MUSC Health
Medical University of South Carolina

Employee Health Services
57 Bee Street, Charleston, SC 29407
Email: ehs1@musc.edu

Offsite Clearance Process and Instructions:

You have indicated that you will be completing all necessary requirements for the health clearance portion of your onboarding process, off-site.

Please note: by choosing this option you will need to coordinate all required components and cover any related expenses for the exam and screenings. This will be at your expense and not reimbursed by MUSC Health.

In order to receive a medical clearance from MUSC Employee Health Services (EHS), all sections included in the attached packet must be completed prior to sending. If you don't have a Primary Care Provider to perform and/or order the required screenings and testing, you can utilize an urgent care or walk-in facility.

All components included in this packet need to be completed fully and sent to MUSC EHS in one email with all supporting records. Once all requirements have been met, MUSC EHS will review and provide a report of medical clearance to the HR team. In order to expedite the clearance and avoid delays, please be sure to send one email with all necessary documentation listed above to MUSC EHS at ehs1@musc.edu

This message contains a great amount of detail, but we want this process to be as seamless as possible for you and avoid any potential delays in your start date. If you have questions, please reach out to onboarding specialist.

Use the below checklist of onboarding requirements for easy tracking.

- ☐ **Section A: Vitals**
  - Completed by applicant.
- ☐ **Section B: Vision Screen**
  - Completed by provider or send records of testing within one year.
- ☐ **Section C: Color blind testing**
  - Completed by applicant.
- ☐ **Section D: TB Screening and TB Blood Test**
  - Only Tspot or QuantiFERON blood test accepted. Will need to attach copy of result.
- ☐ **Section E: Urine Drug Screen**
  - This is at the expense of the incoming care team member. See appropriate section for details.
- ☐ **Section F: Accommodations**
  - Completed by applicant.
- ☐ **Section G: Immunization form**
  - Completed and signed by provider or applicant provides proof of each requirement.
- ☐ **Section H: Medical History Form**
  - Completed by applicant.
- ☐ **Section I: OSHA Form**
  - Completed by applicant.

Once all of the above are completed, the packet is ready to be sent to ehs1@musc.edu.

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First Name: _____ **Last Name:** _____ **Date of Birth:** _____

Please Note: All sections of this form are required

Section A – Vitals

Vitals: BP_____HR_____Height_____Weight _____

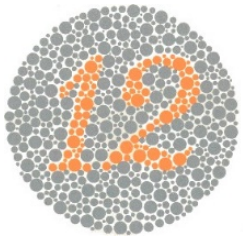
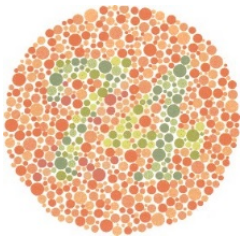
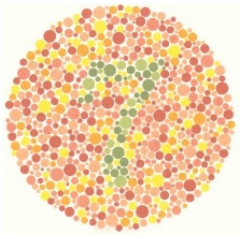
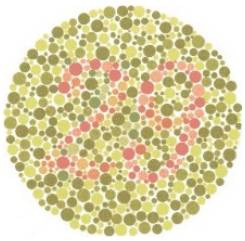
Section B – Vision Screening

(if you have had a vision screen in the last year, complete this section and attach records)

	Left Eye	Right Eye	Both Eyes
Near			
Far			
Corrected ❑		Uncorrected ❑	

Section C – Color Blind Testing

Please provide an answer to what you see in each image below: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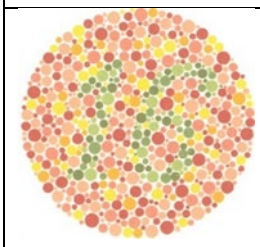	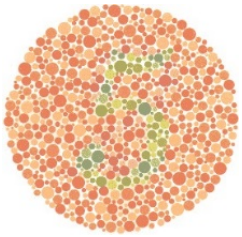	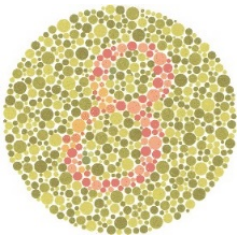	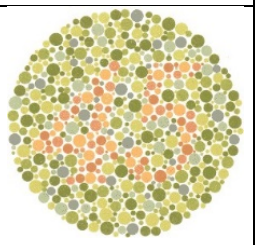
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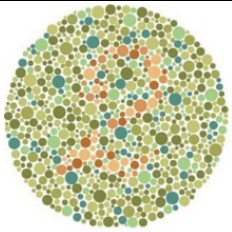			
Answer:	**Answer:**	**Answer:**	

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Section D – Screening for Tuberculosis (TB)

(SC Department of Health and Environmental Control requirement)

Have they ever tested positive for TB?	❑ No	❑ Yes
Have they ever been treated for latent TB?	❑ No	❑ Yes TreatmentDates: _____
Have they been in contact with someone with known TB since your last TB test?	❑ No	❑ Yes
Have they lived outside the USA for >/= one month?	❑ No	❑ Yes
Have they had the BCG vaccine? (typically given outside the USA)	❑ No	❑ Yes
Have they had a live vaccine in the past 30 days?	❑ No	❑ Yes
Are they currently immunosuppressed?	❑ No	❑ Yes
Do they have any of the following symptoms that are unrelated to a current diagnosis or illness? • Cough > three weeks • Weakness • Chronic pain with breathing • Coughing up blood • Unexplained night sweats/chills • Loss of appetite • Low grade fever for > one week	❑ No	❑ Yes Please explain:

Serum Blood Testing for TB (no skin tests accepted)

- Must be done within 90 days prior to start date
- Can be either QuantiFERON Gold or T-Spot and a copy of results must be sent with this packet

Please note: If you have a positive result, copies of the chest x-ray performed after the date of the positive result must be attached.

Section E – 10 Panel Urine Drug Screen

You will need to attach the results of a negative 10 panel urine drug screen for employment purposes. If you take prescription drugs, you need to verify the location performing the drug screen has a Medical Review Officer to review your results and prescriptions and make the determination. Positive drug screen results with copies of prescriptions will not be accepted.

Section F – Accommodations

Do you have a latex allergy? ❑ No ❑ YES

Are you in need of or are you requesting any reasonable accommodations in order to perform your role safely? ❑ No ❑ YES

Please comment on all abnormal findings and/or accommodations needed:

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Name_____
(Last) (First) (M)

Date of Birth___/___/____

Section G - Immunization Records

Option 1: Submit this form (must be signed by a licensed healthcare provider).

OR

Option 2: Submit copies of original records in lieu of this form. Must have proof of each requirement listed below and must be submitted in one email with rest of offsite packet.

Measles, Mumps and Rubella (MMR)					
Date of Positive Rubeola IgG	Date of Positive Rubella IgG	Date of Positive Mumps IgG	OR	Date of Vaccine #1	Date of Vaccine #2

Hepatitis B				
Date of Positive Hep B IgG	OR	Date of Vaccine #1	Date of Vaccine #2	Date of Vaccine #3

Varicella (Chicken Pox)			
Date of Positive Varicella IgG Titer	OR	Date of Vaccine #1	Date of Vaccine #2

Tdap – Required to be given after the age 16 and within the past 10 years	
Date of Vaccine	

Influenza – Required during flu season (August 1st-April 30th)	
Date of Vaccine	

COVID – Primary series required (Pfizer, Moderna, Novavax, Janssen)	
Date of Vaccine #1	Date of Vaccine #2

Medical or religious exemptions are reviewed on a case by case basis, please email Employee Health if an exemption is being requested.

I attest that I have reviewed this candidate's immunization records and the dates above are accurately reflected.

Signature of Licensed Health Care Provider: _____

MUSC Health
MEDICAL UNIVERSITY of SOUTH CAROLINA

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OCCUPATIONAL HEALTH MEDICAL HISTORY QUESTIONNAIRE

(For applicants who have received conditional offers of employment)

Version: **Version Date:**

Name _____

Date of Birth _____

Phone Number _____

To the Applicant: You have been made an offer of employment, conditional on the successful completion and passing of the pre-employment screening and medical exam. The purpose of this exam is:

- ❑ To determine whether you currently have the physical and mental qualifications necessary to perform the job that has been offered without posing a threat to the health and/or safety of yourself or others;
- ❑ To determine if any reasonable accommodations may be necessary
- ❑ To establish baseline data for medical surveillance for specific occupational exposures (examples: tuberculosis, HepatitisB);
- ❑ To ensure compliance with OSHA standards.

This information is kept in a separate medical file with access limited to Employee Health staff and is protected by Federal and State law.

Position applied for:_____Start Date:_____Supervisor: _____

Section A: General Information

- ❑ Do you currently have a contagious disease or infection that would pose a significant risk of transmission to others and that cannot be accommodated by postponing your employment start date? □ Yes □ No

If yes, please explain: _____

- ❑ Have you ever been tested for tuberculosis? □ Yes □ No

If yes, what was the date of your last PPD skin test, blood test (Quantiferon/T-Spot)?: _____

- ❑ Do you have any physical or mental disabilities that would prevent you from performing the essential functions of the job you have been offered? □ Yes □ No

If yes, please explain: _____

- ❑ Do you require any accommodations to physical or mental disabilities in order to perform the essential functions of the job you have been offered?

If yes, please explain: _____

- ❑ Do you currently have any sensitivity to chemicals or materials typically found in a hospital environment (i.e., latex, formaldehyde, radiation, etc.)? □ Yes □ No

If yes, please explain and list any reasonable accommodations needed: _____

_____

Section B: Drug Use

- ❑ Do you currently use any illegal drugs or controlled substances? □ Yes □ No
- ❑ Do you currently abuse any legally prescribed drugs or controlled substances? □ Yes □ No
- ❑ Do you currently take any legally prescribed drugs or controlled substances that may affect your ability to perform the essential functions of the job you have been offered? □ Yes □ No

If yes to any of the above questions, please explain: _____

_____

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OCCUPATIONAL HEALTH MEDICAL HISTORY QUESTIONNAIRE
(For applicants who have received conditional offers of employment)

Version: **Version Date:**

Name _____

Date of Birth _____

Phone Number _____

Section C: Applicable Functional Limitations

Please check below regarding any limitations related to the following?

Activity	No Limitation	Yes, limitation – please explain restriction in detail
Lifting, bending or carrying		
Standing, sitting or stooping		
Reaching, pushing or climbing		
Walking or crawling		
Grasping, twisting or turning		
Vision or hearing		
Driving		
Operating machinery		
Working at heights		

Have you ever:	Yes	No	If Yes, please explain
Had any medical problems			
Had any operations			
Had any allergies			
Experienced claustrophobia			
Smoked or used tobacco products			

Have you ever had any of the following?

Condition	Yes	No	Condition	Yes	No
Frequent/severe headaches			Hernias		
Vision Problems			Head injury		
Eye Injuries or defects			Dizzy or fainting spells		
Color Blindness			Epilepsy/seizures/convulsions		
Hearing difficulties			Paralysis		
Ear abnormalities			Coordination problems		
Frequent of chronic cough			Balance problems		
Asthma			Neck injury or pain		
Bronchitis			Pain moving arms/legs		
Pneumonia			Back injury or pain		
Tuberculosis			Other neck/back problems		
Other lung disease			Arthritis		
Shortness of breath			Joint swelling or stiffness		
Chest pain			Hand or foot numbness		
Heart palpitations/pounding			Tendonitis		
Heart disease			Pain moving foot or ankle		
Heart attack if yes, when: _____			Foot problems		
Heart murmurs			Skin rash or eczema		
High blood pressure			Allergies/Hay fever		

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

Employee Health Services
57 Bee Street
Charleston, SC 29425
Telephone: (843) 792-2991 email: ehs1@musc.edu

OSHA Respirator Medical Evaluation Questionnaire

Section 1910.134, Appendix C (Mandatory)

Today's date:_____ Name:_____ Dept/Position:_____

Height:_____ft._____in. Weight:_____lbs. Birthdate:_____ Age (to nearest year):_____ Sex (circle one): Male / Female

Phone number where you can be reached by the health care professional who reviews this questionnaire (include Area Code): _____

The best time to phone you at this number:_____

Has your department told you how to contact the health care professional who will review this questionnaire? (circle one): Yes / No

Check the type of respirator you will use (you can check more than one category):

❑ N, R, or P disposable respirator (filter-mask, non-cartridge type only).

❑ Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

Have you worn a respirator? (circle one): Yes / No If "yes," what type(s):_____

YES/	NO	
		1. Do you **currently** smoke tobacco, or have you smoked tobacco in the last month?
		2. Have you **ever had** any of the following conditions?
		a. Seizures (fits)
		b. Diabetes (sugar disease)
		c. Allergic reactions that interfere with your breathing
		d. Claustrophobia (fear of closed-in places)
		e. Trouble smelling odors
		3. Have you **ever had** any of the following pulmonary or lung problems?
		a. Asbestosis
		b. Asthma
		c. Chronic bronchitis
		d. Emphysema
		e. Pneumonia
		f. Tuberculosis
		g. Silicosis
		h. Pneumothorax (collapsed lung)
		i. Lung cancer
		j. Broken ribs
		k. Any chest injuries or surgeries
		l. Any other lung problem that you've been told about
		4. Do you **currently** have any of the following symptoms of pulmonary or lung illness?
		a. Shortness of breath
		b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline
		c. Shortness of breath when walking with other people at an ordinary pace on level ground
		d. Have to stop for breath when walking at your own pace on level ground
		e. Shortness of breath when washing or dressing yourself
		f. Shortness of breath that interferes with your job
		g. Coughing that produces phlegm (thick sputum)
		h. Coughing that wakes you early in the morning
		i. Coughing that occurs mostly when you are lying down
		j. Coughing up blood in the last month
		k. Wheezing
		l. Wheezing that interferes with your job
		m. Chest pain when you breathe deeply

YES/	NO	
		n. Any other symptoms that you think may be related to lung problems
		5. Have you **ever had** any of the following cardiovascular or heart problems?
		a. Heart attack
		b. Stroke
		c. Angina
		d. Heart failure
		e. Swelling in your legs or feet (not caused by walking)
		f. Heart arrhythmia (heart beating irregularly)
		g. High blood pressure
		h. Any other heart problem that you've been told about
		6. Have you **ever had** any of the following cardiovascular or heart symptoms?
		a. Frequent pain or tightness in your chest
		b. Pain or tightness in your chest during physical activity
		c. Pain or tightness in your chest that interferes with your job
		d. In the past two years, have you noticed your heart skipping or missing a beat
		e. Heartburn or indigestion that is not related to eating
		f. Any other symptoms that you think may be related to heart or circulation problems
		7. Do you **currently** take medication for any of the following problems?
		a. Breathing or lung problems
		b. Heart trouble
		c. Blood pressure
		d. Seizures (fits)
		8. If you've used a respirator, have you **ever had** any of the following problems? (If you've never used a respirator, check the following space and go to question 9)
		a. Eye irritation
		b. Skin allergies or rashes
		c. Anxiety
		d. General weakness or fatigue
		e. Any other problem that interferes with your use of a respirator
		9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?

MUSC Employee Health Services will review your responses and may contact you if any follow up questions or a clinic appointment is necessary to determine your medical clearance for fit testing. You will receive an email in return providing you with the medical clearance to provide to the person completing your fit test.

I certify the above information is correct: _____ **Date:** _____