NON- GRADY EMPLOYED STAFF
NEW HIRE PACKET

(Contractors, Vendors, Agency)

Employee Health and Wellness Center
80 Jesse Hill Jr. Drive, SE, Clinic GA021
Atlanta, GA 30303
404-616-4600

INITIAL ONBOARDING HEALTH REQUIREMENTS

(Grady employee, medical staff, faculty, resident, contractor, vendor, volunteer, student)

1. ☐ Respirator Medical Evaluation *(waived with proof of FIT testing within past 1 year)*

OSHA requires the use of respirators to protect workers on the job from occupational disease caused by breathing contaminated air. This evaluation must be performed by a physician or licensed health care professional (PLHCP). It evaluates the physiological burden associated with respirator use. This evaluation is used to determine if it is medically safe for a worker to wear a respirator.

Required for Physician, NP, PA, anesthetist, nurse, care coordinator, chaplain, dentist, dental assistant, food service, housekeeping, interpreter, laundry, maintenance and engineering, nursing assistant, medical assistant, nutritionist, ordering organizer, clinical pharmacist, PT/OT /RT, speech therapist, security, safety, social worker, resource center associate, technicians, transporters, any role not mentioned above that provides-patient facing services or involves entering patient rooms

What does a Respirator Medical Evaluation involve?

- A review of the OSHA Respirator Medical Evaluation Questionnaire (**mandatory**)
- A limited physical exam in addition to any other testing may be required based on the job, workplace condition and health status

How should I prepare for the evaluation?

- Obtain the OSHA Medical Evaluation Questionnaire from Employee Health and Wellness Clinic or GradyNet

How often is a Respirator Medical Evaluation required?

- Initially
- When there are signs or symptoms that are related to the ability to wear a respirator
- When a physician or licensed health care professional (PLHCP) requires testing
- When the work conditions change

2. ☐ Respirator FIT Testing or ☐ Proof of FIT testing with a NIOSH approved respirator (*within past 1 year)*

Tight-fitting respirators, must form a tight seal with your face or neck to work properly. If your respirator doesn't fit your face properly, contaminated air can leak into your respirator face-piece. A FIT test is performed to test the seal between the respirator face-piece and the face of the worker.

What must occur before the test can be performed?

- A **respirator medical evaluation** must be performed by a physician or licensed health care professional (see above)

What type of testing do we offer and what does it involve?

- Qualitative testing**.** This is a pass/fail test, uses the sense of taste or smell or reaction to an irritant to detect leakage, while performing a series of maneuvers

How should you prepare for the respirator FIT?

- Shave any beard, mustache or side burns that will affect the seal of the respirator
  ***You are responsible for maintaining facial hair that will not interfere with mask seal, at all times**

How often must a FIT test be performed?

- At least annually
- If a different respirator face-piece other than the one originally used for fit testing will be used and with changes in physical condition that could affect respirator fit.

Created: 2/15/2021
Updated: 8/10/2021, 8/18/2021, 10/19/2021; 12/15/2021; 3/22/2022, 11/7/2022, 4/2023, 6/2023

Grady

Employee Health and Wellness Center
80 Jesse Hill Jr. Drive, SE, Clinic GA021
Atlanta, GA 30303
404-616-4600

3. ☐ Immunizations

MMR – Measles (Rubeola), Mumps and Rubella

☐ Documentation of **TWO** MMR Vaccine doses **OR**

☐ Laboratory evidence of immunity to Measles, Mumps and Rubella

VARICELLA (Chicken Pox)

☐ Documentation of **TWO** Vaccine doses **OR**

☐ Laboratory evidence of immunity to Varicella

HEPATITIS B

Required for those at risk of being exposed to blood and body fluids: May include *physician, physician assistant, nurse, emergency medical personnel, dental professional, medical/ nursing/dental student, laboratory technician, nursing assistant, radiology technician, patient care technician, respiratory therapist, medical assistant, physical therapist, pharmacist, EVS, housekeeping, hospital volunteer, patient transporter*)

☐ Laboratory evidence of immunity status

☐ Proof of all Hep B vaccines received

INFLUENZA (FLU) Vaccine required starting in August

☐ Documentation of last Influenza vaccine

☐ **TDAP** within last 10 years

4. ☐ Tuberculosis Screening

☐ Documentation of a **TB blood test** (Quantiferon or T-spot) **within 3 months of your start date** (*no prior TB history only*) **OR**

☐ Chest X-ray less than **3 months old** of start date (*history of positive test without medication treatment or with incomplete treatment only*)

☐ Record of completion of medication treatment for TB if applicable

***PPD skin tests are **not** accepted

5. ☐ Vaccine Exemption Request Form (*Follow instructions on form, Grady only evaluates Grady employees, all others must be approved outside of Grady)*

☐ Not applicable

☐ Attached or will submit

We are by appointment only, please contact 404.616.2500 to schedule yours today

Created: 2/15/2021
Updated: 8/10/2021, 8/18/2021, 10/19/2021; 12/15/2021; 3/22/2022, 11/7/2022, 4/2023, 6/2023

Grady

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE ☐ NOT REQUIRED

TO THE EMPLOYEE: Are you able to read and understand the questions contained in this evaluation? ☐ Yes ☐ No ☐ Grady ☐ Morehouse ☐ Emory ☐ _____

Date:_____ Name_____ Job Title: _____ Age: _____ DOB:___/___/____ Employee ID:_____

Gender: ☐ Male ☐ Female Height:_____ ft. _____in Weight: _____lbs. Phone number: _____ The best time to phone you:_____

1. **Has your employer told you how to contact the health care professional who will review this questionnaire?** ☐Yes ☐ No
2. Check the type of respirator you will use (you can check more than one category): ☐ N,R,P disposable respirator (filter-mask, non-cartridge type only). ☐ Other type
3. **Have you worn a respirator (circle one): ☐Yes ☐No If "Yes", what type(s)/size :**_____

Yes	No		Yes	No	
		1. Do you currently smoke tobacco or have you smoked tobacco in the last month?			n. Any other symptoms that you think may be related to lung problems
		2. Have you ever had any of the following conditions?			5. Have you ever had any of the following cardiovascular or heart problems?
		a. Seizures (fits)			
		b. Diabetes (sugar disease)			a. Heart attack
		c. Allergic reactions that interfere with your breathing			b. Stroke
		d. Claustrophobia (fear of closed-in-places)			c. Angina
		e. Trouble smelling odors			d. Heart Failure
		3. Have you ever had any of the following pulmonary or lung problems?			e. Swelling in your legs or feet(not caused by walking)
					f. Heart arrhythmia
		a. Asbestos			g. High blood pressure
		b. Asthma			h. Any other heart problem that you've been told about
		c. Chronic bronchitis			6. Have you ever had any of the following cardiovascular or heart symptoms?
		d. Emphysema			a. Frequent pain or tightness in your chest
		e. Pneumonia			b. Pain or tightness in your chest during physical activity
		f. Tuberculosis			c. Pain or tightness in your chest that interferes with your job
		g. Silicosis			d. In the past two years, have you noticed your heart skipping or missing a beat
		h. Pneumothorax (collapsed lung)			e. Heartburn or indigestion that is not related to eating
		i. Lung cancer			f. Any other symptoms that you think may be related to heart or circulation problems
		j. Broken ribs			7. Do you currently take medication for any of the following problems?
		k. Any chest injuries or surgeries			a. Breathing or lung problems
		l. Any other lung problem that you've been told about			b. Heart trouble
		4. Do you currently have any of the following symptoms pulmonary or lung illness?			c. Blood pressure
		a. Shortness of breath			d. Seizures
		b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline			8. If you've used a respirator, have you ever had any of the following problems?
		c. Shortness of breath when walking with other people at an ordinary pace on level ground			If you've never used a respirator, check the following space ____ and go to question 9
		d. Have to stop for breath when walking at your own pace on level ground			
		e. Shortness of breath when washing or dressing yourself			a. Eye Irritation
		f. Shortness of breath that interferes with your job			b. Skin allergies or rashes
		g. Coughing that produces phlegm(thick sputum)			c. Anxiety
		h. Coughing that wakes you early in the morning			d. General weakness or fatigue
		i. Coughing that occurs mostly when you are lying down			e. Any other problem that interferes with your use of a respirator
		j. Coughing up blood in the last month			
		k. Wheezing			9. Would you like to talk to the health care provider who will review this questionnaire about your answers to this questionnaire?
		l. Wheezing that interferes with your job			
		m. Chest pain when you breathe deeply			

Employee Signature: **Date:**

EMPLOYEE HEALTH AND WELLNESS CENTER (EHWC) ONLY

Created: 1/21/2021

Follow up Medical Examination ☐Required ☐Not required

Updated: 8/16/21, 8/26/21 , 11/22

Reviewing Physician/Provider Name: Signature: Date:

Facial Hairstyles and Filtering Facepiece Respirators

Intended for workers who wear tight-fitting respirators

CLEAN SHAVEN ✓

STUBBLE ✗

LONG STUBBLE ✗

FULL BEARD ✗

FRENCH FORK ✗

DUCKTAIL ✗

VERDI ✗

GARIBALDI ✗

BANDHOLZ ✗

SOUL PATCH ✓

GOATEE ✓
(Careful! Chin hair may easily cross the seal)

CHIN CURTAIN ✗

EXTENDED GOATEE ✗

CIRCLE BEARD ✗

ANCHOR ✓ BALBO ✓
(Careful! Chin hair may easily cross the seal)

VAN DYKE ✗

IMPERIAL ✗

SIDE WHISKERS ✓

MUTTON CHOPS ✗

HULIHEE ✗

HORSESHOE ✓
(Careful not to cross the seal)

ZAPPA ✓

WALRUS ✓

PAINTER'S BRUSH ✓

CHEVRON ✓

HANDLEBAR ✓

PENCIL ✓

LAMPSHADE ✓

ZORRO ✓

VILLAIN ✓
(Careful not to cross the seal)

WET NOODLE ✗

ENGLISH ✗

DALI ✗

Original image vector by fredrisher/Shutterstock.com

*If your respirator has an exhalation valve, some of these styles may interfere with the valve working properly if the facial hair comes in contact with it.
†This graphic may not include all types of facial hairstyles. For any style, hair should not cross under the respirator sealing surface.
Source: OSHA Respiratory Protection Standard
https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=standards&p_id=12716
Further Reading: NIOSH Respirator Trusted-Source Webpage
https://www.cdc.gov/niosh/npptl/topics/respirators/disp_part/respsource3fittest.html

CDC NIOSH
Centers for Disease Control and Prevention
National Institute for Occupational Safety and Health

2017

Tuberculosis Screening Form

Grady Health System
Employee Health and Wellness Clinic
Phone: (404) 616-4600
Email: employeehealth@gmh.edu

☐ Grady _____
☐ Medical School _____
☐Volunteer _____
☐Contract _____
Other _____

Name: _____ **Date of Birth:** _____

Job Title: _____ **ID#** _____ **MR#** _____

Contact Phone # _____ **Work Area/Dept.** _____ **_Supervisor**_____

All employees must complete this Tuberculosis Screening form annually. Based on your responses a TB blood test and/or a CXR may be required for further evaluation.

1. **Do you have a history of a positive TB test** ___No ___Yes, When?_____
   a. If yes, what test type was positive? ___Skin ___Blood (Quantiferon or T-spot)
   b. Treatment was ___Not offered ___Declined ___Started but not finished ___Completed
2. **Have you ever received BCG vaccine?** ___No ___Yes, When?_____
3. **Since your last Annual Health Screen have you**? **(Please explain yes answers below**)
   a. Been exposed to someone known or suspected of having TB? ___No ___Yes
   b. Been tested for TB? ___No ___Yes when, where, and what were the results?
   c. Traveled outside of the U.S.? ___No ___Yes where, for how long, and for what purpose?
   d. Been prescribed steroids, "biologics" (for autoimmune diseases), chemotherapy? ___No ___Yes

(Explain yes answers below)

_____

_____

TUBERCULOSIS SYMPTOMS	ONSET AND DURATION OF SYMPTOMS
1. Cough for ≥ 2 week duration □ yes □ no	
2. Coughing up Blood □ yes □ no	
3. Fever □ yes □ no	
4. Night Sweats □ yes □ no	
5. Unexplained Weight Loss □ yes □ no	**Amount:**
6. Unusual weakness or fatigue □ yes □ no	

Employee Signature_____ **Date**_____

Reviewed By: _____ **Signature**_____ **Date:** _____