Denver Health Pre-Employment

Required Immunizations:

(**Written proof** of Vaccinations listed below is required)

Measles, Mumps, Rubella (MMR) – 2 Vaccinations or + Titers

Varicella (Chicken Pox) – Documented History of disease, 2 Vaccinations or + Titers

Hepatitis B – 3 Vaccinations or + Titers (No exposure to Patients/Sharps/Blood may sign to decline)

Tdap – w/in last 10 years (No exposure to Patients/Children/Sharps may decline)

Influenza – Mandatory for all personnel- (Medical/Religion exemptions must be approved)

TB Skin Test – 2 step PPD required for all new employees – proof of blood test within last 12 months or 2 previous PPDs within last 12 months acceptable. Proof of 1 PPD within last 12 months will only require 2nd PPD placement and read. History of prior positive PPD will require 4 page questionnaire completed and recent Chest X-ray.

Helpful Links to state immunization registries:

www.coloradoiis.com

www.cdc.gov/vaccines/programs/iis/contacts-locate-records.html

DENVER HEALTH
CENTER FOR OCCUPATIONAL
SAFETY AND HEALTH

REGISTRATION FORM

DATE_____

DATE OF BIRTH____/____/_____ SSN #:_____-_____-_____

FIRST NAME:_____ MIDDLE INITIAL:___ LAST NAME:_____

ADDRESS_____CITY_____STATE_____

ZIP_____ PHONE: _____

PERSONAL EMAIL ADDRESS:_____

LEGAL SEX:_____ GENDER IDENTITY: _____

RACE : White/African-American/ Hispanic/Asian/Pacific Islander/Native American

MARITAL STATUS :Married/Single/Divorced/Widowed/Separated/Common Law/Domestic Partner/Other

☐ ENGLISH SPEAKING PREFERRED LANGUAGE_____

PLACE OF CURRENT/FUTURE EMPLOYMENT:_____

JOB TITLE_____ WORK NUMBER _____

EMERGENCY CONTACT

NAME:_____ PHONE NUMBER:_____

EMPLOYER INFORMATION – *New Injury Only*

NAME _____ PHONE _____

INSURANCE NAME _____ CLAIM _____

DENVER HEALTH
CENTER FOR OCCUPATIONAL SAFETY AND HEALTH

Denver Health
Center for Occupational Safety and Health
Health History

Name_____
Last First Middle

Age_____Date of Birth _____

Employer/Agency (Department)_____Position (Job Title) _____

HEALTH HISTORY To be filled out by applicant. All questions must be answered: "Yes, or No".

1. Are you currently under care of a doctor? ☐ Yes ☐ No If yes, for what
   _____
2. Are you currently taking medicine? ☐ Yes ☐ No If yes, please list
   _____
3. Have you ever had surgery? ☐ Yes ☐ No If yes, for what and when. Give year(s)
   _____
4. Have you ever been a patient overnight or longer in a hospital? ☐ Yes ☐ No If yes, for what and when. Give year(s)
   _____
5. Have you been treated for any injuries? ☐ Yes ☐ No If yes, for what and when? Give years _____
   _____
6. How many days have you lost from usual daily activities because of illness or injury during the past year?
   ☐ 0-7 days? ☐ 8-15 days? ☐ 15-30 days? ☐ Over 30 days? # of days _____
7. Have you ever been injured on the job in any way? ☐ Yes ☐ No If yes, describe: _____
   _____
8. Have you ever been treated for or filed for Workmen's Compensation benefits for injury or illness? ☐ Yes ☐ No
   If yes, for what and when? (Give year(s) _____
9. Have you ever been refused a job or terminated from a job for health reasons? ☐ Yes ☐ No
   If yes, explain: _____
10. Have you ever had to transfer from one job to another or change job duties for health reasons? ☐ Yes ☐ No
    If yes, explain: _____
11. Have you ever been deferred for/or discharged from military service for medical reasons? ☐ Yes ☐ No
    If yes, explain: _____
12. Have you ever changed your occupation or place of residence for health reasons? ☐ Yes ☐ No
    If yes, explain: _____
13. Has a doctor ever placed permanent restrictions on the kind of work you should do or advised you to restrict any specific activity due to an injury or illness? ☐ Yes ☐ No
    If yes, list restrictions: _____

Provider Notes:

_____

_____
Provider Signature/Title Date (mm/dd/yy)

Name _____
Last First Middle

Age _____ Date of Birth _____

HAVE YOU EVER HAD - or - DO YOU NOW HAVE - trouble with any of the following? (Check Yes or No)

	YES	NO		YES	NO
1. Eyes or ears _____	☐	☐	27. Intestinal bleeding _____	☐	☐
2. Nose, throat or sinus _____	☐	☐	28. Stomach or Duodenal Ulcer _____	☐	☐
3. Frequent headaches _____	☐	☐	29. GERD (Reflux) _____	☐	☐
4. Dizziness or fainting _____	☐	☐	30. Bowel trouble (or any change in bowel habits _____	☐	☐
5. Convulsions or fits _____	☐	☐	31. Hemorrhoids _____	☐	☐
6. Speech defect _____	☐	☐	32. Disease of colon _____	☐	☐
7. Paralysis or stroke _____	☐	☐	33. Liver or Gall Bladder _____	☐	☐
8. Shortness of breath _____	☐	☐	34. Rupture or hernia _____	☐	☐
9. Chronic cough _____	☐	☐	35. Difficulty in urination _____	☐	☐
10. Persistent hoarseness _____	☐	☐	36. Kidney stones _____	☐	☐
11. Coughing up blood _____	☐	☐	37. Kidney disease _____	☐	☐
12. Difficulty in breathing _____	☐	☐	38. Diabetes _____	☐	☐
13. Night sweats _____	☐	☐	39. Thyroid trouble (high or low) _____	☐	☐
14. Pneumonia _____	☐	☐	40. Back trouble/Neck trouble _____	☐	☐
15. Asthma _____	☐	☐	41. Joint trouble (wrist, elbow, hands, knees, shoulder, hip, feet, ankle) _____	☐	☐
16. Emphysema _____	☐	☐	42. Broken Bones _____	☐	☐
17. Tuberculosis _____	☐	☐	43. Medication allergy _____	☐	☐
18. Other lung diseases _____	☐	☐	44. Other allergies _____	☐	☐
19. Chest pains _____	☐	☐	45. Drug abuse _____	☐	☐
20. Swelling of ankles _____	☐	☐	46. Alcohol (drinking too much) _____	☐	☐
21. Rheumatic Fever _____	☐	☐	47. (Men) Prostate trouble _____	☐	☐
22. Heart trouble _____	☐	☐	48. (Women) Female organ trouble _____	☐	☐
23. Heart murmur _____	☐	☐	49. Treatment for nervous or emotional problem _____	☐	☐
24. High blood pressure _____	☐	☐	50. Current or Former Smoker _____	☐	☐
25. High cholesterol/triglycerides _____	☐	☐	51. Any other illness, injury or surgery _____	☐	☐
26. Heart attack _____	☐	☐			
27. Varicose veins _____	☐	☐			
28. Jaundice _____	☐	☐			

Do you currently have ANY disability/handicap? (hearing?, vision?, extremities?, chronic illness?, etc.)

_____

_____

Please explain any "Yes" answers in the above questions: _____

_____

_____

I, the undersigned, understand that this form will be considered part of the employment application process. I certify that the answers to above questions and the questions on the reverse side of this form are true and accurate as presented. I understand that any factual misrepresentation or false statement may be considered as sufficient cause for dismissal at any time.

I also understand that this examination is a condition of employment. I authorize the Denver Health Center for Occupational Safety and Health (COSH) to conduct an examination. COSH, its medical providers, and medical personal are free to review my medical records.

Applicant's Signature _____ Date ____ / ____ / ____
MM DD YY

Provider Signature _____ Date ____ / ____ / ____
MM DD YY

DENVER HEALTH
CENTER FOR OCCUPATIONAL
SAFETY AND HEALTH

DENVER HEALTH
Employee Immunization History

To comply with the CDC recommendations and DH Policy, **ALL EMPLOYEES, as a condition of employment, are required to provide documentation of vaccination status.** Please complete this form. **If no documentation can be provided, the employee will be required to receive necessary vaccinations unless medically contraindicated.**

Name:_____ **DOB:**_____

Date of Hire:_____ **Date reviewed by COSH:**_____

Do you have any health condition that may suppress your Immune system? □ Yes □ No

Are you Pregnant or likely to become pregnant within the next three months? □ Yes □ No

Clinic use only

Rubella (MMR) Vaccine Date #1_____#2_____

Titer Date_____ Result_____

Mumps (MMR) Vaccine Date #1_____ #2_____

Titer Date_____ Result_____

Rubeola (MMR) Vaccine Date #1_____#2_____

Titer Date_____ Result_____

□ Give MMR # 1

□ Give MMR # 2

□ Draw Titer

Chicken Pox/Varicella **Medically documented** history of disease? □ Yes □ No

If so, Date of disease:_____

Vaccine Date #1_____ #2_____

Titer Date:_____ Result_____

□ Give Vz #1

□ Give Vz #2

□ Draw Titer

Tuberculosis

Have you had a TB skin test w/in the last 12 months? If so, Date _____ Result_____

Have you had a TB blood test w/in the last 12 months? If so, Date_____ Quant or Tspot_____Result_____

Have you ever had a positive TB Test? **If so complete the 4 pg TB Questionnaire.** Last Chest X-Ray Date_____

PPD #1_____ Result_____

PPD #2_____ Result_____

□ No PPD required with proof of -TB Blood test w/in last 12 months

□ One step w proof of PPD in last 12 months

□ Two Step

Hepatitis B Series Vaccine Dates x 3

1_____ Titer Date_____ Result_____

2_____

3_____ Non – Responder □ Yes □ No

□ Start Hep B Series

□ Draw Titer

Tetanus/Diphtheria/Pertussis (Tdap) - Must be w/in 10 years Vaccine Date:_____

□ Give Tdap

Influenza: Vaccine Date:_____

□ Give Flu Vaccine

COSH Reviewer's Name _____ **Title**_____

COSH Reviewer's Signature_____

Revised 9/23/2019