University Hospitals
Employee Health

January 27, 2025

Dear Physician,

Congratulations on your offer of employment through the University Hospitals Health System (UH). We hope your experience here will be positive and rewarding! We ask for your participation in the following steps before your visit with Employee Health:

1) **Schedule an appointment:**
    a. Use this link to schedule your appointment. You may use any available Employee Health site: https://www.uhhospitals.org/health-information/classes-and-events?page=1&event=67&showhiddenevents=true
    b. Need help? Call 1-866-789-8424, option 1 Monday-Friday 7a-3p to reschedule your appointment or for other assistance with scheduling.
    c. If you live outside of the USA and cannot use the link or call: Contact EHRecords@uhhospitals.org with your preferred date/time/location and the Employee Health team will assist you.
2) **Complete onboarding forms:** Email completed forms and any supporting records to EHRecords@uhhospitals.org a week before your assessment so that your profile can be made in the Employee Health system. These include:
    a. Employee Registration Form
    b. Post-Offer Health Assessment Form
    c. Respirator Medical Evaluation Questionnaire
    d. TB Positive Test Questionnaire *(Only if you've ever had a positive TB Test)*
        i. Please also send a copy of your most recent chest film result
    e. Vaccine records including MMR, Varicella, COVID-19, TDaP and Hepatitis B (as available).
3) **Have your labs drawn:** A lab requisition along with available sites is included with this letter. Hospital labs are also available at all Employee Health sites at UH hospitals including Cleveland Medical Center.
    a. Print the requisition and complete the top right section with your name, social security number, sex and date of birth as highlighted in pink. Take the requisition with you to any of the listed Quest labs or UH-based hospital labs as noted in this pac.
    b. Your labs must be completed Monday-Friday as the T-spot (TB) test has to be processed offsite. Plan to have these labs draw at least a week before your assessment if you are able.
        i. If you are not in the Cleveland area prior to your assessment, labs can be done when you come to complete your assessment with Employee Health.

On the day of your visit with Employee Health, you can expect the following:

1) **Assessment:** Review of your health history, blood pressure screen, color vision screen, and drug screen.
2) **Fit Testing:** Come to your assessment clean shaven unless your facial hair is religious in nature.

Welcome to University Hospitals,

Meredith J Walters, CNP

Meredith J. Walters, DNP, MSN, FNP-BC
Manager, Employee Health

University Hospitals
Employee Health

Tips for Your Appointment with Employee Health

Bring a photo ID, send your records as noted above to EHRecords@uhhospitals.org. You do not have to fast for this appointment however you will need to complete a urine drug screen. You will need to be clean shaven for your fit test unless your beard is religious in nature.

Checklist for Planning

Completed	Requirement
	Employee Registration Form
	Post-Offer Health Assessment Form
	Respiratory Medical Evaluation Questionnaire
	Hepatitis B Vaccine Series (2 or 3 vaccine series accepted)
	Hepatitis B Surface Antibody
	Hepatitis B Surface Antigen
	Rubeola (Measles) IgG or MMR Vaccine Series
	Mumps IgG or MMR Vaccine Series
	Rubella IgG or MMR Vaccine Series
	Varicella IgG or Varicella Vaccine Series
	TDaP Vaccine
	COVID-19 Vaccine (exemptions discussed at time of assessment)
	TB Test: T-spot or two step skin test within the last 6 months
	TB Positive Test Questionnaire (if needed)
	Chest Film within the last 6 months (if needed will provide at time of assessment)

How to Find Employee Health

Most Employee Health locations are within the hospitals and/or are easily located by address which can be entered into your GPS. In most cases, the information desk can point you in the correct direction. For Cleveland and Geauga Medical Centers, please see the additional details below to assist you.

Cleveland: Park in the Visitor's Garage next to Rainbow Babies and Children's Hospital (The garage address is **2121 Adelbert Road Cleveland OH 44106**). Proceed to the front of Rainbow Babies and Children's Hospital (next to the garage). Stop at the front desk and ask for a map to Employee Health which is on the 4th floor of the MCCO building.

Geauga: Turn in at the sign for the Emergency Department and continue driving until you see the parking lot marked "Parking for Cardiopulmonary Rehabilitation..." and park there. You will enter through the double doors of the brick building to the left of the Wound Care & Hyperbaric Medicine Center (white building). You will see signage for how to enter the building posted on the door.

University Hospitals
Employee Health

Testing Services
Conveniently located in Northeastern Ohio

Quest Diagnostics

With about 71 Patient Service Centers throughout Ohio, Quest Diagnostics makes it convenient for you to access the testing you need to manage your health. To locate a Patient Service Center and schedule an appointment go to QuestDiagnostics.com/PSC or call 888.277.8772. After your visit, get your results at MyQuest.QuestDiagnostics.com.

Akron–Village
1493 S. Hawkins Ave.
M-F: 8AM-12PM, 1PM-5PM
Tel: 1.330.814.6732
Fax: 1.330.754.2434

Akron–Whitepond
One Park West Blvd., Ste. 130
M-F: 7AM-4PM
Tel: 1.330.815.8605
Fax: 1.330.754.2384

Amherst
917 N. Lake St., Ste.140
M-F: 7AM-5PM
Sat: 8AM-12PM
Tel: 1.440.396.9450
Fax: 1.216.672.0721

Ashland–Baney
1941 S. Baney Rd., Ste. 100
M-F: 7:30AM-4PM
Tel: 1.567.215.3847
Fax: 1.216.672.0526

Ashland–E. Main
663 E. Main St., Ste. 150
M-F: 7AM-3:30PM
Tel: 1.567.215.3858
Fax: 1.216.672.0677

Ashland–Samaritan
1025 Center St., Ste. 101
M-F: 6AM-6PM
Sat: 8AM-12PM
Tel: 1.567.215.3863
Fax: 1.216.452.0419

Ashtabula
3315 North Ridge Rd. E.
M-F: 8:30AM-5PM
Sat: 8AM-12PM
Tel: 1.440.417.8553
Fax: 1.216.452.0421

Aurora
55 N. Chillicothe Rd., Ste. 300
M-F: 7:30AM-4PM
Tel: 1.216.410.7284
Fax: 1.216.553.4671

Austintown
6006 Mahoning Ave., Ste. K
M-F: 6:30AM-4PM
Sat: 7AM-10AM
Tel: 1.330.792.7847
Fax: 1.330.792.7850

Austintown II
20 Ohltown Rd., Ste. 203
M-F: 7AM-4PM
Sat: 8AM-12PM
Tel: 1.866.697.8378
Fax: 1.234.200.3981

Avon
1997 Healthway Dr., Ste. 102
M-F: 7AM-5PM
Sat: 8AM-12PM
Tel: 1.440.506.7571
Fax: 1.216.452.0422

Bagley/Middleburg Heights
18660 Bagley Rd., Bldg. 2, Ste. 305
M-F: 7AM-3:30PM
Sat: 7AM-12PM
Tel: 1.440.234.5666
Fax: 1.440.234.9710

Bainbridge–Chagrin Falls
8185 E. Washington St., Ste. 5A
M-F: 8AM-4:30PM
Tel: 1.216.536.7880
Fax: 1.216.553.4675

Barberton
165 5th St. SE, Ste. A
M-F: 7AM-4:30PM
Sat: 8AM-12PM
Tel: 1.330.696.3291
Fax: 1.330.754.2379

Barberton–Tuscora
201 5th St. NE, Ste. 4
M-F: 7:30AM-4:30PM
Tel: 1.330.814.9272
Fax: 1.330.754.2278

Bath
605 N. Cleveland Massillon Rd.
M-F: 7AM-4PM
Tel: 1.330.665.2563
Fax: 1.330.665.2576

Beachwood
25501 Chagrin Blvd., 2nd Fl.
M-F: 7AM-3:30PM
Tel: 1.234.346.1402
Fax: 1.216.553.4676

Beachwood–Ahuja
3999 Richmond Rd., Ste. A
M-F: 7:30AM-6PM
Sat: 8AM-12PM
Tel: 1.234.293.9937
Fax: 1.216.820.4239

Bedford–Blaine Ave.
50 Blaine Ave., Ste. 101
M-F: 8AM-12:30PM, 1PM-4PM
Tel: 1.440.384.9248
Fax: 1.216.539.0150

Boardman
945 Boardman Canfield Rd., Ste. 1
M-F: 7AM-4PM
Tel: 1.866.697.8378
Fax: 1.234.226.5926

Broadview Heights
5901 E. Royalton Rd., Ste. 1300
M-F: 7:30AM-4PM
Sat: 8AM-12PM
Tel: 1.216.346.2249
Fax: 1.216.367.9330

Canton
4638 Hills and Dales Rd. NW
M-Th: 7AM-4:30PM
F: 7AM-3:30PM
Tel: 1.330.479.2081
Fax: 1.330.479.2547

Chardon–Geauga One
13221 Ravenna Rd., Ste. 4A
M-F: 7:30AM-5PM
Sat: 8AM-11AM
Tel: 1.216.554.6272
Fax: 1.216.452.9205

Chesterland
8055 Mayfield Rd., Ste. 104A
M-F: 8:30AM-4:30PM
Tel: 1.216.399.0320
Fax: 1.216.452.0424

Concord
7500 Auburn Rd., Ste. 1300
M-F: 7AM-5PM
Sat: 8AM-12PM
Tel: 1.216.402.3440
Fax: 1.216.452.0426

Conneaut
158 W. Main Rd., Ste. A
M-F: 7:30AM-4PM
Tel: 1.440.381.3215
Fax: 1.216.452.0427

Cuyahoga Falls
462 Howe Ave.
M-F: 6:30AM-11:30AM, 12PM-2PM
Sat: 7AM-12PM
Tel: 1.330.929.1559
Fax: 1.330.929.1847

Cuyahoga Falls–Graham Rd.
96 Graham Rd, Ste. A
M-F: 8AM-4:30PM
Tel: 1.330.802.0987
Fax: 1.216.452.0403

Cuyahoga Falls–Portage Trl.
600 Portage Trl.
M,T,Th,F: 7:30AM-12PM, 12:30PM-4:30PM
W: 7:30AM-11:30AM
Tel: 1.330.802.9470
Fax: 1.330.754.4866

Elyria–Gates
125 E. Broad St., Ste. 301
M-F: 8:30AM-5PM
Sat: 8AM-12PM
Tel: 1.440.396.2374
Fax: 1.216.452.9162

Elyria–Tri City
1120 E. Broad St., Ste. 100
M-F: 7:30AM-4PM
Tel: 1.440.433.8605
Fax: 1.216.539.0330

Euclid
18599 Lakeshore Blvd., Ste. 700
M-F: 8AM-4:30PM
Tel: 1.216.470.5268
Fax: 1.216.539.2024

Fairlawn
3800 Embassy Pkwy., Ste.160A
M-F: 6:30AM-5PM
Tel: 1.330.803.7247
Fax: 1.216.452.0405

Geneva
890 W. Main St., Ste. 100
M-F: 7AM-4:30PM
Sat: 8AM-12PM
Tel: 1.440.417.2685
Fax: 1.216.452.9555

Green–Crossings
1835 Franks Pkwy.
M-F: 7:30AM-4PM
Sat: 8AM-12PM
Tel: 1.330.690.9999
Fax: 1.330.754.2451

Green–YMCA
3838 Massillon Rd., Ste. 310
M-F: 7:30AM-4PM
Sat: 8AM-12PM
Tel: 1.330.715.8800
Fax: 1.330.754.2462

Hudson
5778 Darrow Rd., Ste. 102
M-F: 7AM-4PM
Tel: 1.216.440.4756
Fax: 1.216.820.4254

Independence
6150 Oak Tree Rd., Ste. 100D
M-F: 8AM-4:30PM
Tel: 1.216.554.9629
Fax: 1.216.539.3595

Kent
401 Devon Pl., Ste. 200
M-F: 7AM-4PM
Tel: 1.330.235.4995
Fax: 1.216.553.4681

Appointments recommended. Hours and locations subject to change. Please refer to QuestDiagnostics.com for the most current information.

University Hospitals
Employee Health

Testing Services Conveniently located in Central Ohio

Quest Diagnostics

With 51 Patient Service Centers throughout Central Ohio, Quest Diagnostics makes it convenient for you to access the testing you need to manage your health. To locate a Patient Service Center and schedule an appointment go to QuestDiagnostics.com/PSC or call 1.888.277.8772. After your visit, get your results at MyQuest.QuestDiagnostics.com.

Ashland–Ohio Healthway
1720 OhioHealth Way, Ste. 1200
M-F: 7:30AM-4PM
Tel: 1.567.425.1575
Fax: 1.614.591.9871

Bucyrus–N. Sandusky Ave.
725 N. Sandusky Ave., Ste. 2
M-F: 7AM-4PM
Tel: 1.567.409.9040
Fax: 1.614.591.9873

Cambridge
1341 Clark St., GW Room 8
M-F: 7AM-5PM
Tel: 1.740.801.3825
Fax: 1.614.318.4934

Chillicothe
869 N. Bridge St., Ste. 20 Lab
M-F: 7:30AM-4:30PM
Tel: 1.740.993.9710
Fax: 1.614.591.9874

Circleville Lab
600 N. Pickaway St.
M-F: 7AM-5PM
Sat: 7AM-12PM
Tel: 1.614.616.0000
Fax: 1.614.285.3406

Circleville Plaza
1434 Circleville Plaza Dr.
M-F: 7:30AM-3:45PM
Tel: 1.740.412.7717
Fax: 1.614.459.9877

Columbus–Bexley Health
2222 Welcome PL, Ste. B
M-F: 8AM-4PM
Tel: 1.614.809.4204
Fax: 1.614.285.3480

Columbus–Brice Rd.
99 N. Brice Rd. N., Ste. 150
M-W, F: 7AM-4:30PM
Th: 7AM-4PM
Tel: 1.380.799.2225
Fax: 1.614.863.9426

Columbus–Doctors Hospital
5100 W. Broad St., Ste. 1460
M-F: 7AM-5PM
Sat: 8AM-12PM
Tel: 1.614.623.4586
Fax: 1.614.318.4911

Columbus–Doctors MOB
5193 W. Broad St., Ste. 300
M-F: 7AM-5PM
Tel: 1.614.671.4242
Fax: 1.614.285.3444

Columbus–Market Exchange
500 E. Main St., Ste. 102
M-F: 8AM-4:30PM
Tel: 1.614.671.5315
Fax: 1.614.285.3428

Columbus–Mid OH–Olentangy River Rd.
3705 Olentangy River Rd., Ste. 112
M-Th: 7:30AM-5PM
F: 7:30AM-4:30PM
Tel: 1.614.671.3475
Fax: 1.614.285.3422

Columbus–Neuro Tower
3535 Olentangy River Rd., Ste. B1517
M-F: 7:30AM-4PM
Tel: 1.614.857.5085
Fax: 1.614.318.4954

Columbus–OhioHealth Pkwy.
3430 OhioHealth Pkwy., Ste. 1250
By Appt. 8AM-5PM
Tel: 1.614.306.4000
Fax: 1.614.318.4930

Columbus–Riverside Lab
3535 Olentangy River Rd., Ste. Y180
M-F: 6:30AM-6:30PM
Sat: 7AM-12PM
Tel: 1.614.753.3000
Fax: 1.614.318.4916

Columbus–Wilkins Med.
285 E. State St., Ste. 350
M-F: 7AM-4:30PM
Tel: 1.614.616.5500
Fax: 1.614.318.4974

Delaware–Grady Hospital
561 W. Central Ave., First Fl.
M-F: 7AM-5PM
Sat: 8AM-12PM
Tel: 1.614.395.7505
Fax: 1.614.318.4949

Delaware–Lewis Center
7853 Pacer Dr., Ste. 3E
M-F: 7:30AM-4:30PM
Tel: 1.740.513.9770
Fax: 1.614.318.4953

Delaware–Lexington Blvd.
6 Lexington Blvd.
M-F: 8AM-4:30PM
Tel: 1.220.246.0500
Fax: 1.614.318.4966

Delaware HC–OhioHealth Blvd.
801 OhioHealth Blvd.
M-F: 7:30AM-4PM
Tel: 1.220.246.1404
Fax: 1.614.318.4967

Delaware–W. William St.
2295 W. William St.,Ste. 200
M-F: 7:30AM-4PM
Tel: 1.220.262.0985
Fax: 1.614.318.4975

Dublin–Bradenton
5130 Bradenton Ave., Ste. C
M-F: 7AM-4:30PM
Sat: 8AM-12PM
Tel: 1.380.209.7904
Fax: 1.614.717.4415

Dublin Family Care
250 W. Bridge St., Ste. 102
M-Th: 8AM-5PM
F: 8:30AM-4:30PM
Tel: 1.220.262.0990
Fax: 1.614.318.4979

Dublin Hospital
7450 Hospital Dr., Ste. 175
M-F: 7AM-5PM
Sat: 8AM-12PM
Tel: 1.220.262.0988
Fax: 1.614.318.4977

Dublin Primary
6905 Hospital Dr., Ste. 110
M-F: 8AM-4PM
Tel: 1.220.262.0995
Fax: 1.614.318.4983

Eastside Columbus HC–E. Main
4850 E. Main St., Ste 100
M-F: 7:30AM-4:30PM
Tel: 1.614.809.1106
Fax: 1.614.318.4909

Gahanna–Havens Corners
504 Havens Corner Rd., Ste. 1
M-F: 7:30AM-4PM
Tel: 1.614.342.9725
Fax: 1.614.318.4958

Gahanna HC–N. Hamilton
765 N. Hamilton Rd., Ste. 245
M-F: 7AM-5PM
Tel: 1.614.342.9720
Fax: 1.614.318.4945

Grandview–Yard Ave.
1125 Yard Ave., Ste. 200
M-F: 8AM-5PM
Tel: 1.614.706.8418
Fax: 1.614.318.4950

Grove City–Kelnor
4191 Kelnor Dr., Ste. 200
M-F: 7AM-5PM
Sat: 8AM-12PM
Tel: 1.614.671.0247
Fax: 1.614.318.4922

Hardin Hospital
921 E. Franklin St.
M-F: 7AM-5PM
Sat: 8AM-12PM
Tel: 1.567.305.1930
Fax: 1.614.591.9869

Hilliard Health–All Seasons Dr.
4343 All Seasons Dr., Ste. 200
M-F: 7AM-5PM
Tel: 1.740.908.0306
Fax: 1.614.318.4957

Jerome–Marysville
10150 St. Rte. 42
M-F: 7:30AM-5PM
Tel: 1.614.616.5644
Fax: 1.614.318.4963

Lancaster
1532 N. Memorial Dr.
M-F: 7:30AM-4:30PM
Tel: 1.740.823.0845
Fax: 1.614.318.4941

Lexington–E. Main St.
231 E. Main St.
M-F: 7:30AM-4:30PM
Tel: 1.419.914.1570
Fax: 1.614.591.9870

Mansfield–Balgreen Dr.
770 Balgreen Dr., Ste. 105
M-F: 7AM-5PM
Tel: 1.567.303.8785
Fax: 1.614.591.9872

Mansfield Hospital
335 Glessner Ave., Ste. 200
M-F: 7AM-5PM
Sat: 8AM-12PM
Tel: 1.419.914.1565
Fax: 1.614.591.9868

Marion
1069 Delaware Ave., Ste. B
M-F: 7AM-3PM
Tel: 1.419.560.1738
Fax: 1.740.223.7095

Marion Lab–Delaware Ave.
1040 Delaware Ave.
M-F: 7AM-5:30
Sat: 8AM-12PM
Tel: 1.567.908.9161
Fax: 1.614.318.4988

Marion–University Dr.
130 University Dr., Ste. 1200
M-F: 7AM-4PM
Tel: 1.567.908.9375
Fax: 1.614.591.9878

University Hospitals
Employee Health

Testing Services Conveniently located in Central Ohio

Quest Diagnostics

New Albany
5150 Dublin-Granville Rd., Ste. 240
M-F: 7:30AM-4:30PM
Tel: 1.614.867.8350
Fax: 1.614.318.4927

Obetz–Alum Creek
4335 Alum Creek Dr., Ste. 200
M-F: 7:30AM-4PM
Tel: 1.614.616.0920
Fax: 1.614.285.3434

Pickerington–Refugee Rd.
1010 Refugee Rd., Ste. 100
M-F: 6:30AM-5PM
Sat: 8AM-12PM
Tel: 1.614.381.2090
Fax: 1.614.318.4932

Powell Fam. Med.
4141 N. Hampton Dr., Ste. 200
M-Th: 7:30AM-5PM
F: 7:30AM-4PM
Tel: 1.740.513.0520
Fax: 1.614.318.4959

Reynoldsburg–Davidson Dr.
1450 Davidson Dr.
M-F: 7AM-4:30PM
Tel: 1.614.817.2690
Fax: 1.614.318.4939

Shelby Outpatient Lab
199 W. Main St.
M-F: 7AM-6PM
Sat: 7AM-11:30AM
Tel: 1.567.425.1730
Fax: 1.614.591.9876

Upper Arlington–Tremont Rd.
3363 Tremont Rd., Ste. 200
M-F: 7AM-5PM
Tel: 1.614.616.5555
Fax: 1.614.318.4972

Van Wert Hospital
1250 S. Washington St.
M-F: 7AM-5PM
Sat: 8AM-12PM
Tel: 1.567.259.9385
Fax: 1.614.591.9875

Van Wert North
214 Towne Center Blvd.
M-F: 7:30AM-4:30PM
Tel: 1.567.433.5955
Fax: 1.614.907.8429

Wellness Center Lab–Ontario
1750 W. 4th St.
M-F: 8AM-4:30PM
Tel: 1.567.425.1555
Fax: 1.614.212.4507

Westerville Lab–Polaris
300 Polaris Pkwy., Ste. 130
M-F: 6:30AM-5PM
Sat: 8AM-12PM
Tel: 1.220.246.2530
Fax: 1.614.318.4970

University Hospitals
Employee Health

Registration Form

Last Name _____ **First Name** _____ **Middle Name** _____

Alternative Name _____ **Social Security Number** _____ **Date of Birth** _____ (mm/dd/yyyy)

Mailing Address _____ **City** _____ **State** _____ **Zip Code** _____

Home Phone

Cell Phone _____ (please provide mobile phone where you can receive reminders)

Cell Phone Carrier

- ○ AT&T
- ○ T-Mobile
- ○ Verizon
- ○ Other (please list) _____

Email address (where you can receive appointment reminders/communication on lab results _____

Facility where you will work (ie. Cleveland Medical Center) _____

Department (ie. Cardiology) _____

Position (selection one option below)

- ○ Credentialed provider (non-trainee) including physician, nurse practitioner, physician assistant
- ○ Fellow
- ○ Resident
- ○ Employee (list job) _____
- ○ Student
- ○ Volunteer
- ○ Contractor

Have you ever been employed through University Hospitals Health System?

- ○ No
- ○ Yes - Position _____

Date of employment _____

REVISED
2:41 pm, Mar 23, 2023

RESIDENTS & FELLOWS

University Hospitals

Name _____

SSN/MRN _____

Sex: *(circle)* Male Female

DOB: (mm/dd/yyyy) _____

LABORATORY REQUISITION

Carveout: Send to UHHS

Location

- ☒ Cleveland Employee Health - 69309979
- ☐ Elyria Employee Health - 69309980
- ☐ Geauga Employee Health - 609309207
- ☐ Mentor Employee Health - 69309981
- ☐ Orange Employee Health - 69309982
- ☐ Parma Employee Health - 69309983
- ☐ Portage Employee Health - 69309984
- ☐ St. John Employee Health - 69309985
- ☐ Beachwood Occupational Health - 69309987
- ☐ Chardon Occupational Health - 69309988
- ☐ Mentor Occupational Health - 69309990
- ☐ Parma Occupational Health - 69309991
- ☐ Samaritan Occupational Health - 69305814
- ☐ Streetsboro Occupational Health - 69309992
- ☐ Volunteer Services Employee Health -69309986

Date _____ Collection Time _____ Medical Director: Sean M. McNeeley, MD

Submitted by _____ Other Ordering Provider (Name/Signature) _____

ORDER USING REQUISITION ENTRY

Needlestick Exposure

Source Patient

- ☐ Rapid HIV or HIV ½ antigen/antibody screen with reflex to confirmation – 91431 LAV

Call back number for positive HIV results:

- ☐ Hepatitis B Surface Antigen – 498 SST
- ☐ Hepatitis C Antibody – 8472 SST

Employee

- ☐ Rapid HIV or HIV ½ antigen/antibody screen with reflex to confirmation – 91431 LAV
- ☐ Hepatitis B Surface Antibody – 8475 SST
- ☐ Hepatitis B Surface Antigen – 498 SST
- ☐ Hepatitis C Antibody – 8472 SST
- ☐ HIV RNA, Quantitative, PCR (if indicated per protocol) – 40085 LAV
- ☐ Hepatitis C RNA, Quantitative, PCR (if indicated per protocol) – 35645 SST

Post Exposure Prophylaxis

- ☐ Human Chorionic Gonadotropin, Serum Quantitative (aka HCG) Females only – 8396 SST
- ☐ CBC and Auto Differential – 6399 LAV
- ☐ Comprehensive Metabolic Panel (aka CMP) – 92665 SST

Onboarding Labs

- ☒ Mumps Antibody IGG – 8624 SST
- ☒ Rubeola Antibody IGG – 964 SST
- ☒ Rubella Antibody IGG – 802 SST
- ☒ Varicella Zoster Antibody IGG – 4439 SST
- ☒ Hepatitis B Surface Antibody – 8475 SST
- ☐ Latex IgE – 8927 SST
- ☒ T-Spot TB – 37737 – LiHep Green No Gel

For Credentialing/Dialysis

- ☒ Hepatitis B Surface Antigen – 498 SST

VALID FOR 2025 SEASON

EMPLOYEE HEALTH

University Hospitals

TB History Questionnaire and TSpot Order

Name: _____ DOB: _____

SSN: _____ Maiden/Previous Name: _____

Company: _____

Department: _____ Job: _____

Country of Birth: _____

	Yes	No
Have you visited/lived in a country with a high TB rate for >1 month? (Any country other than the US, Canada, Australia, New Zealand, Japan and South Korea and those in northern/ western Europe)?	☐	☐
Are you currently or planning to be immunosuppressed? (HIV, organ transplant recipient, on chronic steroids, TNF-alpha antagonist or other immunosurressant medications)?	☐	☐
Have you had close contact with someone who has had infectious TB?	☐	☐
Have you ever received a BCG vaccine?	☐	☐
Have you ever had a positive TB skin test (also called a PPD or tine test)? If yes,.....date: _____	☐	☐
Have you ever had a positive TB blood test? If yes, ... date: _____	☐	☐
Have you ever had a positive Chest X-ray for TB? If yes..... date: _____	☐	☐
Have you ever been treated for TB?	☐	☐

If yes, explain

TB Risk Factor:

Is this test part of possible exposure? ☐ ☐

Exposure Date: _____ Method of Exposure: _____

T-spot test ordered date: _____ Results will be scanned and entered upon receipt

Follow up:

Clinician Signature: _____ Date: _____

Centers for Disease Control and Prevention. Healthcare Personnel Baseline Individual TB Risk Assessment. Retrieved December 11 2023 from https://www.cdc.gov/tb/topic/infectioncontrol/pdf/healthCareSettings-assessment.pdf

University Hospitals

Employee Health Services

Post-Offer Health Assessment Form

Personal Data

Name (First, M, Last) _____ **Maiden Name**_____

Date of birth: _____ **Age:** _____ **Country of Birth:** _____

UH Job Title and Department _____

Personal Email: _____ **Phone:** *if we need to contact you* _____

Primary Work Location _____

Will you be working entirely remotely**?** Yes ☐ No ☐

Do you have a primary care provider? Yes ☐ No ☐

If no, information about options available to you will be provided at time of your assessment.

Review of Systems

Can you do the essential functions of your job without reasonable accommodation? Yes ☐ No ☐

If you answered "No" and an accommodation is needed, be prepared to present documentation to Employee Health within 2 weeks of your onboarding assessment for further review.

Do you have any of the following?

- ☐ Dizziness/Vertigo
- ☐ Seizure
- ☐ Head injury
- ☐ Stroke
- ☐ Migraines
- ☐ Eye problems
- ☐ Wear glasses/contacts
- ☐ Problem with color vision
- ☐ Hearing loss
- ☐ Cough/shortness of breath
- ☐ Asthma/COPD
- ☐ Heart disease/Heart attack
- ☐ Irregular/skipped heart beats
- ☐ High blood pressure
- ☐ Chest pain/tightness
- ☐ Hepatitis
- ☐ Unexplained weight loss/gain
- ☐ Diabetes or thyroid disease
- ☐ Numbness/tingling in arms/hands
- ☐ Numbness/tingling in legs/feet
- ☐ Neck/back pain
- ☐ Back injuries/ruptured discs
- ☐ Joint pain/swelling/arthritis
- ☐ Skin problems (rash, eczema, psoriasis)
- ☐ Untreated mental health disorder
- ☐ Immunocompromised condition
- ☐ Latex Allergy

Have you had any hospital stays, surgeries or emergency dept. visits in the last year for conditions that could potentially affect your ability to do your job ? Yes ☐ No ☐

If yes, please explain:

Do you take any prescription, over-the-counter, or herbal medications? Yes ☐ No ☐

If yes, please list

Have you had any work-related injuries, chemical or body fluid exposures? Yes ☐ No ☐

Yes If yes, please list

If you have any restrictions related to a Workers' Compensation claim, you will be asked to present documentation within 2 weeks of your onboarding assessment.

Vaccination History

All employees, regardless of work site, need to complete this section. New employees not working remotely must present vaccine documentation at the time of your onboarding assessment

Have you had:	**Yes**	**No**	**Unsure**
The MMR vaccine (measles, mumps, rubella)?	☐	☐	☐
The disease chicken pox, shingles or the chicken pox vaccine (varicella)?	☐	☐	☐
The TDaP (tetanus, diphtheria, pertussis) vaccine within the last 10 years?	☐	☐	☐
The Hepatitis B vaccination series? (this is a series of 2-3 injections spaced several months apart)	☐	☐	☐
*The current season's COVID-19 vaccine?	☐	☐	☐
*The current season's Flu vaccine?	☐	☐	☐

*The current season is the period from August to April of the following year (example August 2020 to April 2021)

I hereby certify that all answers and statements made on this health history form are complete and true to the best of my knowledge. I understand that any misleading statement, misrepresentation, and/or omission of medications or information may be cause for termination of employment. This post-offer assessment, including drug testing, will be required for employment with University Hospitals Health System. I understand that any job offer is contingent upon successful completion of the assessment and UH's receipt of satisfactory drug screen results and I agree to provide and sign all required authorizations and/or releases.

Patient Signature _____ Date: _____

FOR INTERNAL USE ONLY

My signature indicates that i have reviewed this form in entirety with the person named above.

Clinician Signature: _____ Date: _____

RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE
Part A

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 employee, Patient ID:_____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 employee 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: ☐ Male ☐ Female
5. Your height: _____ ft. _____ in. 6. Your weight: _____ lbs.
7. Your job title: _____ Job title not in list: _____
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 health care professional who will review this questionnaire? ☐ Yes ☐ No
11. Check the type of respirator you will use (you can check more than one category):
    a. ☐ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
    b. ☐ Other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).
12. 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 employee who has been selected to use any type of respirator.

	Yes	No
1. Do you *currently* smoke tobacco, or have you smoked tobacco in the last month?	☐	☐
2. Have you *ever had* any of the following conditions?		
a. Seizures (fits):	☐	☐
b. Diabetes (sugar disease):	☐	☐
c. Allergic reactions that interfere with your breathing:	☐	☐
d. Claustrophobia (fear of closed-in places):	☐	☐
e. Trouble smelling odors:	☐	☐
3. Have you *ever had* any of the following pulmonary or lung problems?		
a. Asbestosis:	☐	☐
b. Asthma:	☐	☐
c. Chronic bronchitis:	☐	☐
d. Emphysema:	☐	☐
e. Pneumonia:	☐	☐
f. Tuberculosis:	☐	☐
g. Silicosis:	☐	☐
h. Pneumothorax (collapsed lung):	☐	☐
i. Lung cancer:	☐	☐
j. Broken ribs:	☐	☐
k. Any chest injuries or surgeries:	☐	☐
l. Any other lung problem that you've been told about:	☐	☐
4. Do you *currently* have any of the following symptoms of pulmonary or lung illness?		
a. Shortness of breath:	☐	☐
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline:	☐	☐
c. Shortness of breath when walking with other people at an ordinary pace or 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:	☐	☐
n. Any other symptoms that you think may be related to lung problems:	☐	☐

Part A. Section 2. (Mandatory) (Continued)

	Yes	No
5. Have you *ever had* any of the following cardiovascular or heart problems?		
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:	☐	☐
h. Any other heart problem that you've been told about:	☐	☐
6. Have you *ever had* any of the following cardiovascular or heart problems?		
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:	☐	☐
7. Do you *currently* take medication for any of the following problems?		
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?		
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:	☐	☐
9. Would you like to talk to the healthcare professional who will review this questionnaire about your answers to this questionnaire?	☐	☐

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-face piece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

		Yes	No
10	Have you *ever lost* vision in either eye (temporarily or permanently)?	☐	☐
11	Do you *currently* have any of the following vision problems?		
	a. Wear contact lenses:	☐	☐
	b. Wear glasses:	☐	☐
	c. Color blind:	☐	☐
	d. Any other eye or vision problem:	☐	☐
12.	Have you *ever had* an injury to your ears, including a broken ear drum?	☐	☐
13.	Do you *currently* have any of the following hearing problems?		
	a. Difficulty hearing:	☐	☐
	b. Wear a hearing aid:	☐	☐
	c. Any other hearing or ear problem:	☐	☐
14.	Have you *ever had* a back injury?	☐	☐
15.	Do you *currently* have any of the following musculoskeletal problems?		
	a. Weakness in any of your arms, hands, legs, or feet:	☐	☐
	b. Back pain:	☐	☐
	c. Difficulty fully moving your arms and legs:	☐	☐
	d. Pain or stiffness when you lean forward or backward at the waist:	☐	☐
	e. Difficulty fully moving your head up or down:	☐	☐
	f. Difficulty fully moving your head side to side:	☐	☐
	g. Difficulty bending at your knees:	☐	☐
	h. Difficulty squatting to the ground:	☐	☐
	i. Climbing a flight of stairs or a ladder carrying more than 25 lbs:	☐	☐
	j. Any other muscle or skeletal problem that interferes with using a respirator:	☐	☐

Examiner Comments:

University Hospitals

GENERAL CONSENT

SERVICE WILL NOT BE PROVIDED TO ANYONE WHO CHANGES OR ALTERS THE TERMS OR LANGUAGE OF THIS CONSENT FORM

Patient _____ _____ _____ _____

Last name | First Name | Middle Initials | Date of Birth

Authorization for Treatment

This is the consent form for you to authorize University Hospitals (UH) to provide Services to the Patient named above. UH performs Services in a variety of settings, including medical centers, doctor's offices, health centers, home care, and hospice. Those who provide the Services may not be physicians. Services may be provided by independent practitioners, including physicians, who are not employees or agents of UH. All of University Hospitals Health System, Inc. locations and providers are called UH in this form. UH is a teaching institution and healthcare personnel in training may be present and participate in providing care. UH is not responsible for the acts or omissions of providers who are not directly controlled by UH. As used in this form, Services are the diagnostic, therapeutic, medical, physician, nursing, technical, and/or surgical services and/or procedures and associated support, including, but not limited to, x-rays, photographs, and laboratory testing necessary for care and quality assurance. Services may be provided through telehealth, utilizing technology to connect me and/or data about me to providers who may not be in the same physical location. Except in some circumstances, such as an emergency, any Services will be performed after I have been informed of the benefits and material risks associated with such Services and I have given my verbal consent. I understand that the Services do not guarantee a specific outcome or recovery.

By signing below, I, as or on behalf of the Patient, consent to receive and authorize UH to provide the Services.

Authorization to Access & Release Information

I acknowledge receipt of the University Hospitals Notice of Privacy Practices, which describes how UH may access and/or release all or any part of Patient information (including, but not limited to, information regarding substance abuse, HIV testing, AIDS and psychiatric treatment) for purposes required by State and/or Federal law; in cooperation with a law enforcement investigation; treatment, billing or collecting payment for Services, and/or health care operations, which include improving quality, accreditation, training and education, performance improvement initiatives, discharge planning, risk management, for research-related purposes, population health, including improvement of healthcare delivery and communications, participation in health information exchange(s), including Clinisync, patient registries, organ procurement organizations and clinical collaborations, or as otherwise authorized and for any other permissible purpose. UH retains patient medical records in accordance with applicable law. UH may, unless otherwise refused, photograph and/or audio or video record me or the Services I receive, including those in which I am identifiable. UH will own such images or recordings and may use them for any lawful purpose.

I agree to release my Social Security number to the manufacturer of any medical device that I may receive, in accordance with both federal law and regulations. I release the Hospital from any liability that might result from the disclosure of this information. I may revoke this permission at any time.

Assignment of Benefits & Payment

I assign to UH, all benefits for all Services received or to be received. I direct the Patient's insurer(s) and other third parties to pay such benefits directly to UH and/or my physician(s). I hereby agree to pay any and all UH or affiliated provider fees that exceed or that are not covered by insurance coverage, including for Services deemed to be experimental or investigational, and waive any and all notices and demands in the event of non-payment. Subject to any applicable UH financial assistance policy, I understand and agree to pay the charges incurred by the Patient, including for personal use and/or convenience items, and hereby authorize the hospital to bill me or any other applicable party for such use. I authorize UH to pursue payment for services and appeal the denial of payment for services, on my behalf.

Medicare/TRICARE/Champus Payment

I certify that the information I gave is correct. I authorize any holder of medical or other information about the Patient to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim (including TRICARE/Champus claims). I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for professional services to the provider furnishing these services or authorize such provider to submit a claim to Medicare for payment to me.

By signing this form, I acknowledge, as applicable:

For Medicare and/or Champus/Tricare beneficiaries, I have been provided with an unaltered copy of the notice from Medicare and/or Champus/Tricare regarding my rights as a Medicare and/or Champus/Tricare patient.

Authorization to Contact

I authorize UH, any of its affiliated providers, to contact me for any purpose by any means I have provided, including telephone, voicemail, text message, email, or similar communication methods, including to remind me about upcoming appointments, to provide information related to those appointments (e.g., cancellations), or to provide other educational information related to my care, including eligibility to participate in research studies. I acknowledge that these communications or messages may contain protected health information.

I consent to receive text messages and/or telephone calls or other communications using live, artificial or prerecorded voices, automatic telephone dialing systems, or any other computer-aided technologies from UH and its business associates, including billing services, collection agencies, or other third parties for any purpose. I understand this consent to communications is not required to receive Services from UH and that data usage and other charges may apply.

I may revoke this consent to any or all of these communications at any time.

Patient Personal Property

I understand that UH is not responsible for loss or damage to money and valuables, unless these are placed in the hospital safe.

Certification

I certify that to the best of my knowledge and belief the information provided is complete and correct. I understand that this consent is subject to revocation by me at any time except to the extent UH has already acted in reliance on this form. **I UNDERSTAND THAT CHANGES OR ALTERATIONS TO THIS FORM ARE NOT BINDING ON UH AND REFUSAL TO SIGN MEANS I MAY NOT RECEIVE SERVICES**

I AM THE PATIENT OR AUTHORIZED TO SIGN THIS DOCUMENT. I HAVE READ ALL THE ABOVE AND UNDERSTAND ITS TERMS.

Printed Patient Name	Hospital No.		
Signature of Patient	Date	Time	
Signature of Legal Representative, if patient is unavailable	Relationship	Date	Time
Witness	Date	Time	