UF | Student Health Care Center
UNIVERSITY of FLORIDA
Office of the Director

P.O. Box 117500 | 280 Fletcher Drive
Gainesville, FL 32611-7500

Occupational Medicine: SHCC@Shands
Phone: (352) 294-5700 | Fax: (352) 846-2003

January 1, 2016

Dear New University of Florida Medical or Dental Resident/Fellow:

Welcome to the University of Florida. I hope that you will find your training experience here challenging and profoundly worthwhile.

As director of the UF Student Health Care Center (SHCC), it is my role to oversee the Occupational Medicine Program for the University. It is our goal at this program to tailor the Preplacement Health Assessment Evaluations of new employees to the individual job description and duties. As Medical and Dental Residents or Fellows, your patient care duties make a preplacement screening process both advisable and necessary. Via this evaluation, we hope to minimize any occupational risks to you and to ensure that you can safely perform the essential functions of your new job. Please make sure you print your name and UF ID number legibly on each page.

Please complete the Preplacement Screening Patient Contact Forms (www.ehs.ufl.edu/programs/occmed/healthassess/residents) and return them to the UF SHCC in the attached self-addressed envelope by May 1.

- **Section I: Medical History –** Includes completing questions on pages 1-2. Please complete the box on page 2 about how we should contact you if more information is needed prior to beginning your Residency/Fellowship Program.
- **Section II: Immunization History –** Must be completed and signed by a physician or authorized health professional certifying the accuracy of your immunization data. Go to your university or college's student health services or your hospital's occupational health service for completion of this information. **Your immunization history will not be accepted if you complete the form and sign it yourself. Please take the time to collect all specific immunization and/or titer dates and any X-ray results and submit these together. You will not proceed through the medical clearance process to official hire until all records are received, reviewed and approved.**
- **Medical History Questionnaire for N-95 Filtering Face Respirator –** Complete this additional one-page form, as you may be required to be fitted for this piece of protective equipment.

Please note that the specific medical history information you supply will be kept confidential and will not be shared with your Residency/Fellowship director or program. The SHCC Occupational Medicine physician will determine if additional medical information, testing or a physical examination is needed based on the medical information you provide. SHCC Occupational Medicine personnel may notify you if additional information is needed. Should additional vaccinations or titers be necessary, it is your responsibility to get these before you start your residency. If a physical examination is recommended, it may be performed here at the SHCC Occupational Medicine Department in Gainesville or at an alternative site if approved by your Residency/Fellowship program. Should you have your physical at a site other than the UF SHCC, we will provide the required PE forms.

Once all needed documentation is completed, the SHCC Occupational Medicine personnel will either recommend you for duty with certain specified restrictions or modifications to your job duties or you will be recommended for full duty without limitations.

If you have any questions regarding the UF's Preplacement Screening and Medical Monitoring Programs for Medical and Dental Residents/Fellows, please feel free to contact Mike Wuerz at (352) 294-5700 or by email to wuerz@ufl.edu . Once again, welcome to the University of Florida.

Sincerely,

Guy W. Nicolette, MD, CAQSM

Director, UF Student Health Care Center (http://shcc.ufl.edu/)
Director, UF Sports Medicine Fellowship Program (http://chfm.ufl.edu/programs/primary-care-sports-medicine-fellowship/)

PLB/cbh

Mike Wuerz, RN, Occ Medicine
UF Student Health Care Center
P.O. Box 100148
Gainesville, FL 32610-0148

Resident/Fellow Clearance Program
UF Student Health Care Center
ATTN: Mike Wuerz, RN, Occ Med
P.O. Box 100148
Gainesville, FL 32610-0148

2016 RESIDENT/FELLOW

Preplacement Screening Patient Contact Form
UF Residency / Fellowship

The information requested on these pages is necessary in order to minimize any occupational risks to you and to insure that you can safely perform the essential functions of your new job. Medical History information on this form will be kept in a confidential file at the SHCC, and will not be shared with your Employer, Program or Director without your written permission/consent. Immunization Documentation may be shared with your Program and the Occupational Medicine Department of your work site.

Name: _____ **Date of Birth:** _____
(Last, First, Middle Initial) (mm / dd / yy)

UF ID #: _____

Work Site - Gainesville: _____ **Jacksonville:** _____ **Other:** _____

Position Number: _____ **Job Title:** **Resident / Fellow (circle one)**

Department: _____ **Supervisor/Prog Director:** _____

Section I - Medical History

Do you have now, have you ever had, or have you received treatment for the following:

Yes	No		If ***YES*** use as many lines below as needed to explain
☐	☐	Hospitalizations/Surgeries	
☐	☐	Allergies to medications/foods	
☐	☐	Current Medications: doses and Frequency	
☐	☐	Visual loss (one or both eyes)	
☐	☐	Blindness	
☐	☐	Tuberculosis	
☐	☐	Difficulty hearing/hearing aides	
☐	☐	Deafness	
☐	☐	HIV	
☐	☐	Allergic rhinitis	
☐	☐	Hepatitis (type)	
☐	☐	Other liver disease (type)	
☐	☐	Diabetes (type)	
☐	☐	Carpal tunnel syndrome	
☐	☐	Other hand/wrist problems	
☐	☐	Back or neck injury	
☐	☐	Chronic back pain	

Preplacement Screening Patient Contact Form
UF Residency / Fellowship

Name: _____ **UFID#:** _____

Yes	No		If ***YES*** use as many lines below as needed to explain
☐	☐	Disc problems or sciatica	
☐	☐	Limited activities due to back or neck injury or pain	
☐	☐	Seizures	
☐	☐	Alcohol abuse/alcoholism	
☐	☐	Drug abuse/addiction	
☐	☐	Immunosuppression	
☐	☐	Latex allergy or other skin sensitivities	

Have you ever had a work-related illness or injury? Yes ___ No

If yes, explain: _____

Are you currently recovering from any significant illness or injury? Yes ___ No

If yes, explain: _____

Do you have any medical or psychological conditions that you feel may prevent you from completely and safely performing the duties outlined in your job description, or do you require/request any modifications to your job duties? Yes ___ No ___ If yes, explain: _____

_____

In working with patients you will have the potential for mutual exposures to blood borne pathogens and communicable diseases. You have an ethical and legal obligation to ***disclose any chronic communicable disease or blood borne pathogen infection****, such as HIV, Hepatitis C, or Hepatitis B, prior to placement. Failure to do so may be grounds for dismissal.*

Do you have a communicable disease or blood borne pathogen infection?

_____

Would you like to speak to a UF Student Health / Occupational Medicine clinician about any of the information you have given above? Yes ___ No ___ If yes, daytime phone (_____) _____

How may we contact you if we need more information?

E-mail address: _____ **Phone#:** _____

Mailing Address: _____

Other #s: _____

Signature: _____ Date: _____

Preplacement Screening Patient Contact Form

UNIVERSITY of FLORIDA

Name: Date of Birth: UF ID #:

Required Immunizations

Positive titer for immunity will substitue for shots on numbers 1 - 5. Titers must have labs attached.*

	Mo/Day/Year	Mo/Day/Year	Mo/Day/Year	Titer Date & Result*
1. **Measles** (2 doses after 1st birthday)			\\\\\\\\\\	
2. **Mumps** (2 doses after 1st birthday)			\\\\\\\\\\	
3. **Rubella** (2 doses after 1st birthday)			\\\\\\\\\\	
4. **Varicella** (Chicken Pox; 2 doses)			\\\\\\\\\\	
5. **Hepatitis B** (3 doses or positive titer)				
6. **Tdap** (adult booster from 2005 or later)		\\		

Required Tuberculosis Screening

Tuberculosis screening must be either: 2 negative TST's** (PPD's) or a negative Interferon Assay within 12 months prior to start date. BCG is not a substitute for a previous positive screening for TB. If there is a history of a prior positive TB screening result then see below.

PPD** #1 Skin Test (Tuberculosis Screening)	Date Placed	Date Read	MM	Neg or Pos
PPD** #2 Skin Test (Tuberculosis Screening)	Date Placed	Date Read	MM	Neg or Pos
Interferon-based Assay* (instead of PPD's)		Date	Result	

(OR)

If past positive PPD or positive Interferon Assay you must submit documentation: 1) the positive screening BCG is not a substitute for a previous positive screening for TB, 2) chest x-ray within 12 months prior to start date (record below), and 3) UF TB surveillance form.

Past positive PPD Skin Test	Date Placed	Date Read	MM	Neg or Pos
Interferon-based Assay* (attach copy of lab)		Date	Result	
CXR* (only if past positive PPD)		Date	Result	

*All titers, assays, and chest X-rays must have results attached

**TST's(PPD's) placements should be at least 7 days apart and cannot be placed within 28 after a live virus immunization like measles, mumps, rubella, or varicella. TST's(PPD's) should be read within 48 - 72 after placement.

Official Office Stamp Here	**Authorized Signature**	**Date**

An official stamp from a doctor's office, clinic, or health department AND an authorized signature must appear here or this form will not be approved. You may not be the authorized signator of your own form.

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