



New Employee Health Screening



Name: _____
 HCN: _____
 Date of Birth: _____
 Employee Number: _____

LAST NAME	FIRST NAME	MIDDLE INITIAL
ADDRESS		
CITY/TOWN		POSTAL CODE
PHONE		EMAIL ADDRESS
DEPARTMENT/PROGRAM		JOB TITLE
FAMILY PHYSICIAN		PHYSICIAN PHONE #
AREA OF REGION: <input type="checkbox"/> City Hospitals <input type="checkbox"/> Health & Comm. Services (St. John's) <input type="checkbox"/> Long Term Care (St. John's) <input type="checkbox"/> Rural Avalon <input type="checkbox"/> Bonavista <input type="checkbox"/> Burin <input type="checkbox"/> Clarendville		

Health Information	
Allergies (eg. medication, food, latex, environmental, or other):	Yes <input type="checkbox"/> No <input type="checkbox"/>
If YES, please list: _____	
If YES, have you had allergy testing completed? _____	

Do you have any concerns regarding your ability to safely perform your job? Yes No

Do you have any restrictions that require accommodation in the workplace? Yes No

Please forward completed form to occhealth@easternhealth.ca

Employee Declaration		
I certify that all statements on this New Employee Health Screening Form are true and complete to the best of my knowledge.		
_____ Employee's PRINTED Name	_____ Employee's Signature	_____ Date

Eastern Health acknowledges and respects the privacy of individuals. This personal information is being collected under the authority of Sections 61 of the [Access To Information and Protection of Privacy Act](#), and will be used to assist in determining your fitness for work with Eastern Health. Please direct any questions about this collection to: Eastern Health Information Security & Privacy Office, Mt. Pearl Square, 709-777-8025.