RETURN COMPLETE FORM BEFORE DUE DATE:_____

S & A UNIFIED HOME CARE, INC.
2729 Coney Island Ave, Brooklyn, N.Y. 11235
Phone: (718) 980-6100 Fax: (718) 873-9311

ATTENTION 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 **BEFORE** expiration date comes.

- ✓ Physical Exam (Signed by Physician)
- ✓ TB screen questionnaire (PPD needed if "**YES**" replied to any questions)
- ✓ Drug Screen - only for **HHA/PCA (LAB REPORT REQUIRED!)**

If you have any questions, please call Medical department at **(718) 980-6100 ext. 255, 257 ,267.** Please mail it to us or fax it over to **(718)-873-9311** or send it by email: **medical@saunified.com**

Tenga en cuenta que debe **renovar el examen médico anual** o será **SUSPENDIDO** de todas las asignaciones de trabajo (según la regulación del Departamento de Salud del Estado de Nueva York) como empleado de S&A Unified. Revise la lista de documentos a continuación que debe enviar a S&A Unified Home Care **ANTES** de que llegue la fecha de vencimiento.

- ✓ Examen Físico (Firmado por Médico)
- ✓ Cuestionario de detección de TB (PPD necesario si respondió "**SÍ**" a alguna pregunta del TB)
- ✓ Detección de drogas: solo para HHA/PCA (¡SE REQUIERE INFORME DE LABORATORIO!)

Si tiene alguna pregunta, llame al departamento médico al **(718) 980-6100 ext.255.** Por favor envienos ya sea por fax **(718)-873-9311** o por correo electrónico: **medical@saunified.com**

Пожалуйста обратите внимание что вам требуется пройти ежегодный медицинский осмотр у врача и сдать необходиние анализы **ДО ИСТИЧЕНИЯ** срока действия вашей предыдущей медицины. В ином случае, вы будете **ОТСТРАНЕНЫ** от вашей работы в нашем офисе как хоматенд.

Список необходимых документов:

- ✓ Медицинское обследование
- ✓ ТВ Анкета (PPD Тест (Манту/Рентген) нужен в случае положительных ответов)
- ✓ Тест на наркотики- только для **HHA/PCA (ОБЯЗАТЕЛЬНО ЛАБОРАТОРНАЯ РАСПЕЧАТКА!)**

Если у вас возникли вопросы, пожалуйста, обратитесь в HR по телефону **(718) 980-6100 добавочный 257, 267, 255.** Результаты обследования вы можете прислать нам по почте или по факсу **(718) 873-9311** или по электронной почте: **medical@saunified.com**

请注意，您的**年度体检需要续期更新**，否则您将被**暂停**作为 S&A Unified 员工的所有工作任务（根据纽约州卫生部法规）. 请您必须在**到期前**完成并提交以下的文件给 S&A Unified Home Care.

- ✓ 年度体检表（医生签名）
- ✓ 结核病筛查问卷（如果其中一个问题的回答为"**是**"，则需要 PPD 皮试）
- ✓ 尿毒 - **仅适用于 HHA/PCA（需要化验报告！）**

如果您有任何疑问，请致电医疗部门 **(718) 980-6100** 分机：**224**。请邮寄或传真新的体检表格及报告至**(718)-873-9311**，或发送电子邮件至：**medical@saunified.com.**

الى جميع العاملين فى شركتناA&S تنوية هام اذا تم ارسال تجديد للفحوصات الطبية التى يتم تجديده كل عام ولم يتم تقديم الفحوصات فى الموعد المقرر لها سوف يتم رجوعك الى العمل بعد الانتهاء من جميع الفحوصات نرجو الالتزام بذلك
وذلك تبعا للقانون التى اقرته وزارة الصحه العامة فى نيوريوك
الفحوصات نرجو الالتزام بذلك
وذلك تبعا للقانون التى اقرته وزارة الصحه العامة فى نيوريوك
اذا كان لديك اى استفسار يمكنك الاتصال على مكتبنا
718-980-6100
او ارسال الفحوصات على الايمل الخاص
Medical@saunified.com

ANNUAL PHYSICAL EXAMINATION FORM

S&A UNIFIED HOME CARE, INC.
Phone: (718) 980-6100; Fax: **(718) 873-9311**;
Email: **medical@saunified.com**

EMPLOYEE NAME:_____ **DOB:** _____

I. HEALTH SCREEN (MEDICAL / PSYCHOLOGICAL HISTORY)

☐ YES	☐ NO	CANCER	☐ YES	☐ NO	DRUG ALCOHOL ABUSE/ADDICTION
☐ YES	☐ NO	DIABETES	☐ YES	☐ NO	EPILEPSY/SEIZURE DISORDER
☐ YES	☐ NO	HEART/CARDIOVASCULAR DISEASE	☐ YES	☐ NO	PSYCHIATRIC/BEHAVIORAL DISORDER
☐ YES	☐ NO	HYPERTENSION	☐ YES	☐ NO	OTHER:_____
☐ YES	☐ NO	KIDNEY DISEASE	☐ YES	☐ NO	ARE ANY MEDICINES TAKEN?
☐ YES	☐ NO	TUBERCULOSIS	☐ YES	☐ NO	IF SO, FOR WHAT?_____
☐ YES	☐ NO	ALLERGIES (IF YES, SPECIFY)_____			

II. MANDATORY VACCINES / IMMUNIZATION AND LAB TESTS (To be Completed by Doctor)

RUBELLA	DATE:_____	☐ IMMUNE	☐ NON-IMMUNE	TITER:_____
RUBEOLA (born after Jan 1, 1957) **attached lab report is required!**	DATE:_____	☐ IMMUNE	☐ NON-IMMUNE	TITER:_____
I MMR vaccine	DATE:_____	LOT:_____		EXP.DATE_____
II MMR vaccine	DATE:_____	LOT:_____		EXP.DATE_____
FLU VACCINE	DATE:_____	LOT:_____		EXP.DATE_____

DRUG SCREEN (PCA/HHA only): DATE:_____ ☐ NEGATIVE ☐ POSITIVE
AT LEAST 8 DRUGS ❗ **ATTACHED LAB REPORT IS REQUIRED** ❗

III. REVIEW OF SYSTEMS (To be Completed by Doctor)

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

IV. TB SCREEN (Tuberculosis Questionnaire)

☐ YES	☐ NO	CHEST PAIN	☐ YES	☐ NO	FATIGUE
☐ YES	☐ NO	CHRONIC COUGH	☐ YES	☐ NO	FEVER
☐ YES	☐ NO	HEMOPTYSIS (COUGHING UP BLOOD)	☐ YES	☐ NO	LACK OF APPETITE
☐ YES	☐ NO	HOARSENESS	☐ YES	☐ NO	NIGHT SWEAT
☐ YES	☐ NO	SHORTNESS OF BREATH	☐ YES	☐ NO	YELLOW OR DARK SPUTUM
☐ YES	☐ NO	UNEXPLAINED WEIGHT LOSS	☐ YES	☐ NO	WHEEZING

History of temporary or permanent residence for more than one month in a country with a high rate of TB within the past 12 months (i.e. any country other than Australia, Canada, New Zeland, the United States, and those in western or northen Europe)	☐ YES ☐ NO
Current or planned immunosuppression, including HIV infection, receipt of an organ transplant, treatment with an TNF-alpha antagonist or other immunosuppressive medication.	☐ YES ☐ NO
Have you been exposed to or treated for Tuberculosis since last physical exam?	☐ YES ☐ NO

NOTE: If the answer is "**YES**" to any questions above, a follow-up TB Screening (i.e., PPD, QuantiFERON, or Chest X-Ray) is required.

PPD (Quantiferon): DATE GIVEN:_____ DATE READ:_____ ☐ NEGATIVE_____mm ☐ POSITIVE_____mm
If POSITIVE, provide **CHEST X-RAY** results: DATE:_____ RESULT:_____

V. DOCTOR

☐ This individual is free from any health impairment that is a potential risk to the patient or other employees or which may interfere with the performance of his/her duties including habituated or addicted to any depressants, stimulants, narcotics, drugs, alcohol or other substances that may alter behavior.
☐ This individual is able to work with the following limitations:_____
☐ This individual is not physically/mentally able to work (specify reason):_____

Physician's Name: _____
Physician's Signature: _____
License # **Date:**

Office Stamp!

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DECLINATION OF INFLUENZA VACCINATION

Employee Full Name:_____ DOB: _____

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 of Employee: _____ Date: _____

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HIV[1] CONFEDENTIALITY

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.

Employee Signature:_____ Date: _____

RN Signature:_____ Date: _____

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HEPATITIS B VACCINE
CONSENT/DECLINATION FORM

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.

Employee Signature:_____ Date: _____

RN Signature:_____ Date: _____