EVMS
Eastern Virginia Medical School

Occupational Health

Phone: 757-446-5870 FAX: 757-446-7188

To: Incoming Residents and Fellows

Re: Health Requirements for Residents and Fellows at EVMS

Welcome to Eastern Virginia Medical School (EVMS). Incoming residents and fellows must have a physical exam performed by a physician, nurse practitioner, or physician's assistant who is not in your residency or fellowship program and who is not related to you within four months prior to your residency start date. You are responsible for the costs of all health requirements including the physical exam, immunizations, antibody titers, tuberculin skin testing, and chest x-ray if indicated. The Occupational Health Department cannot perform your physical examination.

EVMS adheres to the Centers for Disease Control (CDC) guidelines regarding immunization of health-care workers. You must provide copies of immunization documentation (i.e. shot records), laboratory reports indicating immunity, and documentation of placement and results of tuberculin skin tests. If you have previously had a positive tuberculin skin test, please complete the enclosed TB Symptom Surveillance Questionnaire, documentation of evaluation for treatment, and chest x-ray report from the past twelve months. Hepatitis B vaccine will be offered to all incoming residents/fellows who have not been previously vaccinated. You must submit all health requirement documentation to the Occupational Health office by May 11. Failure to comply with the School's health requirements may delay the beginning of your residency or fellowship program. If you are a former EVMS student, please contact Occupational Health at 757-446-5870 or OccHealth@evms.edu.

Do not return medical forms to the program you are entering. Please keep a copy of original documents for your personal records. All documents should be mailed to the Occupational Health Office at the following address:

Occupational Health
Eastern Virginia Medical School
721 Fairfax Avenue Norfolk,
VA 23507
Attention: Occupational Health

In addition, employment is contingent upon the successful completion of a drug screen. Drug screens can be scheduled Monday through Friday between the hours of 9:00am and 3:00pm during the months of May and June in the Occupational Health office by calling (757) 446- 5870. If, you are not able to have a drug screen in June, you will be given an appointment during your orientation period.

Eastern Virginia Medical School
Pre-Placement Medical Questionnaire/Physical Exam

ARE YOU A CURRENT OR FORMER EVMS STUDENT? ☐ YES or ☐ NO

Section 1: Identification

Applicant Name: _____

Sex: ☐ Female ☐ Male Social Security Number: _xxx____/___xx___/_____

Date of Birth: _____/_____/_____ Height: _____Ft. _____In. Weight: _____Lb

Department: _____ Job Title: _____

This form is to help the medical provider assess your ability to perform the essential functions of the job for which you have applied, whether accommodations are appropriate or required, and/or your need for special or emergency procedures. Some job classifications may require additional information and examination. This information is confidential. It will be part of your medical record.

Relative to this job, is there any health-related condition for which you require accommodation, i.e. job modification, structural changes to the work area? If so, please list:

1. _____ 3. _____
2. _____ 4. _____

Section 2: Personal Medical History

Have you ever had any of the following? (Please Circle)

Allergies/allergic reaction	YES	NO	Heart attack	YES	NO
Angina	YES	NO	Irregular heart beat	YES	NO
Asthma	YES	NO	Pain or tightness in your chest	YES	NO
Back problems	YES	NO	High blood pressure	YES	NO
Chest injury	YES	NO	Hearing/ear problems	YES	NO
Chronic bronchitis	YES	NO	Hepatitis	YES	NO
Claustrophobia	YES	NO	Kidney disease	YES	NO
Diabetes	YES	NO	Lung disease	YES	NO
Ear injury	YES	NO	Pneumothorax	YES	NO
Emphysema	YES	NO	Seizures	YES	NO
Epilepsy	YES	NO	Stroke	YES	NO

If yes to any, please explain: _____

_____

Do you currently have any of the following symptoms of pulmonary or lung illness? (Please Circle)

Shortness of breath	YES	NO
Shortness of breath when walking on level ground or up a slight incline	YES	NO
Shortness of breath when walking with others at an ordinary pace on level ground	YES	NO
Have to stop for breath when washing or dressing yourself	YES	NO

Coughing that produces phlegm (thick sputum)	YES	NO
Coughing that wakes you up early in the morning	YES	NO
Coughing that occurs mostly when you are lying down	YES	NO
Coughing up blood in the last month	YES	NO
Wheezing	YES	NO
Chest pain when you breathe deeply	YES	NO
Any other symptoms that you think may be related to breathing problems	YES	NO

If yes to any, please explain: _____

_____

Do you currently have any of the following musculoskeletal problems? (Please Circle)

Weakness in any of your arms, legs, or feet	YES	NO
Back pain	YES	NO
Difficulty fully moving your arms or legs	YES	NO
Pain or stiffness when you lean forward or backward at the waist	YES	NO
Difficulty moving your head up and down or side to side	YES	NO
Difficulty bending at the knees	YES	NO
Difficulty squatting to the ground	YES	NO
Difficulty climbing a ladder or stairs carrying more than 25 pounds	YES	NO
Any other muscle or skeletal problem	YES	NO

If yes to any, please explain: _____

List any hospitalizations you've had, reason, and date: _____

_____

Have you ever been injured or exposed at a previous job? (Exposure includes, but is not limited to, blood/body fluid exposures, hazardous material/chemical spills, infectious disease exposures, etc.) If so, please list:

_____

Have your physical activity been restricted or have you lost time from work during the past five years? If so, please explain:

_____

Section 3: Allergies and Exposures

Have you ever had a reaction, allergy, or sensitivity to any drugs (such as codeine or penicillin), food, plants, chemicals, or latex?

_____

_____

Have you ever worked with any of the following? (Please Circle)

Anesthetic Gases	YES	NO	Lasers	YES	NO
Antineoplastic/cytotoxic drugs	YES	NO	Lead	YES	NO
Asbestos	YES	NO	Pesticides	YES	NO
Ethylene Oxide	YES	NO	Radiation/radioactive material	YES	NO
Formaldehyde	YES	NO	Animal dander	YES	NO
Glutaraldehyde (Cidex)	YES	NO	Any other substances	YES	NO

If yes to any, please explain:_____

_____

Section 4: Hearing and Vision

Do you currently have any of the following hearing or vision problems? (Please Circle)

Difficulty hearing	YES	NO	Near Sighted	YES	NO
Wearing a hearing aid	YES	NO	Far Sighted	YES	NO
Have you ever had injury to your ears, including a broken ear drum?	YES	NO	Have you ever lost vision in either eye (temporarily or permanently)?	YES	NO
Any other hearing or ear problems?	YES	NO	Any other vision or eye problems?	YES	NO
Color blind	YES	NO	Do you wear contact lenses or glasses?	YES	NO

If yes to any, please explain:_____

_____

When was your last eye exam? _____

Section 5: Respirators Applies to anyone that may have to wear a respirator to perform certain tasks, i.e., TB protection, organic vapor protection, etc.

Have you used a respirator? Yes _____ No _____

If you used a respirator, have you ever had any of the following problems? (Please Circle)

Eye irritation	YES	NO
Skin allergies or rash	YES	NO
Anxiety	YES	NO
General weakness or fatigue	YES	NO
Any other problem that interferes with your use of a respirator	YES	NO
Any other muscle or skeletal problem	YES	NO

If yes to any, please explain: _____

_____

Section 6: Medications

Are you are currently taking medications for any of the following conditions? (Please Circle)

Breathing or lung problems	YES	NO	Heart trouble	YES	NO
Blood pressure	YES	NO	Seizures	YES	NO

If yes to any, please explain: _____
_____

List other medications that you currently taking: _____
_____

Do you take any medications or have any medical conditions to disclose in case of a medical emergency? _____
_____

Do you take medications before or during work which you believe could affect your physical or mental function or performance? (If yes, please list: _____

Do you have any other health problems, concerns, or limitations? _____
_____

Privacy Statement: The information contained in this form is strictly confidential and is kept only in the Eastern Virginia Medical School Occupational Health office. The contents of this file may only be viewed by the Medical Director, the Occupational Health staff, or the treating Physician without your express consent. Your records will not be released without your consent unless mandated by regulatory or legal request.

I the undersigned, certify the above information to be true. I understand that my employment is contingent on a recommendation of the Occupational Health office regarding fitness for duty. Falsification of any information in this questionnaire may result in disciplinary action including termination of employment.

Applicant's Signature Date

Eastern Virginia Medical School
Section 7: Resident/Fellow Immunization Record

Name: _____ Date of Birth: _____

Gender: _____ Phone: _____ E-mail: _____

Program: _____

Section A: Required Immunizations

Immunization documentation must be completed by physician or authorized clinic personnel. Positive titer for immunity will substitute for immunizations. Hep B vaccine and titer are both essential;
Measles, Mumps, Rubella, and Varicella requirements may be satisfied by 2 vaccinations OR positive titer.
ALL TITERS MUST HAVE LABORATORY DOCUMENTATION ATTACHED.

	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	*Titer-Date/Results*
1. Measles (2 doses after 1st birthday)				
2. Mumps (2 doses after 1st birthday)				
3. Rubella (2 doses after 1st birthday)				
4. Varicella (chicken Pox: 2 doses)				
5. T-DAP (adult booster after 2005)				
6. Hepatitis B (3 doses)				

Section B: Tuberculosis Screening (2 PPDs required within 12 months prior to start date)

1. PPD Skin Test (TB screening)	Date Placed	Date Read	_____ mm	☐ neg ☐ pos
2. PPD Skin Test (TB screening)	Date Placed	Date Read	_____ mm	☐ neg ☐ pos

If past positive PPD, you must submit documentation of the positive PPD with the millimeter reading (record above), a negative (normal) chest x-ray within 12 months prior to start date (record below), and an EVMS TB surveillance form (see section 9).
Persons who have received BCG and/or Persons who have historically poor rates of return for TST reading must have a Interferon Gamma Release Assay Blood Test done. Date_____
Results_____

Chest x-ray (only if PPD convertor)		Result	Attach copy of chest x-ray report

Section C: Other Vaccines (optional)

	Mo/Day/Yr	Mo/Day/Yr
Hepatitis A		
Polio (last date)		
☐ Menomune or ☐ Menactra		
Other:		

Section 8: Physical Examination by a physician, nurse practitioner or physician assistant within four (4) months prior to the program start date. Examinations performed by a first-degree relative or in-law will not be accepted.

Applicant/Patient Name: _____

Date of Birth: _____ Weight: _____ lb. Height: _____ft. _____ in.

B/P: _____ Pulse: _____

Far Vision: _____ Corrected ☐ Near Vision: _____ Corrected ☐

Color Vision: _____ Normal ☐ Deficient ☐

Exam:		Comment
_____	Skin	_____
_____	Head	_____
_____	Neck	_____
_____	Ears	_____
_____	Eyes	_____
_____	Nose	_____
_____	Mouth	_____
_____	Heart	_____
_____	Lung	_____
_____	Chest	_____
_____	Abdomen	_____
_____	Genitalia	_____
_____	Rectum	_____
_____	Extremities	_____
_____	Neurological	_____
_____	Orthopedic	_____
_____	Other	_____

Health Care Provider's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ - _____ Fax: (_____) _____ - _____

Signature: _____ Date: _____

Section 9: Tuberculosis Symptom Surveillance Questionnaire
(Please complete this form ONLY if you have had a PREVIOUS POSITIVE PPD.)

Name: _____ Date of Birth: _____/_____/_____

Program: _____ Year: _____

When did you convert to PPD positive? Date: _____/_____/_____

How many millimeters was the PPD reading? _____

When was your last chest x-ray? (Include Chest X-ray Report) ___/____/____

What was the result? _____

Did you ever take INH therapy? YES NO

If yes, for how long and were there complications?_____

Do you have a chronic cough? YES NO
If yes, for how long? _____

Have you had unexplained weight loss? YES NO
If yes, please explain. _____

Do you suffer from malaise? YES NO
If yes, please explain._____

Do you suffer from night sweats? YES NO
If yes, please explain. _____

Do you have an unexplained fever? YES NO
If yes, for how long? _____

Do you have chest pain? YES NO
If yes, please explain. _____

Are you coughing up blood? YES NO
If yes, please explain. _____

_____ _____
Signature Date

_____ _____
Reviewed by (Occupational Health) Date

Revised 1/28/2014