



Dear Allied Healthcare Professional,

Thank you for your interest in working with HealthSource Global Staffing!

Whether you are a Technician, Therapist, CNA or other medically skilled professional, we welcome you to the HealthSource team.

HealthSource is happy to provide you with high paying short term assignments that give you the opportunity to make money while having flexibility and control over your work and life activities.

Please pay close attention to our file requirements. They will vary depending on your medical specialty. Your file needs to be complete prior to traveling with HealthSource. Our staff will work with you to facilitate this process.

Thank you for choosing to travel with HealthSource!

Sincerely,

HEALTHSOURCE GLOBAL STAFFING

What to Bring To Your Assignment

- **Complete File**

Hand-carry 3 sets of your complete file. Do not pack it in your luggage as it can become separated from you. All HealthSource Global documentation must reflect your legal name. Your file should include everything listed on the Standard File Requirements Checklist. Your recruiter will inform you of any additional requirements.

- **Cash and/or Credit Cards**

As with any trip that you might take, incidental expenses will occur. Please make sure you travel with enough cash, credit/debit cards or traveler's checks to cover meals, laundry, telephone calls, transportation for your leisure time and any incidental expenses.

- **Working Uniform or Scrubs**

Hospitals do not provide working uniforms or scrubs for most specialties. Please bring the appropriate attire for your nursing specialty or medical profession.

Healthsource Global Staffing Standard File Requirements

Below are our standard file requirements. Certain facilities may request additional documentation. Your file must be complete and in compliance while on assignment. Please provide clear photocopies of all certifications, nursing licenses, social security card, and your government issued photo ID.

Your complete file should include the following documents:

- Consent for Background Investigation & Drug Screening
- Physical within 1 year—Date of physical ___/___/___

- Negative PPD within 1 year—Date Read ___/___/___

Or if positive PPD:

- Chest x-Ray within 2 Years—Date Given ___/___/___

And:

- Annual TB Questionnaire—Date Completed ___/___/___

IMMUNIZATION STATUS

- Hep B Vaccination Declination

Or:

- Hep B Titer Immune Non Immune

Or:

- Hep B Series 1) ___/___/___ 2) ___/___/___ 3) ___/___/___

Proof of immunizations or positive titer results for Mumps, Rubeola (measles), Rubella and Varicella. Immunizations must include the date given and initials of the healthcare provider. The titer results can show the words "positive/immune," or a numerical value. If a number is given, a lab range indicating whether a number reflects a positive titer must be included. **All vaccine and titer requirements vary with each facility.**

- MMR Immunization(s)—Date ___/___/___ Date ___/___/___

OR

- Rubella Titer Immune Non Immune
- Rubeola Titer Immune Non Immune
- Mumps Titer Immune Non Immune

- Varivax Immunization—Date ___/___/___

OR

- Varicella Titer Immune Non Immune

PAYROLL DOCUMENTS

- Notarized I-9 form
- W-4 form

- Employment Application
- Professional Reference #1 (Current within 1 year)
- State License _____ Lic # _____ Expires ___/___/___
- Government Issued Photo ID—passport or driver's license
 - Hand-carry original and include a clear photocopy
- Social Security Card—for payroll purposes
 - Hand-carry original and include a clear photocopy
- Clinical Skills Checklist—Specialty _____
- Clinical Skills Checklist—Specialty _____

CERTIFICATIONS (clear photocopies of front and back)

- BLS Expires ___/___/___ (required for ALL units)
- ACLS Expires ___/___/___ (ER, ICU, & PACU)
- PALS Expires ___/___/___ (ER, PEDS, & PICU)
- Other: _____ Expires ___/___/___
- Other: _____ Expires ___/___/___
- Other: _____ Expires ___/___/___

SIGNATURE DOCUMENTS

- Employee Confidentiality Agreement
- Employee Awareness Statement for California Penal Codes
- Health Insurance Portability & Accountability Act (HIPAA)
- Blood Borne Pathogens In-Service
- OSHA Standards and Competency Assessment
- 2008 National Patient Safety Goals

All Standard File Requirements must remain current while on assignment. Noncompliance will not be tolerated by the company or medical facility.



Employment Application

Last Name _____ First Name _____ Middle _____
 (Name as it appears on you SS card)

Street _____ County _____
 (Current/Permanent Mailing Address)

City _____ Province/State _____ Zip Code _____

Email Address _____ Fax # _____

Social Security Number _____ Date of Birth _____

Emergency Contact Name _____ Phone # _____ Cell # _____

Type of Professional RN LVN/LPN TECH CNA Other please specify _____

Are you currently working in your profession? Yes No If no, why? _____

What language(s) do you speak fluently? _____ How did you hear about us? _____

Licensure: (Include **clear** photocopies of all licenses held.)

State: _____ License # _____ Exp. Date: _____ State: _____ License # _____ Exp. Date: _____

State: _____ License # _____ Exp. Date: _____ State: _____ License # _____ Exp. Date: _____

Current Certifications: (Provide **clear** photocopies of all certification held)

BLS _____ Expires _____ ACLS _____ Expires _____ PALS _____ Expires _____ NRP _____ Expires _____ FHM _____ Expires _____ TNCC _____ Expires _____ CHEMO _____ Expires _____

Other (s) _____

Education	City & State	Month/Year Graduated	Diplomas, Degrees received
College			
Graduate School			

Employment History (DO NOT LIST AGENCY NAMES.) Please start with your current or most recent job.

We will use your current resume for all other job history information

Hospital/Employer _____ Teaching Facility: Y / N Pay Rate: \$ _____ /hr or yr

Street address _____ City _____ State _____ Zip _____

Dates of employed: From _____ To _____ Reason for leaving _____

Position held _____ Unit Specialty _____ Did you do charge? Y / N

Responsibilities _____

Immediate Supervisor _____ Phone _____



Hospital/Employer _____ Teaching Facility: Y / N Pay Rate: \$ _____/hr or yr
Street address _____ City _____ State _____ Zip _____
Dates of employed: From _____ To _____ Reason for leaving _____
Position held _____ Unit Specialty _____ Did you do charge? Y / N
Responsibilities _____
Immediate Supervisor _____ Phone _____

Hospital/Employer _____ Teaching Facility: Y / N Pay Rate: \$ _____/hr or yr
Street address _____ City _____ State _____ Zip _____
Dates of employed: From _____ To _____ Reason for leaving _____
Position held _____ Unit Specialty _____ Did you do charge? Y / N
Responsibilities _____
Immediate Supervisor _____ Phone _____

1. Yes No Is there any medical condition(s) which may limit your ability to perform any function required of a nurse?
2. Yes No Have you ever been convicted of a crime other than a minor traffic violation?
3. Yes No Has your professional license or certification ever been investigated or suspended?
If you answered Yes to any of the questions above, please explain below. Use additional paper if needed.

Can you submit verification of your legal right to work in the USA? Yes No

I attest that the information provided in this application is complete and accurate, to the best of my knowledge. Providing incomplete or inaccurate information may result in disqualification from the program, and may be a violation of state law(s) that could result in civil penalties.

Print Name _____

Signature _____ **Date** _____



Employment Reference

Applicant name: _____ SS#: _____

Name of Hospital/Facility: _____

Address, City, State: _____

Name of Supervisor: _____
(Manager, Charge Nurse or higher) Please Print Title

I hereby authorize my past and present employers to provide information to HealthSource Global Staffing about my job performance while in their employment, permanent or temporary. I hereby release all such employers and their representatives from all liabilities for issuing this information to HealthSource. I also authorize HealthSource to disclose the client facilities for which I have expressed an employment interest.

Applicant's Signature _____ Date _____

	Above Average	Average	Below Average
Accurate and thorough documentation			
Adaptability to patient assignment			
Attendance and punctuality			
Enthusiasm toward job			
Communication skills			
Clinical skills			
Problem solving skills			
Professional appearance			
Productivity			
Professionalism			
Quality of work			
Cooperation			
Leadership ability			

Dates of Employment: From (MM/YY) _____ To (MM/YY) _____

Specialty / Unit worked _____

Reason for Leaving: Terminated Lay-Off Resigned Temporary Employee

Would you hire this healthcare professional again? Yes No

Supervisor's Signature _____ Title _____ Date _____



Employment Reference

Applicant name: _____ SS#: _____

Name of Hospital/Facility: _____

Address, City, State: _____

Name of Supervisor: _____
(Manager, Charge Nurse or higher) Please Print Title

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Problem solving skills			
Professional appearance			
Productivity			
Professionalism			
Quality of work			
Cooperation			
Leadership ability			

Dates of Employment: From (MM/YY) _____ To (MM/YY) _____

Specialty / Unit worked _____

Reason for Leaving: Terminated Lay-Off Resigned Temporary Employee

Would you hire this healthcare professional again? Yes No

Supervisor's Signature _____ Title _____ Date _____



Employee Confidentiality Agreement

As an employee of HealthSource Global Staffing, you have both a legal and ethical responsibility to protect the privacy of employees, client nurses and hospitals as well as all proprietary information of HealthSource Global Staffing. All information that you see or hear regarding nurses, staff, patients, directly or indirectly, is completely confidential and must not be discussed or released in any form, except when required in the performance of your duties. If you have access to employee information, you are expected to treat such information in the same confidential manner.

Unauthorized disclosure of medical information is also criminally punishable as a misdemeanor. The mere public acknowledgement of HIV disease, psychiatric disorders, drug abuse or alcohol abuse may expose the company to both substantial fines and liability to the person.

Any information provided to you by the nurses or hospitals is considered confidential and should not be shared with other except when required in the performance of your duties. I have read the above information and understand that any violation of this agreement is cause for immediate action.

Print Name

Signature

Date



Employee Awareness Statement for California Penal Codes

California Law requires all hospital employees to sign statements acknowledging that they are aware of their responsibilities with regard to section 11166 of the California Penal Code and Section 15630 of the California Welfare and Institutions Code, and to comply with the state obligations.

Section 11166 (Child Abuse) of the Penal Code requires any child care custodian, medical practitioner or employee of a child protective agency who has knowledge of or observes a child in his/her professional capacity or within the scope of his/her employment who he/she knows or reasonably suspects has been the victim of child abuse to report the suspected instance of child abuse to a child protective agency immediately or as soon as practically possible by telephone and to prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.

Section 15630 (Elder Abuse) of the Welfare and Institutions Code requires any elder of dependent adult care custodian, health practitioner, or employee of a county adult protective services agency or a local law enforcement agency who in his/her professional capacity or within the scope of his/her employment, either has observed and incident that reasonably appears to be physical abuse, has observed a physical injury where the nature of the injury, it's location on the body or the repetition of the injury, clearly indicates that physical abuse had occurred, or is told by an elder or dependent adult that he/she has experienced behavior constituting physical abuse, shall report the known or suspected instance of physical abuse either to the long-term care ombudsman coordinator or to a local law enforcement agency when the physical abuse is alleged to have occurred in a long-term care facility, or to their county adult protective services agency or to a local law enforcement agency when the physical abuse is alleged to have occurred anywhere else, immediately or as soon as possible, by telephone and to prepare and send a written report thereof within 36 hours.

Section 11160-1163 (Suspected Violent Injuries/Suspected Domestic Violence Injuries) of the Penal Code requires reporting of any cases of patients with physical injuries caused by violent behavior to include domestic violence. Any health practitioner employed in a health facility, clinic, or physicians office who is in his/her professional capacity or within the scope of his/her employment, provides medical services for physical condition to a patient whom he/she knows or reasonably suspects is a person described as follows, shall immediately make a report of:

1. Any person suffering from any wound or other injury inflicted by his/her own act or inflicted by another where the injury is by means of a firearm.
2. Any person suffering from any wound or other physical injury inflicted upon the person where the injury is the result of assaultive or abusive conduct

This report shall be made to a local law enforcement agency as follow:

1. A report by telephone shall be made immediately or as soon as practically possible.
2. A written report shall be prepared and sent to a local law enforcement agency within two working days of receiving the information regarding the person.

I certify that I have read and understand this statement and will comply with my obligation under these laws. Furthermore, I understand that I may be fully prosecuted by the State under these Penal Codes for failure to comply with the law.

Print Name

Signature Date

HealthSource Representative Date



Health Insurance Portability and Accountability Act (HIPAA)

This notice describes how health information about you may be used and disclosed. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I authorize HealthSource Global Staffing the use and disclosure of my health information. I understand that this will be used by HealthSource Global Staffing and its clients to evaluate my qualifications for employment opportunities as it relates to the healthcare field. This information may also be used for workers compensation and similar programs, and/or when necessary to reduce or prevent a serious threat to your health and safety, or health and safety of others. We will only make disclosures to a person or organization able to help prevent the threat.

I further understand that if a person that receives this information is not a healthcare provider, the information disclosed may be re-disclosed and no longer protected by regulations. I understand that I may revoke this authorization at any time by sending a written request to HealthSource Global Staffing, except to the degree that action has been taken in reliance on upon this authorization.

This authorization will expire one year from the dated signature below.

Print Name

Signature

Date



Blood Borne Pathogens In-Service

The purpose of this in-service is to ensure the safety of both the patient and the medical service personnel in the workplace. The in-service will include the following:

- Exposure to Blood Borne Pathogens
- Prevention of Needle Stick Injuries
- Needle Capping
- Universal Precautions
- Who is at Risk
- Appraising the Risk
- Personal Protection
- Disposal of Biohazards
- New Laws and Federal Acts
- New Technologies

This in-service is provided to all HealthSource Global Staffing healthcare workers and consists of a "Safety Trainer Video" and verbal presentation.

I understand and agree to comply with all safety standards set forth by my employer, HealthSource Global Staffing.

I certify by my signature below, that I have been provided with the HealthSource Global Staffing Blood Borne Pathogens In-service.

Print Name

Date of In-Service

Signature

In-service Conducted by HealthSource Global Staffing Representative

OSHA Standards and Competency Assessment

In compliance with JCAHO and OSHA requirements, I acknowledge that I have successfully completed the competency assessment as well as all of the following:

- Age Specific Job Requirements
- Back Safety
- Blood Borne Pathogens/Infectious Disease
- Disinfection and Sterilization
- Electrical Safety
- Ergonomics for Healthcare Workers
- Fire Safety
- Handling of Hazardous Materials
- Hand Washing
- HIPAA Privacy Compliance
- Personal Protective Equipment
- Patient Bill of Rights
- Patient Confidentiality
- Radiation Safety
- Tuberculosis
- Violence in the Workplace
- 2007 Patient Safety goals
- Cultural diversity and sensitivity training

Print Name

Signature

Date

HealthSource Representative

Date

Facts about the 2008 National Patient Safety Goals

On June 1, 2007, The Joint Commission's Board of Commissioners approved the 2008 National Patient Safety Goals. The Goals and related requirements are below. New Goals and requirements are indicated in bold and accreditation program applicability is indicated in brackets. Gaps in the numbering indicate a Goal has been "retired," usually because the requirements were integrated into the standards. Program-specific language changes are omitted from this version.

This year's new requirements (3E and 16A) have a one-year phase-in period that includes defined expectations for planning, development and testing ("milestones") at 3, 6 and 9 months in 2008, with the expectation of full implementation by January 2009. See the Implementation Expectations for milestones.

- Goal 1 Improve the accuracy of patient identification.
- 1A Use at least two patient identifiers when providing care, treatment or services. [Ambulatory, Assisted Living, Behavioral Health Care, Critical Access Hospital, Disease-Specific Care, Home Care, Hospital, Lab, Long Term Care, Office-Based Surgery]
- 1B Prior to the start of any invasive procedure, conduct a final verification process, (such as a "time out,") to confirm the correct patient, procedure and site, using active—not passive—communication techniques. [Assisted Living, Home Care, Lab, Long Term Care]
- Goal 2 Improve the effectiveness of communication among caregivers.
- 2A For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the information record and "read-back" the complete order or test result. [Ambulatory, Assisted Living, Behavioral Health Care, Critical Access Hospital, Disease-Specific Care, Home Care, Hospital, Lab, Long Term Care, Office-Based Surgery]
- 2B Standardize a list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the organization. [Ambulatory, Assisted Living, Behavioral Health Care, Critical Access Hospital, Disease-Specific Care, Home Care, Hospital, Lab, Long Term Care, Office-Based Surgery]
- 2C Measure and assess, and if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values. [Ambulatory, Behavioral Health Care, Critical Access Hospital, Disease-Specific Care, Home Care, Hospital, Lab, **Long Term Care**, Office-Based Surgery]
- 2E Implement a standardized approach to "hand off" communications, including an opportunity to ask and respond to questions. [Ambulatory, Assisted Living, Behavioral Health Care, Critical Access Hospital, Disease-Specific Care, Home Care, Hospital, Lab, Long Term Care, Office-Based Surgery]
- Goal 3 Improve the safety of using medications.
- 3C Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used by the organization, and take action to prevent errors involving the interchange of these drugs. [Ambulatory, Behavioral Health Care, Critical Access Hospital, Home Care, Hospital, Long Term Care, Office-Based Surgery]
- 3D Label all medications, medication containers (for example, syringes, medicine cups, basins), or other solutions on and off the sterile field. [Ambulatory, Critical Access Hospital, Hospital, Office-Based Surgery]

Facts about the 2008 National Patient Safety Goals

- 3E Reduce the likelihood of patient harm associated with the use of anticoagulation therapy. [Ambulatory, Critical Access Hospital, Home Care, Hospital, Long Term Care, Office-Based Surgery]**
- Goal 7 Reduce the risk of health care-associated infections.
- 7A Comply with current **World Health Organization (WHO) Hand Hygiene Guidelines** or Centers for Disease Control and Prevention (CDC) hand hygiene guidelines. [Ambulatory, Assisted Living, Behavioral Health Care, Critical Access Hospital, Disease-Specific Care, Home Care, Hospital, Lab, Long Term Care, Office-Based Surgery]
- 7B Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection. [Ambulatory, Assisted Living, Behavioral Health Care, Critical Access Hospital, Disease-Specific Care, Home Care, Hospital, Lab, Long Term Care, Office-Based Surgery]
- Goal 8 Accurately and completely reconcile medications across the continuum of care.
- 8A There is a process for comparing the patient's current medications with those ordered for the patient while under the care of the organization. [Ambulatory, Assisted Living, Behavioral Health Care, Critical Access Hospital, Disease-Specific Care, Home Care, Hospital, Long Term Care, Office-Based Surgery]
- 8B A complete list of the patient's medications is communicated to the next provider of service when a patient is referred or transferred to another setting, service, practitioner or level of care within or outside the organization. The complete list of medications is also provided to the patient on discharge from the facility. [Ambulatory, Assisted Living, Behavioral Health Care, Critical Access Hospital, Disease-Specific Care, Home Care, Hospital, Long Term Care, Office-Based Surgery]
- Goal 9 Reduce the risk of patient harm resulting from falls.
- 9B Implement a fall reduction program including an evaluation of the effectiveness of the program. [Assisted Living, Critical Access Hospital, Disease-Specific Care, Home Care, Hospital, Long Term Care]
- Goal 10 Reduce the risk of influenza and pneumococcal disease in institutionalized older adults.
- 10A Develop and implement a protocol for administration and documentation of the flu vaccine. [Assisted Living, Disease-Specific Care, Long Term Care]
- 10B Develop and implement a protocol for administration and documentation of the pneumococcus vaccine. [Assisted Living, Disease-Specific Care, Long Term Care]
- 10C Develop and implement a protocol to identify new cases of influenza and to manage an outbreak. [Assisted Living, Disease-Specific Care, Long Term Care]
- Goal 11 Reduce the risk of surgical fires.
- 11A Educate staff, including operating licensed independent practitioners and anesthesia providers, on how to control heat sources and manage fuels with enough time for patient preparation, and establish guidelines to minimize oxygen concentration under drapes. [Ambulatory, Office-Based Surgery]
- Goal 12 Implementation of applicable National Patient Safety Goals and associated requirements by components and practitioner sites.
- 12A Inform and encourage components and practitioner sites to implement the applicable National Patient Safety Goals and associated requirements. [Networks]



Facts about the 2008 National Patient Safety Goals

- Goal 13 Encourage patients' active involvement in their own care as a patient safety strategy.
- 13A Define and communicate the means for patients and their families to report concerns about safety and encourage them to do so. [Ambulatory, Assisted Living, Behavioral Health Care, Critical Access Hospital, Disease-Specific Care, Home Care, Hospital, Lab, Long Term Care, Office-Based Surgery]
- Goal 14 Prevent health care-associated pressure ulcers (decubitus ulcers).
- 14A Assess and periodically reassess each resident's risk for developing a pressure ulcer (decubitus ulcer) and take action to address any identified risks. [Long Term Care]
- Goal 15 The organization identifies safety risks inherent in its patient population.
- 15A The organization identifies patients at risk for suicide. [Behavioral Health Care, Hospital (applicable to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals)]
- 15B The organization identifies risks associated with long-term oxygen therapy such as home fires. [Home Care]
- Goal 16 Improve recognition and response to changes in a patient's condition.**
- 16A The organization selects a suitable method that enables health care staff members to directly request additional assistance from a specially trained individual(s) when the patient's condition appears to be worsening. [Critical Access Hospital, Hospital]**

I have read and understand the 2008 National Safety Goals.

Print Name

Signature

Date

HealthSource Representative

Date



Employee Authorization to Release Employee Information and Consent for Background Investigation and Random Drug Screening

My signature below signifies my authorization for HealthSource Global Staffing to release any or all information contained within my employment file to any medical facility or entity with whom the company contacted to receive HealthSource Global Staffing and any regulatory or governmental agency upon that agency's request. My signature further allows HealthSource Global Staffing to request any additional necessary medical information from my care provider(s) to complete HealthSource Global Staffing medical history for my employee file.

I agree to submit to random alcohol and/or drug screens used for the purpose of determining my fitness for employment or continued employment, and I hereby authorize HealthSource Global Staffing to conduct background investigations of my activities, education and employment.

I agree that HealthSource may make the decision to release any and all information at its discretion providing such release is made to authorized representatives of appropriate entities as described. I understand that in all other cases, my employment records will remain confidential and will only be released with my written authorization.

My signature here indicates that I have read this **Employee Authorization to Release Employee Information and Consent for Background Investigation and Random Drug Screening** in its entirety and understand its contents.

Print Name

Signature

Date

HealthSource Representative

Date



Hepatitis B Vaccination Declination

OSHA requires all health care workers to have the opportunity to have the Hepatitis B Vaccination offered to them, by their employer.

1. If you decline to have the Hepatitis B Vaccine, please indicate this by signing and dating under Declination.
2. If you have completed the vaccination series, please indicate this by signing and dating under Completed Series. You must provide documentation of the vaccinations if you sign that you have completed the series.
3. If you are in the process of receiving the series, please indicate this by signing and dating Vaccinations in Progress. Please indicate if you require a dose of the vaccine.

I understand that I will be provided appropriate training at my assigned workplace and will adhere to the policies and procedures of the facility to which I am assigned. I understand that due to my occupational exposure to blood and/or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with the Hepatitis B vaccine, at no cost to me, while on active assignment with HealthSource Global Staffing.

DECLINATION

I decline the Hepatitis B vaccine series. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other infectious material and want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to myself, while on assignment with HealthSource Global Staffing. I accept the responsibility to inform HealthSource Global Staffing of this decision at that time.

Date _____ Signature _____

COMPLETED SERIES

I understand the OSHA guidelines and decline because I have completed the Hepatitis B Vaccination. I will provide documentation of the series to HealthSource Global Staffing.

Date _____ Signature _____

VACCINATIONS IN PROCESS

I understand the OSHA guidelines and need #_____ or booster in the series. I will make arrangements to complete the series or booster, or if on assignment, I will make arrangements with HealthSource Global Staffing to receive this dose of the vaccine series. I will provide documentation of the series/booster to HealthSource Global Staffing and provide appropriate updates.

Date _____ Signature _____

Annual TB Questionnaire

The Annual Tuberculosis Questionnaire is used to evaluate your current TB status. We cannot utilize the tuberculin skin test (PPD or Mantoux), because you have a positive reaction to the test. A positive skin test means that sometime during your life you came into contact with tuberculosis or have had a vaccination to prevent you from contracting tuberculosis. It does not mean that you have TB now.

In the past yearly chest x-rays were performed; however, recent studies show that they are unnecessary. Instead, this health survey will assist Employee Health to monitor possible TB Symptoms. Chest x-rays are required every two years.

TB symptoms can progress slowly and/or mimic other diseases. You can develop symptoms of TB a few weeks after contracting the bacteria – or not until years after the initial infection. This questionnaire targets some of the most common symptoms. Please familiarize yourself with them. You are the first to know when you are not feeling well and may have TB symptoms.

Tuberculosis Health Check Survey

Have you ever experienced any of the following symptoms **NOT** associated with a specific illness (i.e. flu or cold) and lasting 3 weeks or longer?

- | | |
|--------------------------------|--|
| Cough | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Streaked Sputum (phlegm) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Loss of Weight (unplanned) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Night Sweats | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anorexia (loss of appetite) | <input type="checkbox"/> Yes <input type="checkbox"/> No |

This authorization will expire one year from the dated signature below.

Print Name

Signature

Date