MultiCare

Employee Health Services

CONFIDENTIAL EMPLOYEE HEALTH EVALUATION

Please fill in (print) areas below:

NAME: _____ BIRTHDATE: _____

SSN: _____ Start Date (Orientation): _____

Department: _____ Position: _____

The information you provide on this form will be reviewed by the Employee Health Department. The information you provide will be treated as confidential and will only be released as required or permitted by law. It is important that your answers be complete and accurate.

Please explain any "yes" answers.

Per MHS policy, "Employees taking prescribed controlled substances must review with their health care provider, whether use will affect ability to perform the essential functions of the job."

List all currently prescribed medications and over-the-counter and herbal medications, as well as any dietary supplements that may cause drowsiness.

_____ _____

_____ _____

_____ _____

_____ _____

MHS has a responsibility to ensure that every employee is safe and capable of performing the work of their hired position.

Do you have any health problems that require accommodations or that could influence your ability to perform your job? ❑ No ❑ Yes _____

Have you been told by a physician to limit or restrict your work activities because of exposure to noise, chemicals, or radiation? ❑ No ❑ Yes _____

_____

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Do you have any restrictions and/or limitations, permanent or temporary, to your mobility or dexterity due to any physical or mental condition? ❑ No ❑ Yes

(If "yes" please describe each body part and/or limitation involved and whether it is permanent or temporary):

_____

_____

_____

_____

_____

Have you ever made a claim for a job related injury or illness? ❑ No ❑ Yes

(If "yes", provide claim numbers and what body part was involved): _____

_____

_____

Is this claim still open? ❑ No ❑ Yes _____

Have you lost time from work or received a disability award for a previous job related injury or illness? ❑ No ❑ Yes _____

_____

Do you have a Preferred Worker Card? ❑ No ❑ Yes (If "yes", please provide a copy of the completed form.)

Have you ever required any modifications in order to function in your job? ❑ No ❑ Yes

_____

_____

STATEMENT

I have read the above information and understand the questions. The answers given by me are true and correct to the best of my knowledge. I give the Employee Health Department permission to verify my vaccine history in the Washington State Immunization database.

_____ _____

Signature Date

EHS Staff Use Only **EHS Staff Use Only** **EHS Staff Use Only**

NEW HIRE EXAM DETAILS

WA IIS Database review	❑ Complete			
Respirator Clearance	❑ NA	❑ Pass	❑ Fail	
Color Vision	❑ NA	❑ Pass	❑ Fail →	Notice to Supervisor & POCT sent
Hearing Test Required	❑ No	❑ Yes →	Reminder to Supervisor sent	

Medical Clearance required for _____

Due back by _____

Venipuncture: _____

Signature _____ Date _____