

October 12, 2009

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 University of Florida's Student Health Care Center, 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 insure that you can safely perform the essential functions of your new job. Please make sure you print your name and UFID # legibly on each page.

Please complete the Preplacement Screening Patient Contact Forms (<http://www.ehs.ufl.edu/OCCMED/resident.htm>) and return them to UF's SHCC in the attached self-addressed envelope by May 1st.

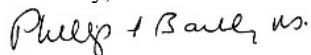
- **Section I: Medical History** includes completing questions on page 1-2. Please complete the box on page 2 about how we can contact you if more information is needed prior to beginning your Residency/Fellowship Program.
- **Section II: Immunization History** must be completed and signed by a physician 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 University's Preplacement Screening and Medical Monitoring Programs for Medical and Dental Residents/Fellows, please feel free to contact Mike Wuerz at (352) 392-0627 or by e-mail to wuerz@ufl.edu. Once again, welcome to the University of Florida.

Sincerely,



Phillip Barkley, M.D.
Director, Student Health Care Center
Clinical Associate Professor and Director, Department of Community Health and Family Medicine
PLB/cbh



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Resident/Fellow Clearance Program
UF, Student Health Care Center
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2010 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)

SS#: _____ **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
<input type="checkbox"/>	<input type="checkbox"/>	Hospitalizations/Surgeries	_____
<input type="checkbox"/>	<input type="checkbox"/>	Allergies to medications/foods	_____
<input type="checkbox"/>	<input type="checkbox"/>	Current Medications: doses and Frequency	_____
<input type="checkbox"/>	<input type="checkbox"/>	Visual loss (one or both eyes)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Blindness	_____
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty hearing/hearing aides	_____
<input type="checkbox"/>	<input type="checkbox"/>	Deafness	_____
<input type="checkbox"/>	<input type="checkbox"/>	Allergic rhinitis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (type)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other liver disease (type)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (type)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Carpal tunnel syndrome	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other hand/wrist problems	_____
<input type="checkbox"/>	<input type="checkbox"/>	Back or neck injury	_____
<input type="checkbox"/>	<input type="checkbox"/>	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
<input type="checkbox"/>	<input type="checkbox"/>	Disc problems or sciatica	_____
<input type="checkbox"/>	<input type="checkbox"/>	Limited activities due to back or neck injury or pain	_____
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	_____
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol abuse/alcoholism	_____
<input type="checkbox"/>	<input type="checkbox"/>	Drug abuse/addiction	_____
<input type="checkbox"/>	<input type="checkbox"/>	Immunosuppression	_____
<input type="checkbox"/>	<input type="checkbox"/>	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: _____

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: _____

