Eastern Health
Occupational Health

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: ❑ City Hospitals ❑ Health & Comm. Services (St. John's) ❑ Long Term Care (St. John's)
❑ Rural Avalon ❑ Bonavista ❑ Burin ❑ Clarenville

Health Information

Allergies (eg. medication, food, latex, environmental, or other): Yes ❑ No ❑

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	DD/MONTH/YYYY 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.