Mason General Hospital & Family of Clinics

Baseline TB Screening

_____ ____/____/_____
Last name, first name, middle initial Date form completed

____/____/_____ (_____)_____
Date of birth Work phone number

Baseline TB screening includes three components:

(1) Assessing for current symptoms of active TB disease
(2) Assessing HCW's history
(3) Testing for the presence of infection with *Mycobacterium tuberculosis* by administering either a single TB blood test *or* a two-step TST.

Symptoms of active TB disease (circle all that are present)

☐ Coughing (>3 weeks) ☐ Chest pain ☐ Fatigue
☐ Night sweats (not hormone related) ☐ Coughing up blood ☐ None of the above
☐ Unintentional weight loss ☐ Fever/chills

Note: If TB symptoms are present, promptly refer HCW for a chest X-ray and medical evaluation before starting work. Do not wait for the TST or TB blood test result.

HCW's history (circle response)

Have you ever had a positive reaction to a TB skin test or TB blood test? Yes No
If yes: Date_____ Number of millimeters of induration _____

Have you had a TB skin test in the past 12 months? Yes No
If yes: Date_____ Number of millimeters of induration _____ Result _____

			Comments
Have you ever had the BCG vaccine?	Yes	No	
Have you ever been treated for latent TB infection?	Yes	No	
Have you ever been treated for active TB disease?	Yes	No	
Have you ever had an adverse reaction to a TB skin test?	Yes	No	
Have you received a live-virus vaccine within the past 6 weeks?	Yes	No	

_____

HEALTH HISTORY QUESTIONNAIRE

Name: _____ DOB: _____
Last First Middle

Home Telephone: _____ Department: _____

Position: _____

Immunization and Infection History: Your history of immunizations and past infections will guide us in offering you immunizations and may be important if you should be exposed to infection during employment. This information is maintained in your confidential health record and is not part of your personnel record. None of this information is used to guide employment decisions such as hiring, firing, or promotions. Please note which infections and immunizations you have had and supply dates as accurately as possible.

Infection or Disease	Year of Clinical Disease	Date of Immunization	Date & Result of Antibody Test
Diphtheria/Tetanus			
Mumps			
Measles (Rubeola, Red Measles)			
Rubella (German Measles)			
Chicken Pox (Varicella)			
Pertussis (Whooping Cough)			
Polio			
Hepatitis B		#1 #2 #3	

IF PROVIDING PROOF OF IMMUNIZATIONS, PLEASE TAKE THE TIME TO FILL IN THE APPROPRIATE DATES IN THE TABLE PROVIDED ABOVE.

Date of last TB skin test: _____ Result: Negative ☐ Positive ☐
If TB skin test is positive, date of last chest x-ray: _____
Where_____
Was it normal? (check one) Yes ☐ No ☐ Don't Know ☐
Were you ever treated with anti-TB medicine? Yes ☐ No ☐
If yes, what medicine?_____ Dates of treatment: From _____ to _____

Do you have allergies to: latex ☐ Other:_____

Revised 10/22/08

Are you color blind? Yes ☐ No ☐ Color Vision Test Pass ☐ Fail ☐

To prevent exposure of patients and other staff to communicable diseases, we request that you report to Occupational Health staff directly should you develop any of the following conditions: (*You can report any of these conditions by using the 24-hour illness reporting form provided on the hospital intranet, caling ext. 3442 and leaving a message, or repor in person to the Employee Health/Infection Control office.)*

A. Viral Hepatitis (you or your immediate family)

B. Parasitic infections (you)

C. Measles, Rubella, Chicken Pox, Herpes Zoster (Shingles), Pertussis (Whooping Cough) (you or your immediate family)

D. Salmonella, Shigella, Campylobacter, or Yersinia infections (you or your immediate family)

E. Tuberculosis

F. Staphylococcal infections such as boils

G. Streptococcal infections such as Strep Throat, Scarlet Fever

H. Oral Herpes infections (Cold Sore or Fever Blisters or Whitlow (Herpes of the hand)

I. Scabies

J Body lice

K. Skin rash, lesions, or dermatitis

L. Fever (while at work or if missing work)

M. Conjunctivitis or red eyes

N. Gastrointestinal illness including diarrhea or vomiting (while at work or if missing work)

O. Respiratory illness (while at work or if missing work)

P. Immune suppression.

If you are immunocompromised, some need to modify your assignment to minimize risk of infection may rarely arise.

Has your physician informed you that you are immunosuppressed for any reason? Yes ☐ No ☐

DECLARATION: The above answers are correct to the best of my knowledge.

_____ _____

Signature Date

Revised 10/22/08

Mason General Hospital
All Departments

Formulated 8/2003
Revised 4/2004, 5/2006
Reviewed

MEDICAL SCREENING FORM FOR RESPIRATORS
Employee Health Policy # 5030

The following information is required under WISHA and OSHA regulations for employees who may need to wear special respirators to prevent exposures to diseases such as SARS, Tuberculosis, Smallpox, and agents used for Biological or Chemical warfare.

At this point in time, this screening form will be used to determine if your health would allow you to wear an N-95 respirator (mask) used to prevent exposure to SARS, and other infectious diseases. Additional screening questions may be necessary to determine your ability to wear this mask. The Employee Health Nurse and/or the Physician who oversees Infection Control/Employee Health will ask you the additional screening questions.

The information will be maintained in your Employee Health File. The physician who oversees the Infection Control/Employee Health Department may review it.

If you prefer, you may have your personal Health Care Provider complete this form for you. If you have questions call the Employee Health Department at extension 3442.

- **At any time throughout the year please notify Employee Health of any change in the condition of your heart and lungs.**

SECTION I MANDATORY QUESTIONS

Your Name:_____ Department:_____

Your Job Title:_____ Today's Date:_____

Gender (circle one): Male Female Your Height: _____ Your Weight:_____

Have you worn a respirator before? Yes____ No____ If yes, what type:_____

SECTION II MANDATORY QUESTIONS

Please circle "yes" or "no" (add a small explanation after yes; ie.(as a child), (on meds. – no problem), (15 years ago)

1. Do you **currently** smoke tobacco, or have you smoked tobacco in the last month? Yes No
2. Have you **ever had** any of the following conditions?
   a. Seizures/convulsions (fits): Yes No
   b. Diabetes (sugar disease): Yes No
   c. Allergic reactions that interfere with your breathing: Yes No
   d. Claustrophobia (fear of closed-in places): Yes No
   e. Trouble smelling odors: Yes No
3. Have you **ever had** any of the following pulmonary or lung problems?
   a. Asbestosis: Yes No
   b. Asthma: Yes No
   c. Chronic bronchitis: Yes No
   d. Emphysema: Yes No
   e. Pneumonia: Yes No
   f. Tuberculosis: Yes No
   g. Silicosis: Yes No
   h. Pneumothorax (collapsed lung): Yes No
   i. Lung cancer: Yes No
   j. Broken ribs: Yes No
   k. Any chest injuries or surgeries: Yes No
   l. Any other lung problem that you've been told about: Yes No

Questionnaire reviewed_____ Referred to HCP_____ Date_____ Signed_____

4. Do you **currently** have any of the following symptoms of pulmonary or lung illness?

a. Shortness of breath:	Yes	No
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline:	Yes	No
c. Shortness of breath when walking with other people at an ordinary pace on level ground:	Yes	No
d. Have to stop for breath when walking at your own pace on level ground:	Yes	No
e. Shortness of breath when washing or dressing yourself:	Yes	No
f. Shortness of breath that interferes with your job:	Yes	No
g. Coughing that produces phlegm (thick sputum):	Yes	No
h. Coughing that wakes you early in the morning:	Yes	No
i. Coughing that occurs mostly when you are lying down:	Yes	No
j. Coughing up blood in the last month:	Yes	No
k. Wheezing:	Yes	No
l. Wheezing that interferes with your job:	Yes	No
m. Chest pain when you breathe deeply:	Yes	No
n. Any other symptoms that you think may be related to lung problems:	Yes	No

5. Have you **ever had** any of the following cardiovascular or heart problems?

a. Heart attack:	Yes	No
b. Stroke:	Yes	No
c. Angina:	Yes	No
d. Heart failure:	Yes	No
e. Swelling in your legs or feet (not caused by walking):	Yes	No
f. Heart arrhythmia (heart beating irregularly):	Yes	No
g. High blood pressure:	Yes	No
h. Any other heart problem that you've been told about:	Yes	No

6. Have you **ever had** any of the following cardiovascular or heart symptoms?

a. Frequent pain or tightness in your chest:	Yes	No
b. Pain or tightness in your chest during physical activity:	Yes	No
c. Pain or tightness in your chest that interferes with your job:	Yes	No
d. In the past two years, have you noticed your heart skipping or missing a beat:	Yes	No
e. Heartburn or indigestion that is not related to eating:	Yes	No
f. Any other symptoms that you think may be related to heart or circulation problems:	Yes	No

7. Do you **currently** take medication for the following problems?

a. Breathing or lung problems:	Yes	No
b. Heart trouble:	Yes	No
c. Blood pressure:	Yes	No
d. Seizures (fits):	Yes	No

8. If you've used a respirator, have you **ever had** any of the following problems?
(If you have never used a respirator, check this box ☐ and then go to question number 9)

a. Eye irritation:	Yes	No
b. Skin allergies or rashes:	Yes	No
c. Anxiety:	Yes	No
d. General weakness or fatigue:	Yes	No
e. Any other problem that interferes with your use of a respirator:	Yes	No

9. Would you like to talk to the health care professional who will review this questionnaire about your answers: Yes No

Your signature:_____ Date:_____

EMPLOYEE HEALTH NOTICE

If you work in any department other than H.I.M., Business Office, Administration, I.S., Materials, or as clerical staff in Nursing Administration you may be exposed to blood or body fluids while doing your job. This may put you at risk of contracting Hepatitis B. There is a vaccine available to prevent Hepatitis B. If you wish this vaccine please schedule an appointment with the Employee Health Nurse as soon as possible. You do not have to pay for this vaccine. Call 426-1611, extension 3442 to schedule an appointment.

Hepatitis B vaccine is given in a series of 3 shots over a 6 month period. If you are eligible for the Hepatitis B vaccine and do not want to receive it at this time (or you have receive the vaccine elsewhere) you must sign the "Temporary Disclaimer" below. This is a legal requirement under OSHA and WISHA bloodborne pathogen regulations. This card must be given to the Employee Health Nurse and will reside in your Employee Health file. If, at a later time, you change your mind and want the vaccine, it will be provided at no cost to you.

I DO WANT the Hepatitis B Vaccine at this time____

TEMPORARY DISCLAIMER FOR HEPATITIS B VACCINE

I understand that due to my possible occupational (on-the-job) exposure to blood or other potentially infectious body fluids, I may be at risk of acquiring the Hepatitis B virus. I have been given an opportunity to be vaccinated with the Hepatitis B vaccine, at no cost to myself. However, I decline (refuse) to be vaccinated at this time. I understand that by refusing the vaccination I remain at risk of acquiring Hepatitis B. In the future I may receive the vaccine, at no cost to myself, should I so desire.

I do not want the Hepatitis B Vaccine at this time because (check one box)____I have already had the vaccine_____

Other Reasons_____

_____
Your Signature

Today's Date

_____
Print Your Name

Date original vaccine given or date of booster series

_____
Date of Hepatitis B Titer

It is the expectation of JCAHO, OSHA, DOH, and Mason General Hospital Policy that all employees complete employee health requirements annually. Employees are required to complete the requirements during their birthday months. To avoid not being scheduled for work, all requirements must be met by the last day of the employee's birthday month. Employee Health will submit a list of employees to Human Resources who have not received their TB tests. This will result in a "no work" schedule until the test is completed.

Mason General Hospital

Formulated 1992
Revised 12/05, 3/06, 9/06, 1/09
Reviewed 1/2004

Tuberculin Skin Test (TST) Documentation Form

Employee Name_____ Dept_____

Site_____ Lot #_____

Expiration Date_____ Date of 1st Test_____

Test Given By_____ Results in (mm)_____

Date Read_____ Read by_____

☐ **1st TST Administered Elsewhere** ☐ **Documentation Received**

Site_____ Lot #_____

Expiration Date_____ Date of 2nd Test_____

Test Given By_____ Results in (mm)_____

Date Read_____ Read by_____

Healthcare Organization: **-**
And/or Designated Agent:

WASHINGTON PRACTITIONER APPLICATION AUTHORIZATION AND RELEASE OF INFORMATION FORM

Modified Releases Will Not Be Accepted

By submitting this authorization and release of information form in conjunction with the Washington Practitioner Application (WPA) and/or the Washington Practitioner Attestation or Credentials Update (CU) form, I understand and agree as follows:

1. I understand and acknowledge that, as an applicant for medical staff membership and/or participating status with the Healthcare Organization(s)* indicated on the WPA for initial credentialing or recredentialing, I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and or other qualifications in a timely manner. I understand that the application will not be processed until the application is deemed complete by the healthcare organization.
2. I further understand and acknowledge that the Healthcare Organization(s) or designated agent will investigate the information in this application. By submitting this application, I agree to such investigation and to information exchange activities of the Healthcare Organization(s) as part of the verification and credentialing process.
3. I authorize all individuals, institutions and entities or organizations with which I am currently or have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status to release the aforementioned information to the designated Healthcare Organization(s), their staffs and agents.
4. I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the clinical privileges or provide services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews if required or requested.
5. I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with providing information, investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of the Healthcare Organization(s) or their respective agent(s) who act in good faith and without malice in connection with the investigation of this application.
6. I acknowledge that I have been informed of, and hereby agree to abide by, the bylaws, rules, regulations, contractual agreements, and policies of the Healthcare Organization.
7 I acknowledge that I am responsible for notifying the Healthcare Organization of any changes/challenges to licensure, DEA, malpractice claims, criminal convictions, hospital privileges or other disciplinary actions.
8. I attest to the accuracy, currency and completeness of the information provided. I understand and agree that any misstatements in or omissions from the CU, WPA, Washington Practitioner Attestation and attachments hereto may constitute cause for denial of the application or summary dismissal or termination of membership/clinical privileges/participation agreement.
9. I agree to exhaust all available procedures and remedies as outlined in the bylaws, rules, regulations, and policies, and/or contractual agreements of the Healthcare Organization(s) where I have membership and/or clinical privileges/participation status before initiating judicial action.
10. I understand that completion and submission of the Authorization and Release does not automatically grant me membership or clinical privileges/participating status with the Healthcare Organization(s)* indicated on the WPA/CU or Attestation.
11. I hereby further authorize and consent to the release of information and/or reporting by the Healthcare Organization(s) to medical associations, licensing boards, the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, and other similar organizations regarding any pertinent information which the Healthcare Organization(s) may have concerning me as long as such release of information and/or reporting is done in good faith and without malice, and I hereby release from liability Healthcare Organization(s) and its staff and representatives for so doing.
12. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application/attestation.

Print Name Here: _____

Signature: _____

(Stamped signature is not acceptable)

Date: _____

Healthcare Organization (e.g. hospital, medical staff, medical group, independent practice association, professional review organization health plan, health maintenance organization, preferred provider organization, physician hospital organization, medical society, credentials verification organization, professional association, medical school faculty position or other health delivery entity or system).

WASHINGTON STATE PATROL

Identification and Criminal History Section
PO Box 42633, Olympia WA 98504-2633

REQUEST FOR CRIMINAL HISTORY INFORMATION
CHILD/ADULT ABUSE INFORMATION ACT
RCW 43.43.830 THROUGH 43.43.845

A REQUESTING AGENCY/ADDRESS

Mason General Hospital
Agency

Medical Staff Office
Attn

901 Mt View Dr -PO Box 1668
Address

Shelton, WA 98584
City/State/Zip

I certify this request is made pursuant to and for the purpose indicated.

Authorized Signature Date

Credentials Specialist (360) 427-9549
Title Area Code/Phone Number

B PURPOSE

Check appropriate box

- ☐ Educational School District (ESD)/School District Volunteer – no fee
- ☒ Non-Profit Business/Organization – no fee (Excluding Schools & ESD's)
- ☐ Profit Business/Organization - $17
- ☐ Adoptive Parent - $17
- ☐ Receive background results electronically

Email address _____

Password _____ (must be at least 8 characters)

Fees: Make payable to **Washington State Patrol** by check, money order, or business account.

Notary letters certifying the results are available upon request (available by mail only). There is an additional $5.00 processing fee per notary seal.

_____ **Notarized Letter(s)**

C APPLICANT OF INQUIRY **(Please provide as much information as possible; name and date of birth are mandatory.)**

Applicant's Name: _____
Last First Middle

Alias/Maiden Name(s): _____

Date of Birth: _____ Sex: _____ Race: _____
Month/Day/Year

Secondary dissemination of this criminal history record information response is prohibited unless in compliance with statute.

D WASHINGTON STATE PATROL IDENTIFICATION & CRIMINAL HISTORY SECTION

As of this date, the applicant named below has no record pursuant to RCW 43.43.830 through 43.43.845.

Mason General Hospital
Requesting Agency

Applicant's Signature

Applicant's Name

Address

City/State/Zip

WSP Use Only

Applicant Right Thumb Print (Optional)

CHILD/ADULT ABUSE RECORD SEARCH GUIDELINES

Refer to Revised Code of Washington (RCW) 43.43.830-43.43.845 for complete information. Child/Adult Abuse Information Act background checks may be conducted by Washington State businesses or organizations. Other states must conduct searches under the Criminal Records Privacy Act, RCW 10.97.

1. **Searches may be conducted only on prospective employees, volunteers, or adoptive parents.**
Background checks may be conducted on prospective employees, volunteers, or adoptive parents who will or may have unsupervised access to children under sixteen years of age, developmentally disabled persons, or vulnerable adults. The background check is for initial employment decisions only.
Background checks on current employees or volunteers should be done through the Criminal Records Privacy Act, RCW 10.97.

2. **Applicants must be notified an inquiry may be made.**
A business or organization shall not make an inquiry to the Washington State Patrol unless the business or organization has notified the applicant who may be offered a position as an employee or volunteer that an inquiry may be made.

3. **A business or organization must prepare a disclosure statement to be signed by the applicant before a background check may be conducted.**
A business or organization shall require each applicant to disclose whether the applicant has been:
(a) Convicted of a crime;
(b) had findings made against him or her in any civil adjudicative proceeding;
(c) has both a conviction and findings made against him or her.

4. **Applicants must be notified of the response.**
The requesting agency shall notify the applicant of the Washington State Patrol's response within ten days after receipt. The employer shall provide a copy of the response to the applicant and shall notify the applicant of such availability.

Notes:
• "Business or organization" means a person, business, or organization licensed in this state, any agency of the state, or other governmental entity, that educates, trains, treats, supervises, houses, or provides recreation to developmentally disabled persons, vulnerable adults, or children under sixteen years of age, or that provides child day care, early learning, or early learning childhood education services, including but not limited to public housing authorities, school districts, and educational service districts.
• The business or organization shall use this record only in making the initial employment or engagement decision. Further dissemination or use of the record is prohibited. A business or organization violating this subsection is subject to civil action for damages.
• Responses are limited to **Washington State records only.**

NOTE: The requested record information is furnished solely on the basis of name and/or description similarity with the subject of your inquiry. Positive identification or non-identification can only be effected upon receipt of fingerprints.

MASON GENERAL HOSPITAL
DISCLOSURE STATEMENT

Pursuant to the requirements of RCW 43.43.830.840, we must ask you to complete the following disclosure statement. This information will be kept confidential.

Have you ever been convicted of any of the following crimes against children or other persons:

YES	NO		YES	NO	
[ ]	[ ]	Aggravated Murder	[ ]	[ ]	First degree promoting prostitution
[ ]	[ ]	First or second degree murder	[ ]	[ ]	Communication with a minor
[ ]	[ ]	First or second degree kidnapping	[ ]	[ ]	First degree arson
[ ]	[ ]	First, second or third degree assault	[ ]	[ ]	First degree burglary
[ ]	[ ]	First, second or third degree rape	[ ]	[ ]	Indecent liberties
[ ]	[ ]	First, second or third degree rape of a child	[ ]	[ ]	Incest
[ ]	[ ]	First or second degree robbery	[ ]	[ ]	Vehicular homicide
[ ]	[ ]	First or second degree manslaughter	[ ]	[ ]	Unlawful imprisonment
[ ]	[ ]	First or second degree extortion	[ ]	[ ]	Simple assault
[ ]	[ ]	First or second degree criminal mistreatment	[ ]	[ ]	Sexual exploitation of minors
[ ]	[ ]	Child abuse or neglect as defined in RCW 26.44.020	[ ]	[ ]	First or second degree custodial interference
[ ]	[ ]	Selling or distributing erotic material to minor	[ ]	[ ]	Malicious harassment
[ ]	[ ]	Custodial assault	[ ]	[ ]	First, second or third degree child molestation
[ ]	[ ]	Child buying or selling	[ ]	[ ]	First or second degree sexual misconduct with a minor
[ ]	[ ]	Or any of these crimes as they may have been renamed	[ ]	[ ]	Patronizing a juvenile prostitute
[ ]	[ ]	Promoting pornography	[ ]	[ ]	Child abandonment
[ ]	[ ]	Prostitution	[ ]	[ ]	Violation of child abuse restraining order

If your answer is “yes” to any of the above, please describe and provide the date(s) of the conviction(s) and the sentence(s) imposed.

(continue to next page)

DISCLOSURE STATEMENT – Page 2

Have you ever been convicted of any of the following crimes relating to financial exploitation of a person 60 years of age or older, who has a functional, mental, or physical inability to care for himself or herself or is a patient in a state hospital:

YES	NO	
[ ]	[ ]	First, second or third degree extortion
[ ]	[ ]	First or second degree robbery
[ ]	[ ]	First, second or third degree theft
[ ]	[ ]	Forgery
[ ]	[ ]	Or any of these crimes as they may have been renamed

If your answer is "yes"to any of the above, please describe and provide the date(s) of the conviction(s) and the sentence(s) imposed.

1. Have you ever been found in any dependency action to have sexually assaulted or exploited any minor or to have physically abused any minor?
   YES[ ] NO[ ]

2. Have you ever been found in a court in a domestic relations proceeding to have physically abused or exploited any minor or to have physically abused any minor?
   YES[ ] NO[ ]

3. Have you ever been found in any disciplinary board final decision to have sexually or physically abused or exploited any minor or developmentally disabled person?
   YES[ ] NO[ ]

4. Have you ever been found in any disciplinary board final decision to have abused or financially exploited any person 60 years of age or older who has a functional, mental, or physical inability to care for himself or herself or who is a patient in a state hospital?
   YES[ ] NO[ ]

5. Have you ever been found by a court in a protection proceeding under Chapter 74.34 RCW to have abused or financially exploited a person 60 years of age or older who has a functional, mental, or physical inability t to care for himself or herself or who is a patient in a state hospital?
   YES[ ] NO[ ]

(continue to next page)

DISCLOSURE STATEMENT – Page 3

If your answer is "yes" to any of questions 1 through 5 above, please describe and provide the date(s) of the finding(s) and the penalty(ies) imposed.

UNDER THE PENALTY OF PERJURY, I certify that the above information is true, correct and complete. I understand that if I am hired/appointed, I can be discharged for any misrepresentation or omission in the above statement. I also understand that if I am hired/appointed, my employment/appointment is conditioned on your receipt of a satisfactory report form the Washington State Patrol.

Signature: _____

Name (print): _____

Date: _____

We may request your fingerprints to obtain from the Washington State Patrol criminal identification system a report of your record of convictions for offenses against persons, civil adjudications of child abuse, and disciplinary board final decisions. If you are hired/appointed before that report is available, YOUR EMPLYMENT/APPOINTMENT WILL BE CONDITIONED UPON THE RECEIPT OF A SATISFACTORY REPORT.

You will be notified of the Washington State Patrol's results within seventy-two hours of receipt and a copy of the response will be available to you upon your requests.