Welcome to Saint Agnes!

Saint Agnes Employee Health

Prior to your appointment with Employee Health, please complete the four forms below in this packet and email them to **Employee.Health@samc.com**.

The four forms are:

1. Authorization For Post Offer Examination
2. Drug and/or Alcohol Testing & Consent
3. PPD Skin Test Tuberculosis Screening
4. Hepatitis B Consent/Refusal

Download this file onto a computer or laptop and fill these forms electronically. Click on the blank lines to fill out your information. ***Signatures and dates will be collected on the day of your appointment.*** Once completed, save the file onto your device and email it to: **Employee.Health@samc.com**

Items to bring to your appointment:

- Valid photo ID (Not expired). Acceptable forms of ID:
    - Driver's license, Government ID, Passport.
- Hard copy of your immunization record and/or titers
- Hard copy of COVID-19 vaccine record

If you have a digital copy of your immunization record and/or titers including your COVID-19 vaccine, you may attach those records along with these four forms in one email. All of these items are necessary to complete your registration and speed up your clearance.

Thank you for your cooperation and see you soon!

- Employee Health Services

Saint Agnes Employee Health
1201 E. Herndon Avenue
Suite 103
Fresno, CA 93720
559.450.3383
559.450.5470-FAX

Authorization For Post Offer Examination

Please fill in the blanks and sign below.

I have been offered the position, _____,

in department, _____, with Saint Agnes Medical Center.

The position is contingent upon satisfactory results of a medical examination. The examination will be performed by the Employee Health Services whose purpose and function is to:

- Determine whether I can perform the job for which I have applied, with or without reasonable accommodation.
- Determine whether I can perform the job without posing a direct threat to my health, safety, or of others.

I understand that the State of California requires Employee Health Services to enter my information and/or vaccine doses administered to the California Immunization Registry (CAIR) - A secure, confidential, statewide computerized immunization system for California residents.

Race** (select all that apply):

☐ American Indian or Alaska Native	☐ Asian
☐ Black or African-American	☐ White
☐ Native Hawaiian or Other Pacific Islander	☐ Other Race
☐ Prefer Not to Say	

***For CAIR use only.*

Ethnicity**(Select one):

☐Hispanic or Latino
☐Not Hispanic or Latino
☐Prefer Not to Say

***For CAIR use only.*

I, _____, authorize Employee Health Services to perform the Post Offer Examination.

_____ _____
Date Applicant Signature

_____ _____
Date Employee Health Representative

Revised: 03/23/2023

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Drug and/or Alcohol Testing Intake & Consent

Last Name | First Name | Middle Initial | Gender

Date of Birth | Social Security # | Driver's License #

Street Address | City | State | Zip

Home Phone | Cell Phone | Work Phone

I hereby acknowledge and understand that I will be asked to provide a urine specimen, a blood sample, a hair sample, saliva, or breath, or a combination of these items. I understand that this testing is being performed at the request of Saint Agnes Medical Center/Foundation. I hereby authorize and hold harmless Saint Agnes Employee Health Services for release of any test results and associated confidential medical information to Saint Agnes.

Name (Print) Date & Time

Signature of Donor

Witness Date & Time

Revised: 04/26/2022

☐ Annual Surveillance
☐ Post Exposure
■ Post Offer Exam

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PPD Skin Test
Tuberculosis Screening

California State Law requires annual/periodic tuberculosis screening on all hospital staff members. Employee Health Services is responsible for conducting this program at Saint Agnes Medical Center.

Name: _____ Position: _____
Date: _____ Employee I.D.#_____ DOB: _____

■ Employee
☐ Med Staff
☐ Volunteer

The following medical conditions may prevent an accurate result of the PPD Skin test by causing an indefinite or inconclusive interpretation when TB infection is present. If you have any of these conditions, please advise Employee Health.

Symptoms Review:	Yes	No
Chronic Cough	☐	☐
Chronic Fatigue	☐	☐
Persistent Night Sweats	☐	☐
Involuntary Weight loss	☐	☐
Are you being treated for any serious medical condition?	☐	☐
Have you received MMR Vaccine, Varicella/Zoster in the last 3 months?	☐	☐

Explain any 'Yes' answers:_____
_____
_____

Are you under Treatment of or for: (Check applicable)
☐ Silicosis (prolong exposure to silica)
☐ Status-post gastrectomy (all or part of the stomach removed)
☐ Chronic renal failure (Kidney failure)
☐ Blood disorder, such as leukemia, lymphoma, or other malignancies
☐ Recent close contact with someone who has active TB
☐ Any condition which requires you to take high doses of cortisone, or other immunosuppressive therapy
☐ Use of alcohol and/or IV drugs
☐ Jejuno-ileal bypass surgery (usually for weight loss)
☐ Positive HIV test
☐ Diabetes mellitus
☐ Cancer/Chemotherapy
☐ Previous diagnosis of TB
☐ X-Ray therapy
☐ 10% below your ideal weight

Have you ever had a ***Positive*** test? ☐ **No** (Provide date, skip questions and sign below) Date of last test: _____
☐ **Yes** (Provide date, answer all questions below & sign) Date of positive: _____

Have you ever had active TB? ☐ No ☐ Yes
Were you ever treated with TB medication? ☐ No ☐ Yes – How long ____months. What medication: _____
Did you receive the BCG? ☐ No ☐ Yes
Have you had a Chest Xray in the last 5 years? ☐ No ☐ Yes – Date: _____Result: ☐ WNL ☐ Other: _____

I have completed the section above to the best of my knowledge and I consent to PPD Skin Test:
Signature_____ **Date:** _____

TO BE COMPLETED BY EMPLOYEE HEALTH SERVICES

PPD Given: M T W Th F _____@_____ ☐ Left Arm ☐ Right Arm

Staff Signature_____

Read on: M T W Th F _____@_____ ☐ Negative ☐ Positive
Induration: _____mm

Evaluator Signature: _____

Comments:
_____
_____
_____
_____

Follow Up: (to be completed by the LVN/RN/MD)
CXR order date: _____ Result ☐Neg ☐Pos

Review Signature_____ LVN/RN/MD

Treatment: ☐None indicated ☐Preventive Treatment
☐INH Start date: _____
☒Other: _____
☐Referred to PCP

Hepatitis B Consent/Refusal

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Name:_____

Date of Birth:_____

Employee ID: _____

Vaccine:
Engerix-B is a non-infectious recombinant DNA Hepatitis vaccine. Clinical studies have shown that following a course of 3 doses according to ACIP recommended schedule of injections, the seroprotection rate for all individuals was 96% at month 7. A lesser degree of protection has been noted when an underlying immunosuppressive condition exists.
If you have immune deficiency problems, your physician should provide a written prescription for any vaccination.
Dosing Schedule:
A total of three doses at 0, 1, and 6 months are required to confer protection. The deltoid muscle is the preferred site of injection for adults.

Initial all that apply:

_____I have received Vaccine Information Statement (VIS). **VIS Version Date**:__10/15/2021____

_____ **Consent**:
I hereby consent to receive the HEPATITIS B VACCINE for my protection against Hepatitis B. This vaccine has been provided to me by Saint Agnes Medical Center at no charge. The vaccine is a series of three injections given intramuscularly. Because this vaccine has not been definitely proven to be safe or unsafe for a developing fetus, I declare that I am not pregnant at this time.

_____ **Refusal**:
I understand that due to my occupational exposure to blood and other potentially infectious material, I may be at risk for acquiring the Hepatitis B virus. I have given the opportunity to be vaccinated with the Hepatitis B vaccine at no charge to myself. However, I have chose to decline the Hepatitis B vaccine at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatis B. If, in the future, I continue to have an occupational exposure to blood or other potentially infectious material and I want to be vaccinated with the Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Dose 1 Date:	Dose 2 Date:	Dose 3 Date:
Manufacturer:_____ Lot: _____ Exp Date:_____ Site: R / L Deltoid Administered by: _____	Manufacturer:_____ Lot: _____ Exp Date:_____ Site: R / L Deltoid Administered by: _____	Manufacturer:_____ Lot: _____ Exp Date:_____ Site: R / L Deltoid Administered by: _____

Signaure:_____Date:_____

Witness:_____

Revised: 04/28/2022

Hepatitis B Vaccine:
What You Need to Know

Many vaccine information statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1. Why get vaccinated?

Hepatitis B vaccine can prevent **hepatitis B**. Hepatitis B is a liver disease that can cause mild illness lasting a few weeks, or it can lead to a serious, lifelong illness.

- **Acute hepatitis B infection** is a short-term illness that can lead to fever, fatigue, loss of appetite, nausea, vomiting, jaundice (yellow skin or eyes, dark urine, clay-colored bowel movements), and pain in the muscles, joints, and stomach.
- **Chronic hepatitis B infection** is a long-term illness that occurs when the hepatitis B virus remains in a person's body. Most people who go on to develop chronic hepatitis B do not have symptoms, but it is still very serious and can lead to liver damage (cirrhosis), liver cancer, and death. Chronically infected people can spread hepatitis B virus to others, even if they do not feel or look sick themselves.

Hepatitis B is spread when blood, semen, or other body fluid infected with the hepatitis B virus enters the body of a person who is not infected. People can become infected through:

- Birth (if a pregnant person has hepatitis B, their baby can become infected)
- Sharing items such as razors or toothbrushes with an infected person
- Contact with the blood or open sores of an infected person
- Sex with an infected partner
- Sharing needles, syringes, or other drug-injection equipment
- Exposure to blood from needlesticks or other sharp instruments

Most people who are vaccinated with hepatitis B vaccine are immune for life.

2. Hepatitis B vaccine

Hepatitis B vaccine is usually given as 2, 3, or 4 shots.

Infants should get their first dose of hepatitis B vaccine at birth and will usually complete the series at 6–18 months of age. **The birth dose of hepatitis B vaccine is an important part of preventing long-term illness in infants and the spread of hepatitis B in the United States.**

Children and adolescents younger than 19 years of age who have not yet gotten the vaccine should be vaccinated.

Adults who were not vaccinated previously and want to be protected against hepatitis B can also get the vaccine.

Hepatitis B vaccine is also recommended for the following people:

- People whose sex partners have hepatitis B
- Sexually active persons who are not in a long-term, monogamous relationship
- People seeking evaluation or treatment for a sexually transmitted disease
- Victims of sexual assault or abuse
- Men who have sexual contact with other men
- People who share needles, syringes, or other drug-injection equipment
- People who live with someone infected with the hepatitis B virus
- Health care and public safety workers at risk for exposure to blood or body fluids
- Residents and staff of facilities for developmentally disabled people
- People living in jail or prison
- Travelers to regions with increased rates of hepatitis B

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

- People with chronic liver disease, kidney disease on dialysis, HIV infection, infection with hepatitis C, or diabetes

Hepatitis B vaccine may be given as a stand-alone vaccine, or as part of a combination vaccine (a type of vaccine that combines more than one vaccine together into one shot).

Hepatitis B vaccine may be given at the same time as other vaccines.

3. Talk with your health care provider

Tell your vaccination provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of hepatitis B vaccine**, or has any **severe, life-threatening allergies**

In some cases, your health care provider may decide to postpone hepatitis B vaccination until a future visit.

Pregnant or breastfeeding people should be vaccinated if they are at risk for getting hepatitis B. Pregnancy or breastfeeding are not reasons to avoid hepatitis B vaccination.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting hepatitis B vaccine.

Your health care provider can give you more information.

4. Risks of a vaccine reaction

- Soreness where the shot is given or fever can happen after hepatitis B vaccination.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5. What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at **www.vaers.hhs.gov** or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff members do not give medical advice.*

6. The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Claims regarding alleged injury or death due to vaccination have a time limit for filing, which may be as short as two years. Visit the VICP website at **www.hrsa.gov/vaccinecompensation** or call **1-800-338-2382** to learn about the program and about filing a claim.

7. How can I learn more?

- Ask your health care provider.
- Call your local or state health department.
- Visit the website of the Food and Drug Administration (FDA) for vaccine package inserts and additional information at **www.fda.gov/vaccines-blood-biologics/vaccines**.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's website at **www.cdc.gov/vaccines**.