legs or feet (not caused by walking)	❑	❑
f. Heart arrhythmia (heart beating irregularly)	❑	❑
g. High blood pressure	❑	❑
If yes, is it under control?	❑	❑
h. Any other heart problem that you've been told about	❑	❑
If yes, to any of the above, please describe, including when: _____		

_____

6. Have you ***ever had*** any of the following cardiovascular or heart symptoms?	Yes	No
a. Frequent pain or tightness in your chest	❑	❑
b. Pain or tightness in your chest during physical activity	❑	❑
c. Pain or tightness in your chest that interferes with your job	❑	❑
d. In the past two years, have you noticed your heart skipping or missing a beat	❑	❑
e. Heartburn or indigestion that is not related to eating	❑	❑
f. Any other symptoms that you think may be related to heart or circulation problems	❑	❑
If yes to any of the above, please describe, including when: _____		

_____

7. Do you ***currently*** take medication for any of the following problems?	Yes	No
a. Breathing or lung problems	❑	❑
b. Heart trouble	❑	❑
c. Blood pressure	❑	❑
d. Seizures (fits)	❑	❑

8. If you've used a respirator, have you ***ever had*** any of the following problems during respirator use? (If you've never used a respirator, check the following box and go to question number 9): ❑	Yes	No
a. Eye irritation	❑	❑
b. Skin allergies or rashes	❑	❑
c. Anxiety	❑	❑
d. General weakness or fatigue	❑	❑
e. Any other problem that interferes with your use of a respirator	❑	❑
If yes to any of the above, please describe: _____		

_____

9. Are you currently taking any medications? If yes, please list here: _____ ❑ ❑

_____
_____
_____
_____
_____

10. Would you like to talk to the health care professional that reviews this questionnaire about your answers to this questionnaire? ❑ ❑

For any "Yes" answers in section 2 (questions 1-9 above), does this condition interfere with your ability to wear a respirator? ❑ ❑

Comment: _____
_____
_____
_____

Signature: _____ **Date:** _____

Internal Occupational Health Department Use Only

- ❑ Approved
- ❑ Approved with restrictions: _____
- ❑ Pulmonary function test and follow-up medical evaluation indicated
- ❑ Denied
- ❑ More information needed

Remarks: _____
_____

Signature: _____ **Date:** _____