Preplacement Forms

Welcome to UCSF! We look forward to seeing you at Occupational Health.

Please complete the following forms and submit them using the button at the bottom of the page. We want to be sure that you are cleared on time to start your new position.

The UCSF Notice of Privacy Practices booklet is also included at the end of the form for your information.

Please call us at 415-885-7580 with any questions. Thanks!
The OHS Team

Submit Forms Below

UCSF Medical Center
Occupational Health Services
Preplacement Evaluation
Disposition Form

Name ___________________
DOB ____________________

PRE 1

Job Title: ________________ **Dept:** __________________ **Work Location:** _______________ **Start Date:** _____________

Your Cell Phone and Email: ____

Supervisor/Manager: _____________________ **Supervisor/Manager Email/Phone:** _______________________________

Do not write below – OHS Use Only

Disposition (check one)

❒ Employee is able to complete essential job functions and assigned tasks without restrictions.

❒ Employee is able to complete essential job functions with the following restrictions:
____
____
____
These restrictions are (circle one) Permanent / Temporary.

❒ Employee is unable to complete essential job functions.

____ ___________________________
OHS Signature Date

Provisional Clearance (check when complete)

❒ Employee has complete initial health surveillance and may work pending test results and completion of any further medical requirements.

____ ___________________________
OHS Signature Date

Final Clearance (check when complete)

❒ Employee has completed all medical requirements for the preplacement process.

____ ___________________________
OHS Signature Date

Medical Hold (if applicable)

❒ Employee may not work until further medical information/evaluation is completed.

UCSF Medical Center

Occupational Health will attach a label here.

PRE 3

Occupational Health Services

Preplacement Evaluation

New Hire Tuberculosis (TB) Screening and Testing Form

New Hires must return to Occupational Health for a PPD Test Reading in 48-72 hours.

Symptom Review ***(Fill out if you have had negative or positive tests.)***

History of positive reaction (swelling or hard, solid, raised shape) to TB skin test? Yes ___ No ___

Has anyone told you not to have another TB skin test?

A. Did you receive treatment? ______________________________ Yes ___ No ___

B. What medication did you take? ___________________________

What is the country of your birth? _________________________

If applicable, what is your immigration date? __________

Have you traveled outside of the United States in the last year?

If yes, where? _______________________________

Have you ever been told by a clinician that your immune system is compromised, not working, or that you were unable to fight infections? Yes ___ No ___

Please check any symptoms you have had for more than three weeks:

_____ **Persistent Cough**	_____ **Excessive fatigue**	____ **Excessive Sweating at night**
____ **Coughing up blood**	_____ **Excessive Weight loss**	____ **Persistent Fever**
____ **I have no symptoms**		
	I attest the above is true	

Employee Signature **Date**

Do not write below this line—OHS use only

I authorize this nurse/clinician to administer a TB skin test (00.1 ml intradermal) for pre-placement evaluation during the 2023 calendar year. Robert Kosnik, MD (signature on file) 1/1/2023, Medical Director, Occupational Health Services

Date Applied	Solution	Lot #	Exp. Date	RA/LA	Placer & Title	Date Read	mm
	___ Aplisol ____ Tubersol						
	____ Aplisol ____ Tubersol						

Solution	Date	Result
Quantiferon	________________________	______ **Positive** _____ **Negative**
Chest X-Ray	________________________	______ **Positive** _____ **Negative**

Read, reviewed, and cleared by:

____________________________ ____________________________ ________________

Printed name **Signature and title** **Date**

UCSF Medical Center

Occupational Health Services
Preplacement Evaluation Hepatitis B
Form

Occupational Health will place a label here.

PRE 5A

To be filled out by new employee
Choose one of the following. If you don't know the answer, consult your clinician for help.

__ To the best of my knowledge, my job title does not put me at risk for contact with blood or body fluids.

__ To the best of my knowledge, my job title does put me at risk for contact with blood or body fluids.

Section A -Consent for Vaccination

I have read the information sheet about Hepatitis B (see back of page) and the Hepatitis B vaccination.

I have had the opportunity to ask questions and understand the benefits and risks of Hepatitis B.

I understand that I must have all 3 doses of vaccine to gain immunity.

As with all medical treatment, there is no guarantee that I will become immune or that I will not experience an adverse side effect from the vaccine. I request that it be given to me.

Signature ______________________ Date ______________________

Section B – Declination of Hepatitis B Vaccination

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B at no charge to myself; however I decline the Hepatitis B vaccine at this time. I understand by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potential infectious materials and I want to be vaccinated with Hepatitis B, I can receive the vaccination series at no charge.

Please check one of the following:

_____I decline the vaccine for personal reasons.

____ I decline the vaccine for medical reasons. I have a medical contraindication.

_____I decline because I have been vaccinated in the past.

Signature ______________________ Date ______________________

Do not write below – OHS Use Only

Product Name	Date Given	Site	Lot # & Exp. Date	Clinician Signature
		R/L		
		R/L		
		R/L		

UCSF Medical Center

Occupational Health will place a label here.

PRE 5B

Occupational Exposure to Hepatitis B Virus (HBV)

Hepatitis B

Hepatitis B is a viral infection of the liver caused by HBV. Each year, approximately 43,000 new infections occur and one million people die worldwide from HBV related liver disease. Most people who have become infected with HBV recover completely, but 5% to 10% will develop chronic disease. Although many chronic carriers do not have symptoms of the disease, they are capable of transmitting the virus to other persons, primarily through blood exposures and sexual contact. They are also at increased risk for chronic liver disease, cirrhosis, or liver cancer.

Occupational Exposure

In the hospital and university research setting, healthcare workers with direct patient contact, laboratory workers and researchers with blood or body fluid contact are at increased risk for acquiring HBV. An unvaccinated individual who receives an accidental blood or body fluid exposure from an infected source has up to a 30% chance of becoming infected with HBV. Each year in the US, several hundred healthcare workers contract HBV and some will die from liver related diseases.

Vaccination

Infection with HBV is preventable. The Hepatitis B vaccine is offered to healthcare workers and other staff, who may have a potential exposure, at no cost to the employee. Full immunization requires completion of the series of three vaccinations given over a six month period. Over 90% of healthy people who receive the vaccine develop antibodies that protect them from HBV. At this time, it is believed that immunity produced from the vaccine should last indefinitely and there is no need for boosters. The vaccine has minimal side effects. A few people may experience tenderness or redness at the injection site, a low grade fever, rash, nausea, joint pain, and/or mild fatigue.

Treatment of Exposure

If an individual has received the Hepatitis B vaccine and has documented antibodies to HBV, no treatment is necessary at the time of exposure. Those who or not vaccinated or have negative antibodies to HBV need Hepatitis B immunoglobulin (HBIG) following an exposure.

Reporting and Exposure

UCSF has a 24 hour Needlestick and Exposure Hotline for anyone who has a blood or body fluid exposure. Anyone with an exposure should call the Hotline at 415-353-STIC (7842).

UCSF Medical Center

Occupational Health Services Preplacement
Evaluation Questionnaire

Occupational Health will place a label here.

PRE 6A

To be filled out by new employee

I have reviewed the description and physical requirements of the job for which I am applying.

Signature ______________________ Date ______________

Do you have any condition, illness, injury, or are you taking any medication that affect any of the following job related abilities for your position as identified in your job description?

☐ Yes ☐ No

If yes, please explain

Please answer the following questions:

Vision

Any vision problem which would affect your ability to:

Read or see up close	☐ Yes	☐ No	☐ Unknown
See at a distance	☐ Yes	☐ No	☐ Unknown
Distinguish colors	☐ Yes	☐ No	☐ Unknown
See in dim light	☐ Yes	☐ No	☐ Unknown
Work at a computer monitor	☐ Yes	☐ No	☐ Unknown
Work under fluorescent lighting	☐ Yes	☐ No	☐ Unknown

Hearing

Any hearing problems which would affect your ability to:

Hear a normal speaking voice	☐ Yes	☐ No	☐ Unknown
Hear in noisy situations	☐ Yes	☐ No	☐ Unknown
Requires you to avoid exposure to excessive noise	☐ Yes	☐ No	☐ Unknown

Speech

Any speech condition which would affect your ability to communicate with others by speech

☐ Yes ☐ No ☐ Unknown

UCSF Medical Center

Occupational Health Services Preplacement Evaluation Questionnaire

Occupational Health will place a label here.

PRE 6B

Movement & Strength
Any problems with any of the following body parts that would affect your ability to:

Shoulder or elbow

Move either shoulder or fully extend	☐ Yes	☐ No	☐ Unknown
Either arm overhead	☐ Yes	☐ No	☐ Unknown
Lift with either arm	☐ Yes	☐ No	☐ Unknown
Push or pull with either arm	☐ Yes	☐ No	☐ Unknown
Twist or turn either arm	☐ Yes	☐ No	☐ Unknown

Hand or wrist

Do repetitive grasping or gripping	☐ Yes	☐ No	☐ Unknown
Do forceful grasping or gripping	☐ Yes	☐ No	☐ Unknown
Do repetitive or rapid finger movements	☐ Yes	☐ No	☐ Unknown

Foot or leg

Walk	☐ Yes	☐ No	☐ Unknown
Squat	☐ Yes	☐ No	☐ Unknown
Kneel	☐ Yes	☐ No	☐ Unknown
Climb stairs	☐ Yes	☐ No	☐ Unknown
Walk on uneven or slippery surfaces	☐ Yes	☐ No	☐ Unknown

Neck

Fully bend or rotate your neck	☐ Yes	☐ No	☐ Unknown
Hold your neck in a fixed position for a prolonged period of time	☐ Yes	☐ No	☐ Unknown

Back

Sit for a prolonged time	☐ Yes	☐ No	☐ Unknown
Stand for a prolonged time	☐ Yes	☐ No	☐ Unknown
Bend your back frequently	☐ Yes	☐ No	☐ Unknown
Lift or carry up to 25 pounds	☐ Yes	☐ No	☐ Unknown
Lift or carry up to 45 pounds	☐ Yes	☐ No	☐ Unknown
Lift or carry greater than 45 pounds	☐ Yes	☐ No	☐ Unknown

UCSF Medical Center

Occupational Health Services Preplacement Evaluation Questionnaire

Occupational Health will attach a label here.

PRE 6C

Breathing

Do you have any breathing problems which would affect your ability to:

Work outdoors in cold, hot, or humid weather	☐ Yes	☐ No	☐ Unknown
Work around fumes or dust	☐ Yes	☐ No	☐ Unknown
Work around pollens, dusts, or molds	☐ Yes	☐ No	☐ Unknown
Work rapidly for a prolonged time	☐ Yes	☐ No	☐ Unknown
Run	☐ Yes	☐ No	☐ Unknown
Climb stairs or walk uphill	☐ Yes	☐ No	☐ Unknown
Walk while carrying greater than 10 pounds	☐ Yes	☐ No	☐ Unknown
Walk while carrying greater than 25 pounds	☐ Yes	☐ No	☐ Unknown
Walk while carrying greater than 45 pounds	☐ Yes	☐ No	☐ Unknown

Cardiac

Do you have any heart problem or are you taking any medication which would limit your ability to:

Walk rapidly or for a prolonged period of time	☐ Yes	☐ No	☐ Unknown
Run	☐ Yes	☐ No	☐ Unknown
Climb stairs or walk uphill	☐ Yes	☐ No	☐ Unknown
Walk while carrying greater than 10 pounds	☐ Yes	☐ No	☐ Unknown
Walk while carrying greater than 25 pounds	☐ Yes	☐ No	☐ Unknown
Walk while carrying greater than 45 pounds	☐ Yes	☐ No	☐ Unknown
Change positions rapidly	☐ Yes	☐ No	☐ Unknown

Balance and/or consciousness

Do you have any conditions or are taking any medication which would cause:

Dizziness or loss of balance	☐ Yes	☐ No	☐ Unknown
Fainting or loss of consciousness	☐ Yes	☐ No	☐ Unknown
Seizures or convulsions	☐ Yes	☐ No	☐ Unknown
Inability to do night shift or variable shift work	☐ Yes	☐ No	☐ Unknown

UCSF Medical Center

Occupational Health Services Preplacement Evaluation Questionnaire

Occupational Health will attach a label here.

PRE 6D

Psychological and/or Emotional Disorder

Do you have any condition which would cause:

Inability to work closely with others	☐ Yes	☐ No	☐ Unknown
Inability to follow multiple directions or multitask	☐ Yes	☐ No	☐ Unknown
History of claustrophobia or inability to be in a confined space or wear a face mask	☐ Yes	☐ No	☐ Unknown

Allergies

To latex	☐ Yes	☐ No	☐ Unknown
To medication you may be exposed to at work	☐ Yes	☐ No	☐ Unknown
Foods—please list	☐ Yes	☐ No	☐ Unknown

____

Perfumes or smells—please list	☐ Yes	☐ No	☐ Unknown

____

Animals—please list	☐ Yes	☐ No	☐ Unknown

____

Immune System

Any conditions that would limit your ability to work around infectious agents	☐ Yes	☐ No	☐ Unknown

Any other conditions that would limit your ability to do any of your essential job functions as described in your job description or physical requirements:

☐ Yes ☐ No Please explain____

____

Are you a current smoker? ☐ Yes ☐ No

I attest that the above is true to the best of my knowledge. I understand that knowingly answering any of the above questions falsely will lead to immediate dismissal.

______________________________ ______________________

Signature Date

UCSF Medical Center

Occupational Health Services
Preplacement Evaluation
Respirator Medical Evaluation Questionnaire for N95

Occupational Health will attach a label here.

PRE 7A

To be filled out by new employee. Please complete all questions.

Choose one of the following. If you don't know the answer, consult your clinician for help.

- ☐ To the best of my knowledge, my job title does **not** require me to perform direct patient care, visit patient care areas or work in a laboratory with airborne pathogens.
- ☐ To the best of my knowledge, my job **does** require me to perform direct patient care, visit patient care areas or work in a laboratory with airborne pathogens.

Part A. Section 1. (Mandatory)

Sex ❒ Male ❒ Female ❒ Other Height ________________ Weight __________________

Has your employer told you how to contact the health care professional who will review this questionnaire?	❒ Yes	❒ No
Have you worn a respirator?	❒ Yes	❒ No

If yes, what type(s)? ____

Part A. Section 2. (Mandatory)

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?	❒ Yes	❒ No
2. Have you ever had any of the following conditions?		
a. Seizures	❒ Yes	❒ No
b. Diabetes (sugar disease)	❒ Yes	❒ No
c. Allergic reactions that interfere with your breathing	❒ Yes	❒ No
d. Claustrophobia	❒ Yes	❒ No
e. Trouble smelling odors	❒ Yes	❒ No
3. Have you ever had any of the following pulmonary or lung problems?		
a. Asbestosis	❒ Yes	❒ No
b. Asthma	❒ Yes	❒ No
c. Chronic bronchitis	❒ Yes	❒ No
d. Emphysema	❒ Yes	❒ No
e. Pneumonia	❒ Yes	❒ No
f. Tuberculosis	❒ Yes	❒ No
g. Silicosis	❒ Yes	❒ No
h. Pneumonthorax (collapsed lung)	❒ Yes	❒ No
i. Lung cancer	❒ Yes	❒ No
j. Broken Ribs	❒ Yes	❒ No
k. Any chest injuries or surgeries	❒ Yes	❒ No
l. Any other lung problem	❒ Yes	❒ No

4. Do you currently have any of the following symptoms of pulmonary or lung illness?

a.	Shortness of breath	❐ Yes	❐ No
b.	Shortness of breath when walking fast on level ground or walking up a slight hill or incline	❐ Yes	❐ No
c.	Shortness of breath when walking with other people at ordinary pace on level ground	❐ Yes	❐ No
d.	Have to stop for breath when walking at your own pace on level ground	❐ Yes	❐ No
e.	Shortness of breath when washing or dressing yourself	❐ Yes	❐ No
f.	Shortness of breath that interferes with your job	❐ Yes	❐ No
g.	Coughing that produces phlegm (thick sputum)	❐ Yes	❐ No
h.	Coughing that wakes you early in the morning	❐ Yes	❐ No
i.	Coughing that occurs mostly while you are laying down	❐ Yes	❐ No
j.	Coughing up blood in the last month	❐ Yes	❐ No
k.	Wheezing	❐ Yes	❐ No
l.	Wheezing that interferes with your job	❐ Yes	❐ No
m.	Chest pain when you breathe deeply	❐ Yes	❐ No
n.	Any other symptoms you think may be related to lung problems	❐ Yes	❐ No

5. Have you ever had any of the follow cardiovascular or heart problems?

a.	Heart attack	❐ Yes	❐ No
b.	Stroke	❐ Yes	❐ No
c.	Angina	❐ Yes	❐ No
d.	Heart failure	❐ Yes	❐ No
e.	Swelling in your legs or feet (not caused by walking)	❐ Yes	❐ No
f.	Heart arrhythmia (heart beating irregularly)	❐ Yes	❐ No
g.	High blood pressure	❐ Yes	❐ No
h.	Any other heart problem	❐ Yes	❐ No

UCSF Medical Center

Occupational Health Services
Preplacement Evaluation
Respirator Medical Evaluation Questionnaire for N95

Occupational Health will attach a label here.

PRE 7C

6. Have you ever had any of the following cardiovascular or heart symptoms?

a.	Frequent pain or tightness in your chest	❒ Yes	❒ No
b.	Pain or tightness in your chest during physical activity	❒ Yes	❒ No
c.	Pain or tightness in your chest that interferes with your job	❒ Yes	❒ No
d.	In the past two years, have you noticed your heart skipping or missing a beat	❒ Yes	❒ No
e.	Heart burn or indigestion that is not related to eating	❒ Yes	❒ No
f.	Any other symptoms you think may be related to heart or circulation problems	❒ Yes	❒ No

7. Do you currently take medication for any of the following problems?

a.	Breathing or lung problems	❒ Yes	❒ No
b.	Heart trouble	❒ Yes	❒ No
c.	Blood pressure	❒ Yes	❒ No
d.	Seizures (fits)	❒ Yes	❒ No

8. If you've ever used a respirator, have you ever had any of the following problems? (If you've never used a respirator, check here ❒).

a.	Eye irritation	❒ Yes	❒ No
b.	Skin allergies or rashes	❒ Yes	❒ No
c.	Anxiety	❒ Yes	❒ No
d.	General weakness or fatigue	❒ Yes	❒ No
e.	Any other problem that interferes with your use of a respirator	❒ Yes	❒ No

9. Would you like to talk to the health care professional who will review this questionnaire about your answers? ❒ Yes ❒ No

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TB Respirator Clearance ❒ Respirator not required for current/proposed job

❒ Approved for fit testing ❒ Not Approved (Referred for further medical evaluation)

Restriction or Comments: ____ N95 or PAPR

______________________________________ _____________________

Clinician Signature Date

Final_500-0512_Rev0819.qxp_Layout 8/9/19 1:03 PM Page 1

UNIT NUMBER

PT. NAME

BIRTHDATE:

DATE OF SERVICE:

TERMS AND CONDITIONS OF SERVICE: ADMISSION, MEDICAL SERVICES, AND FINANCIAL AGREEMENT (Page 1 of 3)

1. **UCSF MEDICAL CENTER:** is part of the University of California and is comprised of its hospital(s) (UCSF Medical Center, UCSF Medical Center at Mt. Zion, and UCSF Benioff Children's Hospital), its hospital-based clinics, its Primary Care Network clinics, and the UCSF School of Medicine.

2. **MEDICAL CONSENT:** I consent to medical treatments or procedures, X-ray examinations, drawing blood for tests, medications, injections, taking of treatment related photographs, videotaping, laboratory procedures, and hospital services rendered to me under the general and special instructions of the physicians or other health care professionals assisting in my care. To facilitate my care, I consent to evaluation and examination by a physician or other health team professionals who may be physically distant from me via telehealth technologies, including but not limited to two-way video, digital images, and other telehealth technologies as determined by my providers. I also consent to my admission to the UCSF Medical Center if this is necessary for my care.

3. **TEACHING, RESEARCH AND HEALTHCARE INSTITUTION:** The University of California including UCSF Medical Center, is a teaching, research and healthcare institution. I understand that residents, interns, medical students, students of ancillary health care professions (e.g., nursing, x-ray, rehabilitation therapy), post-graduate fellows, and other trainees and visiting professors may observe, examine, treat, and participate at the request and under the supervision of the attending physician in my care as part of the University's medical education programs.

   I also understand that a University institutional review board approves projects conducted by the University researchers in accordance with state and federal law. As a result, I understand that I may be contacted and asked to participate in research studies but I am under no obligation to do so. My decision whether to participate or not will not affect my ability to obtain medical care.

4. **EDUCATION, INSTRUCTIONS, AND PATIENT CARE SURVEYS:** I understand that I may be receiving education, instructions, and surveys about my medical care and services. UCSF Medical Center uses a variety of methods and vendors for these activities and I consent to receiving this communication using those methods, including via e-mail, text message or voicemail, and from vendors, including but not limited to Oneview, EMMI, Healthwise and Healthnuts.

5. **PERSONAL VALUABLES:** UCSF Medical Center asks patients and families not to bring valuable items into its facilities. UCSF Medical Center shall not be liable for the loss of or damage to any money, documents, jewelry, glasses, dentures, furs, cell phones, electronic devices or other articles of unusual value and shall not be liable for loss or damage to any personal property, unless deposited in the fireproof safe maintained by UCSF. The liability for loss of any personal property shall be no more than $500.

6. **RELEASE OF MEDICAL INFORMATION:** The State of California Information Practices Act requires UCSF Medical Center to provide the following information to individuals who supply information about themselves. As a patient of UCSF Medical Center, I will be asked to submit certain personal information, such as my address and phone number, Social Security number, insurance information, medical history and treatment. The principal purpose for requesting this information is to ensure accurate identification, continuity of medical care, and payment for such care. Under federal and state laws and regulations, UCSF Medical Center is authorized to maintain this information. As required by UCSF Medical Center, furnishing all information requested is mandatory unless otherwise noted. I understand that failure to provide such information may affect my medical care and/or insurance benefits and coverage.

   UCSF Medical Center will obtain my written authorization to release information about my medical treatment, except in those circumstances when UCSF Medical Center is permitted or required by law to release information

500-0512A (Rev. 08/19) MEDICAL RECORD COPY GENERAL WITH FINANCIAL AGREEMENT

UNIT NUMBER

PT. NAME

BIRTHDATE:

DATE OF SERVICE:

TERMS AND CONDITIONS OF SERVICE: ADMISSION, MEDICAL SERVICES, AND FINANCIAL AGREEMENT (Page 2 of 3)

(see UCSF Medical Center's Notice of Privacy Practices for a description of the specific circumstances under which UCSF Medical Center may release this information). For example, UCSF Medical Center may release a copy of my patient record to health care providers, health plans, governmental agencies and workers' compensation carriers. Additionally, I understand that if I am diagnosed with cancer, a reportable disease in California, UCSF Medical Center is required by law to report my diagnosis to the State Department of Health Services.

7. **SMOKING:** Smoking is NOT allowed on the premises of UCSF Medical Center. Smoking has been determined to be hazardous to your health. If you are a smoker, we advise you to stop smoking. If you have a recent history of smoking in the last year, we advise you to continue to stop smoking. Alternatives to help curb your cravings for nicotine are available. Patients are not allowed to leave the hospital to smoke. Please speak with your clinical team to learn more about these alternatives or if you have any questions concerning smoking cessation. This policy applies to patients and visitors of the Medical Center.

8. **BEHAVIOR:** UCSF has a zero tolerance for intimidation, violence, and discrimination on our premises. As such, UCSF is committed to maintaining a safe workplace that is free from threats and acts of intimidation, violence, and discrimination. For the safety and security of our patients, visitors and staff, weapons, knives, alcohol, illegal drugs and other dangerous materials are not allowed. It is the expectation of the Medical Center that you and your visitors conduct yourselves in a respectful, non-violent, non-discriminatory, and non-abusive manner and that you do not leave the hospital at any time during your stay. It is against hospital policy for you to leave your assigned unit with property belonging to the hospital (example: gowns, IV machines, oxygen tanks, etc.). You may be discharged if you leave the hospital without informing your clinical team or if you repeatedly violate the hospital's smoking policy.

   I also understand that under California law I or my visitors cannot film, record, or disclose any images or sounds of our/my conversation with a UCSF employee or physician without the consent of all parties to the conversation and that violation of this law may result in criminal or civil liability. Please refer to your patient handbook for more information concerning your stay here at UCSF's hospitals and facilities.

9. **FINANCIAL AGREEMENT:** I understand that even if I have insurance, I may be financially responsible for some or all of my medical services. For instance, if I have a co-pay or deductible, I agree to pay the amounts I owe. If I do not have insurance that covers the service I receive, I agree to pay The Regents of the University of California for professional, hospital and clinic services, including UCSF Medical Center physician services, in accordance with the regular rates and terms of UCSF Medical Center. I also agree to pay for other professional services provided at UCSF Medical Center by other health care providers. If I am unable to pay, I understand I may qualify for public assistance, special payment arrangements and/or charity care. I also understand that when this agreement is signed by my spouse, parent or a financial guarantor, my spouse, parent or financial guarantor shall be jointly and individually liable with me for payment, including all collection fees (attorneys' fees, costs and collection expenses), in addition to any other amounts due. Unpaid accounts referred to outside agencies for collection bear interest at the current legal rate.

10. **ASSIGNMENT OF BENEFITS (INCLUDING MEDICARE BENEFITS):** I authorize and direct payment to UCSF Medical Center of any insurance benefits including hospital insurance and unemployment compensation disability benefits otherwise payable to or on my behalf for UCSF Medical Center services, including emergency services, at a rate not to exceed UCSF Medical Center actual charges. I understand that I am financially responsible for charges not paid pursuant to this agreement. I further agree that any credit balance resulting from payment of insurance or other sources may be applied to any other account owed to UCSF Medical Center by me.

UNIT NUMBER

PT. NAME

BIRTHDATE:

DATE OF SERVICE:

TERMS AND CONDITIONS OF SERVICE: ADMISSION, MEDICAL SERVICES, AND FINANCIAL AGREEMENT (Page 3 of 3)

Patients insured by Part A of the Medicare Act (as primary payer): UCSF Medical Center shall transfer title prior to use of any property (excluding fixed assets or equipment) furnished or supplied to its patient or other customer in connection with its medical services billed pursuant to Medicare Part A. Notwithstanding this title provision, patient accepts that the disposal of medical products or other supplies after use will be governed by UCSF Medical Center handling and disposal protocols.

I have read, agreed to and received a copy of this Terms and Conditions of Service.

Signature of Patient or Signature of Patient Representative

Signature of Witness (required if patient unable to sign) Relationship of Representative to Patient

Signature of Interpreter Language Used

Date of Signing _______________

Elective Section:

Financial Responsibility Agreement by Person Other than the Patient or the Patient's Legal Representative

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement (Paragraph 9) and Assignment of Benefits (including Medicare Benefits) (Paragraph 10) set forth above.

Date Financially Responsible Party Witness

PATIENT RIGHTS NOTICE: (This question only applies to inpatient admissions only)
Would you like your agent under a durable power of attorney for health care or your next of kin to receive a copy of the Patient Rights and Responsibilities Notice? If so, please ask your admitting representative or contact the Patient Relations Department at (415) 353-1936.

500-0512C (Rev. 08/19) MEDICAL RECORD COPY GENERAL WITH FINANCIAL AGREEMENT

UCSF Medical Center

UCSF Benioff Children's Hospital

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT OF RECEIPT

UNIT NUMBER

PT. NAME

Occupational Health will attach a label here.

BIRTHDATE

LOCATION

DATE

The UCSF Notice of Privacy Practice provides information about how we may use and disclose protected health information about you.

In addition to the copy we have provided you, copies of the current notice are available by accessing our website at http://www.ucsfhealth.org and may be obtained throughout UCSF Health System.

I acknowledge that I have received the Notice of Privacy Practice.

____________________________________ _____ / _____ / _____

Signature of Patient or Patient's Representative Date

____________________________________ ____________________

Print Name Relationship to Patient

____

Name of Interpreter (if applicable)

If written acknowledgement is not obtained, please check reason:

- ☐ Notice of Privacy Practice Given - Patient Unable to Sign
- ☐ Notice of Privacy Practice Given - Patient Declined to Sign
- ☐ Other ____

______________________________ _____ / _____ / _____

Signature of UCSF Representative Date

____________________________________ ____________________

Print Name Department

WHITE – MEDICAL RECORD YELLOW – PATIENT OR PATIENT'S REPRESENTATIVE

876-060 (Rev 09/13)

862-082 (Rev. 09/13) WorkflowOne

Effective Date: September 23, 2013

UCSF Medical Center

UCSF Benioff Children's Hospital

NOTICE OF PRIVACY PRACTICE

UNIVERSITY OF CALIFORNIA SAN FRANCISCO UCSF HEALTH SYSTEM

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

UCSF Health System

UCSF Health System is one of the health care components of the University of California. The University of California health care components consist of the UC medical centers, the UC medical groups, clinics and physician offices, the UC schools of medicine and other UC health professional schools, departments engaged in clinical care, the student health service areas on some campuses, employee health units on some campuses, and the administrative and operational units that are part of the health care components of the University of California.

Our Pledge Regarding Your Health Information

UCSF Health System is committed to protecting medical, mental health and personal information about you ("Health Information"). We are required by law to maintain the privacy of your Health Information; provide you information about our legal duties and privacy practices; and inform you of your rights and the ways in which we may use Health Information and disclose it to other entities and persons.

How We May Use and Disclose Health Information About You

The following sections describe different ways that we may use and disclose your Health Information. Some information; such as certain drug and alcohol information, HIV information, genetic information and mental health information; is entitled to special restrictions related to its use and disclosure. Not every use or disclosure will be listed. All of the ways we are permitted to use and disclose information, however, will fall within one of the following categories. Other uses and disclosures not described in this Notice will be made only if we have your written authorization.

How We May Use and Disclose Health Information About You (cont.)

For Treatment. We may use Health Information about you to provide you with medical and mental health treatment or services. We may disclose Health Information about you to doctors, nurses, technicians, students, or other health system personnel who are involved in taking care of you in the health system. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. A doctor treating you for a mental condition may need to know what medications you are currently taking, because the medications may affect what other medications may be prescribed to you. We may also share Health Information about you with other non-UCSF Health System providers. The disclosure of your Health Information to non-UCSF Health System providers may be done electronically through a health information exchange that allows providers involved in your care to access some of your UCSF Health system records to coordinate services for you.

For Payment. We may use and disclose Health Information about you so that the treatment and services you receive at UCSF Health System or from other entities, such as an ambulance company, may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give information to your health plan about surgery or therapy you received at UCSF Health System so your health plan will pay us or reimburse you for the surgery or therapy. We may also tell your health plan about a proposed treatment to determine whether your plan will pay for the treatment.

For Health Care Operations. We may use and disclose Health Information about you for our business operations. For example, your Health Information may be used to review the quality and safety of our services, or for business planning, management and administrative services. We may contact you about alternative treatment options for you or about other benefits or services we provide. We may also use and disclose your health information to an outside company that performs services for us such as accreditation, legal, computer or auditing services. These outside companies are called "business associates" and are required by law to keep your Health Information confidential. We may also disclose information to doctors, nurses, technicians, medical and other students, and other health system personnel for performance improvement and educational purposes.

Appointment Reminders. We may contact you to remind you that you have an appointment at UCSF Health System.

Fundraising Activities. We may contact you to provide information about UCSF Health System sponsored activities, including fundraising programs and events. We may use contact information, such as your name, address and phone number, date of birth, physician name, the outcome of your care, department where you received services and the dates you received treatment or services at UCSF Health System. You may opt-out of receiving fundraising information for the UCSF Health System by contacting us at Records Manager, UCSF, Box 0248, San Francisco, CA 94143-0248, or HIPAAOptOut@support.ucsf.edu, or 1-888-804-4722.

Hospital Directory. If you are hospitalized, we may include certain limited information about you in the hospital directory. This is so your family, friends and clergy can visit you in the hospital and generally know how you are doing. This information may include your name, location in the hospital, your general condition (e.g., fair, stable, etc.) and your religious affiliation. The directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to members of the clergy, such as ministers or rabbis, even if they don't ask for you by name. You have the opportunity to limit the release of directory information by telling UCSF Health System at the time of your hospitalization.

Our disclosure of this information about you if you are hospitalized in a psychiatric hospital will be more limited.

How We May Use and Disclose Health Information About You (cont.)

Individuals Involved in Your Care or Payment for Your Care. We may release medical information to anyone involved in your medical care, e.g., a friend, family member, personal representative, or any individual you identify. We may also give information to someone who helps pay for your care. We may also tell your family or friends about your general condition and that you are in the hospital.

Disaster Relief Efforts. We may disclose Health Information about you to an entity assisting in a disaster relief effort so that others can be notified about your condition, status and location.

Research. The University of California is a research institution. We may disclose Health Information about you for research purposes, subject to the confidentiality provisions of state and federal law. All research projects involving patients or the information about living patients conducted by the University of California must be approved through a special review process to protect patient safety, welfare and confidentiality.

In addition to disclosing Health Information for research, researchers may contact patients regarding their interest in participating in certain research studies. Researchers may only contact you if they have been given approval to do so by the special review process. You will only become a part of one of these research projects if you agree to do so and sign a specific permission form called an Authorization. When approved through a special review process, other studies may be performed using your Health Information without requiring your authorization. These studies will not affect your treatment or welfare, and your Health Information will continue to be protected.

As Required By Law. We will disclose Health Information about you when required to do so by federal or state law.

To Prevent a Serious Threat to Health or Safety. We may use and disclose Health Information about you when necessary to prevent or lessen a serious and imminent threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to someone able to help stop or reduce the threat.

Organ and Tissue Donation. If you are an organ donor, we may release your Health Information to organizations that obtain, bank or transplant organs, eyes or tissue, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are or were a member of the armed forces, we may release Health Information about you to military command authorities as authorized or required by law.

Workers' Compensation. We may use or disclose Health Information about you for Workers' Compensation or similar programs as authorized or required by law. These programs provide benefits for work-related injuries or illness.

Public Health Disclosures. We may disclose Health Information about you for public health activities such as:

- preventing or controlling disease (such as cancer and tuberculosis), injury or disability;
- reporting vital events such as births and deaths;
- reporting child abuse or neglect;
- reporting adverse events or surveillance related to food, medications or defects or problems with products;
- notifying persons of recalls, repairs or replacements of products they may be using;
- notifying a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition;

How We May Use and Disclose Health Information About You (cont.)

Abuse and Neglect Reporting. We may disclose your Health Information to a government authority that is permitted by law to receive reports of abuse, neglect or domestic violence.

Health Oversight Activities. We may disclose Health Information to governmental, licensing, auditing, and accrediting agencies as authorized or required by law.

Lawsuits and Other Legal Proceedings. We may disclose Health Information to courts, attorneys and court employees in the course of conservatorship, writs and certain other judicial or administrative proceedings. We may also disclose Health Information about you in response to a court or administrative order, or in response to a subpoena, discovery request, warrant, or other lawful process.

Law Enforcement. If asked to do so by law enforcement, and as authorized or required by law, we may release Health Information:

- To identify or locate a suspect, fugitive, material witness, certain escapees, or missing person;
- About a suspected victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death suspected to be the result of criminal conduct;
- About criminal conduct at UCSF Health System; and
- In case of a medical emergency, to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may disclose medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine cause of death. We may also disclose medical information about patients of UCSF Health System to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. As required by law, we may disclose Health Information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities.

Protective Services for the President and Others. As required by law, we may disclose Health Information about you to authorized federal officials so they may conduct special investigations or provide protection to the President, other authorized persons or foreign heads of state.

Inmates. If you are an inmate of a correctional institution or under the custody of law enforcement officials, we may release Health Information about you to the correctional institution as authorized or required by law.

Psychotherapy Notes. *Psychotherapy notes* means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record.

Psychotherapy notes have additional protections under federal law and most uses or disclosures of psychotherapy require your written authorization.

Marketing or Sale of Health Information. Most uses and disclosures of your Health Information for marketing purposes or any sale of your Health Information would require your written authorization.

Other Uses and Disclosures of Health Information

Other uses and disclosures of Health Information not covered by this Notice will be made only with your written authorization. If you authorize us to use or disclose your Health Information, you may revoke that authorization, in writing, at any time. However, the revocation will not be effective for information that we have already used and disclosed in reliance on the authorization.

Your Rights Regarding Your Health Information

Your Health Information is the property of UCSF Health System. You have the following rights regarding the Health Information we maintain about you:

Right to Inspect and Copy. With certain exceptions, you have the right to inspect and/or receive a copy of your Health Information. If we have the information in electronic format then you have the right to get your Health Information in electronic format if it is possible for us to do so. If not we will work with you to agree on a way for you to get the information electronically or as a paper copy.

To inspect and/or to receive a copy of your Health Information, you must submit your request in writing to Health Information Management Services, UCSF Medical Center, 400 Parnassus Ave., Room A-88, San Francisco, CA 94143-0308. If you request a copy of the information, there is a fee for these services.

We may deny your request to inspect and/or to receive a copy in certain limited circumstances. If you are denied access to Health Information, in most cases, you may have the denial reviewed. Another licensed health care professional chosen by UCSF Health System will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Request an Amendment or Addendum. If you feel that Health Information we have about you is incorrect or incomplete, you may ask us to amend the information or add an addendum (addition to the record). You have the right to request an amendment or addendum for as long as the information is kept by or for UCSF Health System.

Amendment. To request an amendment, your request must be made in writing and submitted to Patient Relations, UCSF Medical Center, 350 Parnassus Ave., Suite 150, Box 0208, San Francisco, CA 94143-0208, phone 1-415-353-1396, fax 1-415-353-8556. You must be specific about the information that you believe to be incorrect or incomplete and you must provide a reason that supports the request.

We may deny your request for an amendment if it is not in writing, we cannot determine from the request the information you are asking to be changed or corrected, or your request does not include a reason to support the change or addition. In addition, we may deny your request if you ask us to amend information that:

- Was not created by UCSF Health System;
- Is not part of the Health Information kept by or for UCSF Health System;
- Is not part of the information which you would be permitted to inspect and copy; or
- UCSF Health System believes to be accurate and complete.

Addendum. To submit an addendum, the addendum must be made in writing and submitted to Patient Relations, UCSF Medical Center, 350 Parnassus Ave., Suite 150, Box 0208, San Francisco, CA 94143-0208, phone 1-415-353-1396, fax 1-415-353-8556. An addendum must not be longer than 250 words per alleged incomplete or incorrect item in your record.

Right to an Accounting of Disclosures. You have the right to receive a list of certain disclosures we have made of your Health Information.

Your Rights Regarding Your Health Information (cont).

To request this accounting of disclosures, you must submit your request in writing to Health Information Management Services, UCSF Medical Center, 400 Parnassus Ave., Room A-88, San Francisco, CA 94143-0308. Your request must state a time period that may not be longer than the six previous years. You are entitled to one accounting within any 12-month period at no cost. If you request a second accounting within that 12-month period, there will be a charge for the cost of compiling the accounting. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the Health Information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend.

To request a restriction, you must make your request in writing to Patient Relations, UCSF Medical Center, 350 Parnassus Ave., Suite 150, Box 0208, San Francisco, CA 94143-0208, phone 1-415-353-1396, fax 1-415-353-8556. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, only to you and your spouse. *We are not required to agree to your request* except in the limited circumstance described below. If we do agree, our agreement must be in writing, and we will comply with your request unless the information is needed to provide you emergency care.

We are required to agree to a request not to share your information with your health plan if the following conditions are met:

- We are not otherwise required by law to share the information
- The information would be shared with your insurance company for payment purposes
- You pay the entire amount due for the health care item or service out of your own pocket or someone else pays the entire amount for you

Right to Request Confidential Communications. You have the right to request that we communicate with you about your Health Information in a certain way or at a certain location. For example, you may ask that we contact you only at home or only by mail.

To request confidential medical communications, you must make your request in writing to Patient Relations, UCSF Medical Center, 350 Parnassus Ave., Suite 150, Box 0208, San Francisco, CA 94143-0208, phone 1-415-353-1396, fax 1-415-353-8556. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

Copies of this Notice are available throughout UCSF Health System, or you may obtain a copy at our website, http://www.ucsfhealth.org.

Right to be Notified of a Breach. You have the right to be notified if we or one of our Business Associates discovers a breach of unsecured Health Information about you.

Changes to UCSF Health System's Privacy Practice and This Notice

We reserve the right to change UCSF Health System's privacy practices and this Notice. We reserve the right to make the revised or changed Notice effective for Health Information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice throughout UCSF Health System. In addition, at any time you may request a copy of the current Notice in effect.

Questions or Complaints

If you have any questions about this Notice, please contact Patient Relations, UCSF Medical Center, 350 Parnassus Ave., Suite 150, Box 0208, San Francisco, CA 94143-0208, phone 1-415-353-1396, fax 1-415-353-8556.

If you believe your privacy rights have been violated, you may file a complaint with UCSF Health System or with the Secretary of the Department of Health and Human Services, Office for Civil Rights. To file a written complaint with UCSF Health System contact Patient Relations, UCSF Medical Center, 350 Parnassus Ave., Suite 150, Box 0208, San Francisco, CA 94143-0208, phone 1-415-353-1396, fax 1-415-353-8556. You will not be penalized for filing a complaint.