NEWTON-WELLESLEY HOSPITAL

OCCUPATIONAL HEALTH SERVICES
2014 Washington Street
Newton, MA 02462
tel. 617-243-6168
fax 617-243-6143

Welcome to Newton-Wellesley Hospital (NWH)! NWH requires each new hire to complete a pre-placement health screening through Occupational Health Services (OHS) before your Hospital Orientation. Please call OHS at 617-243-6168 at least 2 weeks prior to your orientation to schedule this appointment.

For your pre-placement health screening, you will need to complete the attached screening form as well as provide documentation of the immunizations listed below.

Bringing this documentation and history will help expedite the employee health screening process. If you are unable to provide this written documentation during your employee health screening, you will need to be re-vaccinated and/or have blood work drawn as part of your screening. You will not receive your OHS clearance to start your job until you have completed the health screening requirements.

Your vaccine record or lab results of immunity may be obtained from:

- Your Primary Care office
- Your School Health office
- Your former Employee Health or Occupational Health
- Massachusetts Immunization Information System (MIIS)

The following information is required for all new employees of NWH:

__ Documentation of one ***tuberculosis (TB)*** skin test (within the past three months) OR if you have a history of a past positive skin test, written documentation of your last skin test result and chest x-ray evaluation report. *Some job positions require a two step TB skin test as part of the pre-placement health screening. *TB screening may be performed at your pre-placement health screening. Please be aware that TB skin tests planted in OHS require reading of the test in 48-72 hours.*

__ Documentation of two ***Measles, Mumps, and Rubella (MMR)*** vaccines OR written documentation of blood test/titer for measles (Rubeola), mumps, AND German measles (Rubella).

__ Documentation of two ***Varicella (chicken pox)*** vaccines OR written documentation of blood test/titer for varicella. If you were not vaccinated and you had the disease, please disclose this during your appointment.

The following information may also be reviewed during your OHS appointment:

__ If providing patient care or assigned to a job with the potential for being exposed to blood or body fluids, documentation of ***Hepatitis B Vaccination*** and a ***Hepatitis B antibody titer***.

__ If providing patient care or assigned to a job with the potential for blunt or sharp injury, last ***Tetanus (Tdap or Td)*** vaccination.

__ Last ***influenza*** vaccination

Occupational Health Services

Pre-Placement Screening Form	**Today Date:**
Name:	Date of Birth:
Phone:	Position Applied For:
Orientation Date:	Hiring Manager:

Medications: Please list any medication you are taking (including over-the-counter). Please use back of form if needed.

Medication Yes No	Dose	Reason for Use

Allergies: Please list any allergies you have and explain any reaction(s):

	Check		Reaction	Comments
Allergies	Yes	No		
Medicines				
Chemicals				
Latex				
Other				

Occupational Exposures: Please indicate below if you may be working with the following:

Blood/Body Fluid		Lasers		Chemicals	
Loud Noise		Biological Agents		Other	
Previous work injury or exposure?	Yes	No	Describe:		

Special Accommodations: If needed there is additional room on back

A. Do you have any health condition(s) that may interfere with your ability to perform your job duties in a healthy and safe manner? Explain:
B. Have you have past surgeries, broken bones, or serious MVAs? Explain:
C. Have you ever been told to restrict your physical activity at work? Explain:
D. Will you require any special equipment or assistive devices to perform your job? Explain:
E. Do you currently smoke? Yes No # of pks/day/wk # of years Quit Date:

Office Use Only

Ishihara	
Review:	
BBP prevention and reporting procedure	Smoking cessation program
Back Care and safe patient handling	Ergonomics

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

►**START HERE:** **Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.**

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	**OR**	**List B** Identity	**AND**	**List C** Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date*(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			**B.** Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any)* *(mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** Native American tribal document
		6. Military dependent's ID card		**6.** U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		8. Native American tribal document		**8.** Employment authorization document issued by the Department of Homeland Security
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Examples of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

NEWTON-WELLESLEY HOSPITAL

Newton-Wellesley Hospital
CAREfirst Standards of Excellence

At Newton-Wellesley Hospital, we are committed to our mission of treating and caring for our patients and their families as we would a beloved family member. Every employee contributes to this mission by either performing functions directly related to patient care or supporting the process of providing patient care. Our organizational culture is defined by the CAREfirst philosophy that includes four core values: Compassion, Attitude, Responsibility and Excellence. The CAREfirst Standards of Excellence have been developed with the help of NWH employees and outline specific standards of behavior that support these organizational values. Each and every employee is expected to perform his/her job in accordance with the seven standards listed below:

Attitude
I am committed to serving our customers with compassion and exceeding their expectations.

Appearance
I am committed to the professional appearance of myself, of my work area, and of Newton-Wellesley Hospital.

Commitment to Customer Needs
I am committed to understanding my customers in order to fully meet their needs.

Customer Waiting
I recognize that everyone's time is valuable, and I am committed to courteous, prompt service, and timely communication.

Privacy
I will ensure our customers' right to privacy and modesty.

Safety Awareness
I am responsible for maintaining a safe environment for my customers, co-workers and myself.

Sense of Ownership
I am proud to belong to the Newton-Wellesley Hospital community and my job is important to its mission.

I have read and understand the above standards of behavior and agree to comply with and consistently practice the standards outlined above.

_____ _____
Employee Signature Date

_____
Print Name

NEWTON-WELLESLEY HOSPITAL

CONFIDENTIALITY AGREEMENT

Newton-Wellesley Hospital, a member of Partners HealthCare System, has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their health information. Additionally, Newton-Wellesley Hospital must assure the confidentiality of its employee, payroll, fiscal, research, computer systems, and management information. In the course of my employment/assignment at Newton-Wellesley Hospital or a Partners affiliate, joint venture or a Partners organization/practice, I may come into the possession of confidential information. In addition, my personal access code [User ID and Password] used to access computer systems is also an integral aspect of this confidential information.

By signing this document I understand the following:

1. Access to confidential information without a patient care/business need-to-know in order to perform my job---whether or not that information is inappropriately shared---is a violation of this policy. I agree not to disclose confidential or proprietary patient care and/or business information to outsiders (including family or friends) or to other employees who do not have a need-to-know.
2. I agree not to discuss confidential patient, employee, payroll, fiscal, research or administrative information where others can overhear the conversation, e.g., in hallways, on elevators, in the cafeterias, on the shuttle buses, on public transportation, at restaurants, at social events. It is not acceptable to discuss clinical information in public areas even if a patient's name is not used. This can raise doubts with patients and visitors about our respect for their privacy.
3. I agree not to make inquiries for other personnel who do not have proper authority.
4. I know that I am responsible for information that is accessed with my password. I am responsible for every action that is made while using that password. Thus**,** I agree not to willingly inform another person of my computer password or knowingly use another person's computer password instead of my own.
5. I agree not to make any unauthorized transmissions, inquiries, modifications, or purgings of data in the system. Such unauthorized transmissions include, but are not limited to, removing and/or transferring data from Partner's computer systems to unauthorized locations, e.g., home.
6. I agree to log off a Partners workstation prior to leaving it unattended. I know that if I do not log off a computer and someone else accesses confidential information while the computer is logged on with my password, I am responsible for the information that is accessed.

Newton-Wellesley Hospital, Partners HealthCare System, its affiliates and joint venturers, and Partners Community HealthCare have the ability to track and monitor access to on-line records and reserves the right to do so. Newton-Wellesley Hospital, Partners HealthCare System, its affiliates and joint ventures, and Partners Community HealthCare can verify that those who accessed records did so appropriately.

I have read the above special agreement and agree to make only authorized entries for inquiry and changes into the system and to keep all information described above confidential. I understand that violation of this agreement may result in corrective action, up to and including termination of employment and/or suspension and loss of privileges. I understand that in order for any User ID and/or Password to be issued to me, this form must be completed.

_____ _____

Signature of Employee / Physician / Student / Volunteer / Non-Partners Personnel Date

_____

Print Name

NEWTON-WELLESLEY HOSPITAL

Newton-Wellesley Hospital Drug and Alcohol Free Workplace Statement

Employees are our most valuable resource. Newton-Wellesley Hospital recognizes the value of a healthy workforce and is therefore committed to maintaining a safe, healthful environment, which enhances the welfare of its employees, patients and visitors. Newton-Wellesley Hospital expects all employees to arrive for work free from the influence of drugs and alcohol and to remain free of their influence while on Hospital property or performing business for the Hospital.

As part of the Omnibus drug legislature enacted in November, 1988, Congress passed the Drug-Free Workplace Act of 1988. This statute requires federal grant and contract awardees to certify that they will provide drug-free workplaces for their employees. Newton-Wellesley Hospital has a Substance Abuse Policy to address workplace substance abuse issues. The policy prohibits the unlawful manufacture, distribution, dispensation, possession, use, sale, theft, diversion and being under the influence of or having in ones' system, alcohol or drugs. As a condition of employment, all employees are required to abide by the Drug-Free Workplace Act and Substance Abuse Policy which requires employees to notify the hospital of any criminal drug statute convictions for a violation occurring in the workplace within five days of the conviction.

When there is probable cause to suspect an employee may be under of the influence of drugs or alcohol, he/she will be requested to submit to a medical assessment which may include a drug/alcohol screen. Violations of the Substance Abuse Policy, even for a first violation, may result in corrective action up to and including termination.

Newton-Wellesley Hospital offers the support of the Employee Assistance Program whereby employees may seek voluntary assessment and referral to treatment if necessary.

I acknowledge that I have read the above Drug-Free Workplace Statement.

_____ _____

Signature Date

_____

Print Name

NEWTON-WELLESLEY HOSPITAL

Newton-Wellesley Hospital
Partners HealthCare System
Self-Identification Form

Newton-Wellesley Hospital and Partners HealthCare System, Inc. are equal opportunity/affirmative action employers. We are required to annually report to the federal government the racial/ethnic composition and veteran and disabled status of our workforce.

Name: _____ Social Security Number: _____
Last, First

Race/Ethnic Group (Please mark all applicable categories):

☐ **Hispanic or Latino**
A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

☐ **White (Not Hispanic or Latino)**
A Person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

☐ **Black or African American (Not Hispanic or Latino)**
A person having origins in any of the black racial groups in Africa.

☐ **Asian (Not Hispanic or Latino)**
A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent including, for example Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ **American Indian or Alaska Native (Not Hispanic or Latino)**
A person having origins in any of the original peoples of North or South America (including Central America), and who maintain tribal affiliation or community attachment.

☐ **Native Hawaiian or Other Pacific Islander (Not Hispanic or Latino)**
A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

Veteran (Please mark all applicable categories):

☐ **Not a Veteran**

☐ **Special Disabled Veteran (Vietnam or other)**- A veteran who is entitled to compensation under laws administered by the Veteran's Administration or who has been discharged from active duty because of service connected disability.

☐ **Vietnam Era Veteran**- A veteran who served on active duty for more than 180 days, any part of which duty occurred during the period between August 5, 1964 and May 7, 1975, and who received other than a dishonorable discharge.

☐ **Newly Separated Veteran** - Discharged Date**: _____**
A veteran who is in the one-year period beginning on the date of such veteran's discharge or release from active duty.

☐ **Veteran who served in combat other than Vietnam** - A person who served on active military service in any branch of the United States armed services, during a war or in a campaign or expedition for which a campaign badge has been authorized. Information required to make this determination is available at http://www.opm.gov/veterans/html/vgmedal2.asp.

☐ **Veteran (all others)** - A person not included in a category above and who served on active military service in any branch of the United States armed services, for a minimum period specified by law (can vary, generally 180 days) and who received other than a dishonorable discharge.

Signature: _____ Date: _____

Orig: 7/3/07

Payroll Distribution Program

Choose how you'd like your pay delivered.

Option 1: Direct Deposit

Description: If you have a personal checking or savings account, your pay can be delivered to that account via direct deposit every payday.

You will need to provide your bank account information when you enroll in Direct Deposit. To enroll in direct deposit: log into PeopleSoft, https://ibridge.partners.org and follow the attached instruction.

Deadline: If you do not enter your Direct Deposit information within two weeks of your start date, you will be enrolled in the Money Network® Service.

Option 2: The Money Network Service

Description: If you don't have a personal bank account, your pay will be loaded directly into a Money Network Account every payday. This easy-to-use payroll solution enables you to access your funds by using Money Network™ Checks or an optional Money Network® Paycard. Write a check to yourself and cash if for free to get up to 100% of the funds in your account, withdraw cash for free at thousands of In-Network ATMs nationwide (at least one free withdrawal per pay period), pay bills, make purchases and more.

For details on Money Network, please refer to the attached brochure.

You will be contacted when the welcome package is available for pick up at your Human Resources Department.

Please disburse my pay by:

	Direct Deposit		Money Network Services

If I don't make a selection within 2 weeks of my start date, I will be enrolled, and my pay will begin to be disbursed using the Service. I understand that I can change my pay selection at any time in the future.

Signature **Date** **Campus Location**

Printed **Empl. ID Number** **Hire Date**

FOR OFFICE USE ONLY Date Submitted: Comments

Payroll Distribution Program:
Keep your money safe | Save Time | Save Money | Eco-Friendly