S & A UNIFIED HOME CARE, INC.

îóîõ }v Ç Ave. Brooklyn, N.Y. 112ñ Phone: (718)980-6100 Fax: (718)873-9311

DEAR S & A UNIFIED HOME CARE EMPLOYEE:

Please, be advised, that you need **to renew the annual medical examination** or you will be **SUSPENDED** from all work assignments (as per NYS Department of Health regulation) as S&A Unified employee. Please review the list of documents below you have to submit to S&A Unified Home Care %()25(H[SLUDW GDWH FRPHV

- 9 **Physical Exam (Signed by Employee & Physician)**
- 9 **PPD (or Chest X-Ray with TB Screen)**
- 9 **Drug Screen** RQO\ IRU +$ 3&$ **(Lab Report required!)**

If you have any questions, please call 0HGLFDO department **(718) 980-6100 ext.** Please mail it to us or fax it over to **(718)-873-9311** or send it through email: PHGLFDO**@saunified.com**

Por favor recuerdese que usted tiene que reaser su fisico antes, **si es que usted no lo tiene listo en la fecha endicada usted sera SUSPENDIDO(A) de su caso(s) hasta que recivimos su nuevo fisico**. Por favor, revise la lista de documentos abajo. Usted tiene que someterse a S&A Unified $17(6 GH IHFKD GH H[SLUDFLRQ. Ademas usted tiene que llenar completamente los formularios que nosotros mandamos a usted (es) y porfavor usted tiene que enviarlos a nosotros a nuestra oficina, si usted tiene preguntas porfavor llamanos al **(718) 980-6100 ext.**

- 9 **Examen Físico (Firmado por Empleado y Médico)**
- 9 **PPD (o Radiografía de tórax con pantalla TB)**
- 9 **Drug Screen** VROR SDUD +$ 3&$ **(Informe de laboratorio necesario!)**

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?keb m \Zk \hagbdeb \hijhku, h[jZlbI_kv \ HR Department gm **(718) 980-6100 добавочный** .J_amevIZlu h[ke_^h\Zgby \u fh`_I_ ijbkeZIv gZ beb ih nZdkm **(718)-873-9311** beb ih we_dljhgghc ihqI_ PHGLFDO#VDXQLILHG FRP

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- 9 **Медицинское обследование**
- 9 **PPD Тест (Манту/Рентген)**
- 9 **Тест на наркотики** Ihevdh ^ey ++$ 3&$ **(обязательно лабораторная распечатка!)**

请注意，根据公司系统显示，你下列的体检报告已经或即将到期，从收到信开始算必须在一个月内提供新的体检报告给S&A护理公司。

年度体检表（由员工和医生签名）

皮试（或X光报告和TB）

尿毒--亲人计划不需要

根据纽约卫生局规定，所有的家庭护理必须在文件齐全的前提下方可继续工作， 请尽快与你的家庭医生联系。如有任何问题欢迎致电人事部 718-980-6100 ext. 224.

请邮寄或传真以上文件到 718-873-9311 或发邮件到， cocow@saunified.com

S&A UNIFIED HOME CARE, INC.
2729 Coney Island Avenue, Brooklyn, NY 11235
Phone: (718) 980-6100 Fax: (718) 873-9311
Email: medical@saunified.com

ANNUAL PHYSICAL EXAMINATION FORM

NAME: ______________________ **DATE OF BIRTH:** ______________

I. PAST MEDICAL/PSYCHOLOGICAL HISTORY

Tuberculosis: ☐ No ☐ Yes
Diabetes: ☐ No ☐ Yes
Heart or Cardiovascular Disease: ☐ No ☐ Yes
Hypertension: ☐ No ☐ Yes
Cancer: ☐ No ☐ Yes
Kidney Disease: ☐ No ☐ Yes
Allergies (if yes, specify below): ☐ No ☐ Yes

Epilepsy or seizure disorder: ☐ No ☐ Yes
Drug alcohol abuse or addiction: ☐ No ☐ Yes
Psychiatric or Behavioral Disorder: ☐ No ☐ Yes
Other: ______________________

Are you now taking medicines? If so, for what?
____
____

II. MANDATORY VACCINES/IMMUNIZATION AND LAB TESTS (TO BE COMPLETED BY DOCTOR)

PPD (MANTOUX)
DATE GIVEN: ______________
DATE READ: ______________
RESULTS:
NEGATIVE: ______mm POSITIVE: ______mm

AND

DRUG SCREEN only for HHA/PCA (at least 9 drugs)
DATE DRAWN: ______________
RESULTS:
☐ NEGATIVE
☐ POSITIVE
Attach lab work report required!

❗ **IF POSITIVE, PROVIDE CHEST X-RAY RESULTS:** DATE ______________ RESULTS ______________

RUBELLA:
DATE: ______________
TITER: ______________
RESULTS:
☐ IMMUNE ☐ NOT IMMUNE

MMR BOOSTER (if needed):
DATE: ______________
LOT#: ______________
EXP.DATE: ______________

AND

if born after January 1, 1957:
RUBEOLA:
DATE: ______________
TITER: ______________
RESULTS:
☐ IMMUNE ☐ NOT IMMUNE

MMR BOOSTER (if needed):
I MMR DATE: ______________
LOT#: ______________
EXP.DATE: ______________
II MMR DATE: ______________
LOT#: ______________
EXP.DATE: ______________

Attach lab work report required!

III. FLU VACCINE:

DATE GIVEN: ______________ LOT #: ______________ EXP.DATE: ______________

IV. REVIEW OF SYSTEMS (TO BE COMPLETED BY DOCTOR)

HEAD/NECK: ______________
EENT: ______________
RESP: ______________
CARDIOVASC: ______________
ABD - GI: ______________
GU: ______________
MUSK - SKEL: ______________
NEURO: ______________
ENDOCRINE: ______________
SKIN: ______________
HEIGHT: ______________
WEIGHT: ______________

IV. DOCTOR:

I hereby certify that the above named patient does not have any limitations for employment in the health care field, and contact with patients and other staff. There is no health impairment present that is of potential risk to the employee, patient, family, or other employees, or that may interfere with the performance of his or her duties. I have questioned the patient and see nothing to contradict the patient's assertion that he or she is not habituated or addicted to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior.

PHYSICIAN'S SIGNATURE ______________________ **DATE:** ______________

DOCTOR'S NAME (PRINT): ______________________ PHYSICIAN'S LICENSE#: ______________

PLEASE USE
PHYSICIAN'S STAMP!

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TB SCREEN

Tuberculosis Questionnaire

Employee Name: ______________________ **Evaluation Date:** ______________

Since the employee has a history of a positive Tuberculosis Skin Test, Home Health Care Service Of NY requires an annual screening questionnaire is be completed by a physician. If the employee has experienced any of the following symptoms, a chest x-ray is indicated.

1. Chronic Cough ☐ YES ☐ NO
2. Fever ☐ YES ☐ NO
3. Night Sweat ☐ YES ☐ NO
4. Unexplained Weight Loss ☐ YES ☐ NO
5. Hemoptysis (coughing up blood) ☐ YES ☐ NO
6. Hoarseness ☐ YES ☐ NO
7. Wheezing ☐ YES ☐ NO
8. Shortness of Breath ☐ YES ☐ NO
9. Chest Pains ☐ YES ☐ NO

According to the Center for Disease Control & Prevention an initial chest x-ray needs to be completed for any person with a positive PPD-test, and pulmonary symptoms suggestive of TB. Although there are no data to support the use of a routine chest x-ray for persons whom are asymptomatic, more frequent monitoring of TB should be considered for those who are at increased risk for development of active TB.

S&A Unified Home Care requires a chest x-ray be completed and on file within 30 days of any newly reported positive PPD results, and every 10 years thereafter.

Physician/RN Name: ______________________ **Physician/RN Signature:** ______________

LICENSE #: ______________________ **Date of last Chest X-ray:** ______________

DOCTOR / RN Stamp below: ↓

Essentially, repeated chest x-ray of asymptomatic tuberculin reactors, whether or not they have completed preventative therapy, is no longer recommended. DOH publication (FDS) 83-82-4.
"CDC Personal Health Guideline" AJIC, June 1998, Volume26, p.318. Revised 12/8/2016.

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DECLINATION OF INFLUENZA VACCINATION 2021/2022
FOR HEALTH CARE PERSONNEL

Employee Name: ______________________ **Last 4 digits of SSN#:** ____________

I have been advised that I should receive the influenza vaccine to protect myself and the patients I serve. I have read the Centers for Disease Control and Prevention's (CDC) Vaccine Information Statement explaining the vaccine and the disease it prevents. I have had the opportunity to discuss the statement and have my questions answered by a healthcare provider. I am aware of the following facts:

- Influenza is a serious respiratory disease that kills thousands in the United States each year. Influenza vaccination is recommended for me and all other healthcare personnel to protect this facility's patients from influenza, its complications, and death.
- If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear.
- My shedding the virus can spread influenza to patients in this facility.
- If I become infected with influenza, I can spread severe illness to others even when my symptoms are mild or non-existent.
- I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't, my immunity declines over time. This is why vaccination against influenza is recommended each year.
- I understand that I cannot get influenza from the influenza vaccine.
- The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including all patients in this healthcare facility, coworkers, my family and my community.
- Because I have refused vaccination against influenza, I will be required to wear surgical or procedure masks in areas where patients or residents may be present during the influenza season.

Face Mask Provided:

Signature: ______________________ Date: ______________________

I acknowledge that I have read this document in its entirety and fully understand it. Despite these facts, I have decided to decline the influenza vaccine by my signature below. I realize that I may re-address this issue at any time and accept vaccination in the future.

Signature: ______________________ Date: ______________________

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HIV CONFIDENTIALITY

I ____ understand that while working as an Employee for S&A Unified Home Care, I may care for, have contact with, and/or have access to confidential records of HIV positive clients. I acknowledge that such clients may not be discriminated against and that information as to their HIV positive status is protected by New York State Law.

S&A Unified Home Care has advised me that New York State Law prohibits me from making any further disclosure of such confidential information without the specific written concern of the person to whom it pertains (or of their legal guardian, Designated Representative, or by a Court order), or as otherwise permitted by law, and that any unauthorized further disclosure in violation of state law may result in fine, jail sentence or both.

I understand that a general authorization for the release of medical and or other information is not sufficient authorization for further disclosure of such information pursuant to a general authorization for the release of medical or their information violates New York State Law and may result in a fine, jail sentence or both.

I understand that failure to comply with the foregoing violates both New York State Law and S&A Unified Home Care policy and such failure shall be just cause for immediate termination. I further understand that any breach of confidentiality of HIV positive client records in punishable by fine and or imprisonment.

DRUG TESTING POLICY

As part of your application process or during the course of your employment with S&A Unified Home Care, Inc., as requires by law, you may be subject to drug and/or alcohol testing. You have the right to decline to complete any test required. However, refusal to comply with these test requirements will result in immediate termination of your employment with S&A Unified Home Care, Inc. Furthermore, applicants who attempt to alter their test results in any way will no longer be considered for employment. Current employees who attempt to alter their test results will be terminated at once.

I, ______________________________________, do hereby declare that I am free from illegal drugs and improper use of prescription drugs or alcohol. I acknowledge that a positive test result will constitute cause for denial or termination of employment at S&A Unified Home Care, Inc. I understand what I am being tested for and the procedure involved, and I do hereby freely give my consent.

I understand, agree and will comply with S&A Unified Home Care HIV Confidentiality and Drug Testing Policy

Signature: ______________________________ Date: ________________________

RN Signature: ___________________________ Date: ________________________

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HEPATITIS B VACCINE CONSENT/DECLINATION

Employee Full Name: ______________________________

I acknowledge that I am at risk of exposure or have been unknowingly exposed to the Hepatitis B virus as a result of my employment and acknowledge that the agency will arrange for me to receive the Hepatitis B vaccine. I have read the information sheet concerning the disease, the vaccine and possible adverse reactions to the inoculation. Additionally, I have asked any questions which I may have had and they have been fully answered to my satisfaction. I hereby make the decision to:

☐ **Refuse the Hepatitis B vaccine** and hold harmless the agency. I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring the Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with the Hepatitis B vaccine, at no charge to myself. However, I decline the Hepatitis B vaccination at this time. I understand that by declining the 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 potentially infectious materials and want to be vaccinated with the Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

☐ I'm immune and able to provide proof by request

☐ I have a medical contraindication and able to provide proof by request

☐ I request to receive the Hepatitis B vaccine.

______________________________ ______________________________
Signature Date

______________________________ ______________________________
RN Signature Date