GRAND VIEW HOSPITAL
Sellersville, PA

PRE-PLACEMENT EVALUATION

Name	**Date of Birth**	**Position**	**Department**

I, the undersigned, do certify that all information that I provide in this pre-placement interview is correct. I authorize the disclosure of all information derived through the evaluation process to the Hospital. I authorize the performance of tests required for the completion of the evaluation. I understand that this is only a pre-placement evaluation to establish clearance for my assigned position. I understand that it is decidedly limited in its scope and not meant to replace a thorough physical examination which should be routinely provided through my family practitioner or medical specialist. (Please provide the name of your family practitioner or medical specialist_________________________.) If you do not have a physician, we will supply a card for the Physician Referral Service (Card given: ________________)

Signature of Applicant: ____ **Date:**____________________

Personal History: (Completed by Applicant) Please check all applicable boxes.

- o Tuberculosis (illness or known exposure)
- o Arthritis
- o Heart or Lung problems
- o Hernia
- o Latex allergy
- o Other allergies (please specify below)
- o Epilepsy
- o Diabetes
- o Hepatitis
- o Hepatitis B Vaccine
- o Measles
- o Measles Vaccine
- o Chicken Pox
- o Chicken Pox Vaccine

Please explain all areas checked under Personal History:____

____

____

____

Present Medications: (prescription and over-the-counter) Please list:

____

____

____

Operations, Serious Illness, Serious Injury? □ NO □ YES If YES, please explain:

____

____

____

Evaluation: (Completed by Employee Health Personnel)

Temperature: ______ Pulse: _______ Blood Pressure: _________ Weight: _________ Height: _________
Drug/Alcohol Screen: □ Positive □ Negative Color Vision: □ Pass □ Fail

Health Care Practitioner Comments/Recommendations: ____

____

____

____

____

____ __________________
Health Care Practitioner Signature Date

Human Resources Notified: ___________________ Date:____________ Time:________ Initials:______

3/92, 8/97, 2/00, 4/00

GRAND VIEW HOSPITAL
Sellersville, PA

CONSENT FORM FOR DRUG AND/OR ALCOHOL TESTING COLLECTION
AND RELEASE OF MEDICAL RECORDS

I, ____hereby authorize Grand View Hospital, its staff and employees, to collect drug and/or alcohol sample that will be sent to a designated laboratory which will then test the sample obtained for a variety of drugs and maybe for alcohol as well. I understand that the results o f this screening will be used by my company in the determination of my eligibility for present or continued employment. I understand that the test sample will be obtained by the following method:

- ☐ Urine Drug Screen
- ☐ Breath/Blood Alcohol
- ☐ Other

I understand and consent to the release by Grand View Hospital of the results of my drug and/or alcohol test, my physical examination information, if applicable, and my medical records from ____________ to my employer's Medical Review Officer (MRO) associated with
(Date)

____.
(Company)

I understand that the Grand View Hospital MRO or designee is obligated to discuss with my company representative any information obtained during the interview which render me unsafe or unfit for duty.

I hereby release Grand View Hospital, its employees, staff, agents and servant from any liability or responsibility whatsoever resulting from the drug and alcohol testing or from Grand View Hospital's release of the results of said testing and release of my physical examination information and medical record to my employer or to my employer's MRO.

I understand that I may revoke this Consent to release medical records at any time by notifying Grand View Hospital in writing, or by giving an oral request if I am physically unable to provide a signature. This Consent expires ninety (90) days following the receipt of consent.

____ ________________ ____________
Signature of Patient Date Time

____
Witness

3/92 Revised 5/92, 1/95, 1/95, 1/96. 8/96, 8/98, 8/08

GRAND VIEW HOSPITAL
700 LAWN AVE.
SELLERSVILLE, PA 18960
Phone: 215-453-4016
Fax: 215-453-4748

DONOR NAME	
DATE OF BIRTH	
COLLECTION DATE & TIME	
REASON FOR TEST	
LABORATORY	
MRO	

RAPID SCREEN	**RESULTS**
AMPHETAMINES	
PCP	
THC (marijuana metabolites)	
OPIATES	
COCAINE	
BARB	
BENZ	
OXYCODONE	
MAMP	
PROPOXYPHENE	

COLLECTOR SIGNATURE: ____________________________ EXP. DATE: ______________________

TEMPERATURE: ____________________________________ LOT: ______________________

ADULTERATION CHECK: neg.______ pos. ____________

RESULTS REPORTED TO : ______________________ DATE :_______________

REV 061202, 081304 ,05/09,09/09,04/10.07/11

GRAND VIEW HOSPITAL
EMPLOYEE HEALTH SERVICES

Employee Name: ___________________________________ Date of Birth: _____________

Declination of Immunization

It has been recommended to me by Grand View Hospital Employee Health Services that I receive the following immunization(s). I understand that this recommendation is being made based on OSHA Bloodborne Pathogens regulation. I understand that I may be exposed to potentially infectious diseases and may be at risk of acquiring these infections. I have been given the opportunity to be vaccinated at no charge to me; however, at this time I decline the vaccine/vaccines indicated. I understand that by declining I continue to be at risk of acquiring these infections. I also understand that in some circumstances my work assignment may be limited due to my non-immunity. If, in the future, I choose to receive any of the vaccines listed, I may do so at no charge to me.

- HEPATITIS B VACCINE

______________________________	______________
Employee Signature	Date
______________________________	______________
Witness Signature	Date