



Saint Agnes Employee Health

## Welcome to Saint Agnes!

Before your Employee Health appointment:

### **Complete these forms** (*attached to this packet*)

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

Download and fill these forms electronically, then email to

[Employee.Health@samc.com](mailto:Employee.Health@samc.com)

Signatures and dates will be collected at your appointment.

### **Make sure to bring the following to your appointment:**

- Valid photo ID (Driver's license, Government ID, Passport).
- Hard copy of your immunization record and/or titers
- Hard copy of COVID-19 vaccine record

*(Digital copies of your vaccine records may be emailed with your forms)*

These items are required for registration and clearance.

Thank you and we look forward to seeing you soon!

**Employee Health Services**



**Saint Agnes Employee Health**

**Address:** 1201 E. Herndon Ave. Suite 103  
Fresno, CA, 93720

**Phone:** (559) 450-3383

**Hours of Operation:** Monday-Friday  
7:30am – 12:00pm, 1:00pm – 4:00pm.

(Closed 12:00pm-1:00pm for lunch)

Also closed for Saint Agnes observed holidays.

**MAP**



***Please arrive 15 minutes prior to your appointment*** to allow time for registration and completion of any additional forms. Parking may also need to be considered.

***No-Show policy is 15 minutes.*** If you no-show, you will need to be rescheduled. This may affect your start date.

We encourage you to be well-hydrated as we perform a urine drug screening in the clinic.



**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):**

**Ethnicity\*\*(Select one):**

<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian
<input type="checkbox"/> Black or African-American	<input type="checkbox"/> White
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> Other Race
<input type="checkbox"/> Prefer Not to Say	

<input type="checkbox"/> Hispanic or Latino
<input type="checkbox"/> Not Hispanic or Latino
<input type="checkbox"/> Prefer Not to Say

\*\*For CAIR use only.

\*\*For CAIR use only.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee Health Representative



**Saint Agnes Employee Health**

1201 E. Herndon Avenue  
Suite 103  
Fresno, CA 93720  
559.450.3383  
559.450.5470-FAX

# 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

- Annual Surveillance
- Post Exposure
- Post Offer Exam



**Saint Agnes Employee Health**

1201 E. Herndon Avenue Suite 103  
 Fresno, CA 93720  
 559.450.3383  
 559.450.5470-FAX

# 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.

- Employee
- Med Staff
- Volunteer

Name: \_\_\_\_\_ Position: \_\_\_\_\_  
 Date: \_\_\_\_\_ Employee I.D.# \_\_\_\_\_ DOB: \_\_\_\_\_

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.

<u>Symptoms Review:</u>	Yes	No	<u>Are you under Treatment of or for:</u> (Check applicable)
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Silicosis (prolong exposure to silica)
Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Status-post gastrectomy (all or part of the stomach removed)
Persistent Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chronic renal failure (Kidney failure)
Involuntary Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Blood disorder, such as leukemia, lymphoma, or other malignancies
Are you being treated for any serious medical condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Recent close contact with someone who has active TB
Have you received MMR Vaccine, Varicella/Zoster in the last 3 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Any condition which requires you to take high doses of cortisone, or other immunosuppressive therapy
Explain any 'Yes' answers: _____			<input type="checkbox"/> Use of alcohol and/or IV drugs
_____			<input type="checkbox"/> Jejunio-ileal bypass surgery (usually for weight loss)
_____			<input type="checkbox"/> Positive HIV test
			<input type="checkbox"/> Diabetes mellitus
			<input type="checkbox"/> Cancer/Chemotherapy
			<input type="checkbox"/> Previous diagnosis of TB
			<input type="checkbox"/> X-Ray therapy
			<input type="checkbox"/> 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