

# IODP EMPLOYEE PHYSICAL EXAM PACKET

Attached is the physical exam package, which consists of the following:

## **Physical Exam Policy**

*Instructions and General Considerations*

## **Annual or Pre-Expedition Physical Exam**

*General and Responsibility for Exam Expense*

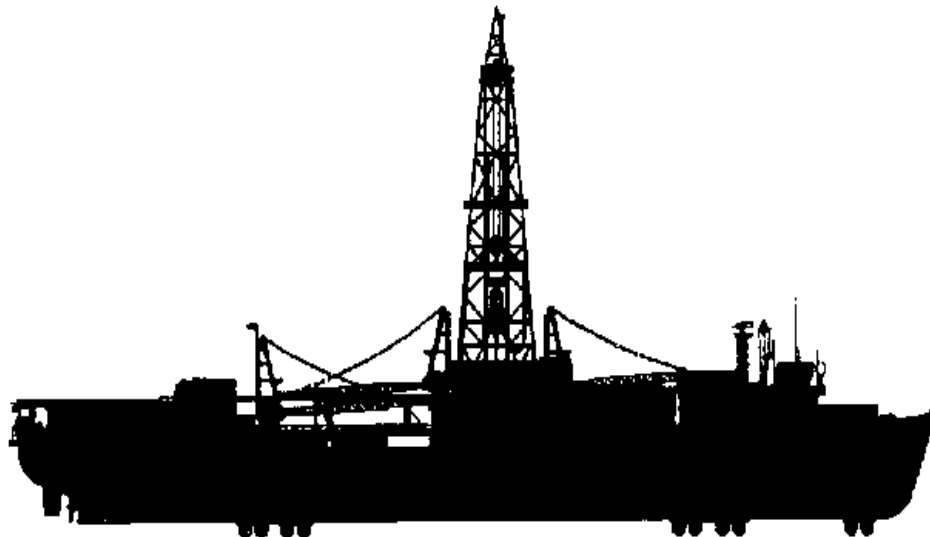
## **New Employee Physical**

*General, Responsibility for Exam Expense, and Medical History Records*

- Attachment 1: Medical History Questionnaire  
*To be signed by the new employee or expedition participant  
New employees must attach copies of immunization records  
and blood type to this form.*
- Attachment 2: Typical Physical Requirements of IODP Employee or Expedition Participant  
*To be given to physician for review, along with all other Attachments.*
- Attachment 3: Medical Exam Requirements & Certification of Eligibility to Participate  
*To be given to physician along with all other Attachments.*
- Attachment 4: Additional Physical Exam Reimbursements for Participants with Depression/Mental Illness/Emotional Problems  
Letter to physician requesting additional information
- Attachment 5: Physical Exam Reimbursement Form for ASPP Personnel **only**
- Attachment 6: OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

**New employee physical exams** should be returned as soon after completion as possible, prior to the new employee's first working day.

**Annual or pre-expedition examinations** should be returned no later than one month prior to departure to join the ship in port.



# International Ocean Discovery Program Physical Exam Policy

## INTRODUCTION

The purpose of the International Ocean Discovery Program (IODP) Physical Exam requirement is to protect the health and safety of all expedition participants and to minimize interference with successful completion of the scientific objectives of each expedition. Physical examination results will determine eligibility for employment and/or expedition participation. All medical information will be kept in secure files and treated confidentially.

All persons offered employment in seagoing positions, employees in seagoing positions, and expedition participants are required to complete a comprehensive physical examination by a licensed physician according to the terms of the International Ocean Discovery Program Physical Exam Policy as detailed in the following pages. Furthermore, IODP may require specific medical or psychological tests and/or evaluations of participant at any time medical conditions warrant.

The reimbursement terms, as outlined in the following pages, are based on a philosophy of payment for examination and evaluation. The International Ocean Discovery Program is not responsible for the cost of any medical or psychological treatment necessary for the individual to meet the requirements of this policy.

**IODP maintains protocols to ensure the security and confidentiality of your personal information. Your information is limited to those who need it to evaluate your physical/mental health. IODP is committed to using protected health information (PHI) about you responsibly. The Notice of Privacy Practices describes how medical information about you may be used and disclosed and how you can get access to this information. Please see the Notice at:**  
<http://sago.tamu.edu/shro/brochures/HIPAAprivacy.pdf>

## GENERAL HEALTH CONSIDERATIONS

### Immunizations

Current information on immunizations required to enter to the port or country of operation is listed on Attachment 1a. New employees are required to attach a copy of records of immunization history to the Medical History Questionnaire (Attachment 1a). If medical records are not provided, immunizations may be given as part of the exam. IODP will cover the cost of required immunizations.

### Medical Supplies

Medical supplies and medication on board the drillship are limited. Each participant is responsible for bringing an adequate supply of medication or medical supplies for treating an existing condition for the duration of an expedition.

### Sea/Motion Sickness

Each participant is encouraged to discuss the possibility of sea/motion sickness with his/her physician. The physician may be able to provide information and/or prescribe medications to prevent or control the symptoms. Employees with concerns about sea/motion sickness should also discuss their situation with the ship's physician as soon as possible after boarding.

### Pregnancy

If a participant suspects she is pregnant, she is advised to see a licensed obstetrician/gynecologist. A participant who is pregnant must provide her obstetrician/gynecologist with a written job description for her position and obtain a certification from the obstetrician/gynecologist. The certification must state that the participant is capable of performing her duties and explain any physical restrictions or limitations. This information is required to determine if participant is eligible for participation in the specified expedition.

### Allergies

To minimize the occurrence of an allergy problem that may arise during an expedition, each participant is asked to bring non-perfumed, non-allergenic hygiene products on the ship.

### **Medical History**

Employees are to complete information on medical history on Attachment 1-1c. Attachment 3 lists all medical tests required as part of the physical exam. If a new employee is unable to provide a medical record evidencing blood type or immunizations, then blood typing and immunizations will be completed as part of the New Employee Exam. Employees are responsible for reporting any serious illness or injury, physical and/or emotional, that is overlooked during the medical examination or that develops after the exam and prior to boarding the ship. In such a situation a follow up medical evaluation may be necessary to determine fitness for sea duty.

### **Distribution**

The physical exam packet is distributed electronically to all ASPP employees. NON-ASPP, participants, scientists receive the packet by mail or they can request the packet electronically. If received electronically, the receiver must confirm receipt of the exam. HR sends reminder emails to ensure that IODP receives the exam in a timely manner. The employee exam is available in Adobe and Word format and also available on the IODP website at [http://iodp.tamu.edu/participants/before\\_exp.html](http://iodp.tamu.edu/participants/before_exp.html)

### **Cabins**

While on board, it is required that employees/participants must share a cabin.

## **ANNUAL OR PRE-EXPEDITION PHYSICALS**

### Regular Seagoing Positions

Employees in regular seagoing positions are required to pass a physical exam once per year, or more often if medical conditions warrant. Regular seagoing positions are those which require working at sea on a rotating basis of two months at sea and two to four months on shore (approximately 4 to 6 months at sea each year, depending on the position.) If a regular seagoing employee's physical exam expires while the employee is on official travel days to port call or at sea, he or she will be required to successfully complete the IODP exam prior to participation in a subsequent expedition. Failure to pass the IODP physical exam will result in the employee's restriction from participation in the scheduled expedition and may result in evaluation of continued employment.

### Positions Requiring Occasional Sea Duty

Employees in positions which may require occasional sea duty must pass the IODP physical exam prior to sailing but not more than once every twelve months, unless medical conditions warrant additional testing. Failure to pass the IODP physical exam will result in the employee's restriction from participation in the scheduled expedition.

The entire completed package is to be submitted to IODP Human Resources which will review the documents for completeness and for the physician's recommendation. The final decision to allow an employee to sail rests with officials of the International Ocean Discovery Program.

## **RESPONSIBILITY FOR EXAM EXPENSE**

The cost of this examination, up to \$400, the maximum amount established for IODP Annual Physical Exams, shall be for IODP's account.

The cost of required immunizations shall be for IODP's account. If required immunizations result in the total exam cost to exceed \$400, the cost of required immunizations will be for IODP's account. Required immunizations are defined as those which are as listed on the medical history questionnaire or those required to enter the country of operation. If the employee has not received a required immunization, or has an expired immunization, then the injections will be given as part of the annual exam.

If additional testing is required by the examining physician in order to make a determination of the employees' health status after any of the initial test listed are inconclusive, those additional tests shall be for the employees' account. This also includes any psychological testing or evaluations the examining physician might require in order to make a determination of being fit to sail.

In the event IODP requests any additional tests after the examining physician has determined the employee is fit to sail, these costs will be for IODP's account. The cost of any treatment, which may be required due to a medical or psychological condition, is for the employees' account.

# **NEW EMPLOYEE PHYSICAL**

## **GENERAL**

All job offers for seagoing positions will be contingent upon the new employee passing the IODP New Employee physical exam. The exam must be given by a licensed physician; the International Ocean Discovery Program (IODP) reserves the right to request a second opinion from another physician. New employees are encouraged to first consult with IODP Human Resources regarding the various tests so as to avoid unnecessary out-of-pocket expenses which might result from the physical exam.

The exam should be scheduled, completed, and returned to the IODP Human Resources prior to the new employee's first day of work. IODP has the option to request additional medical information or tests which may be taken into consideration if appropriate.

The IODP Human Resources will inform the hiring supervisor and the prospective employee whether the individual has passed the physical exam and is eligible for sea duty participation.

## **RESPONSIBILITY FOR EXAM EXPENSE**

The International Ocean Discovery Program will reimburse the new employee up to the maximum amount established for the cost of the physical exam providing:

- (1) the examination is performed according to IODP requirements; and
- (2) the new employee passes the exam.

Any cost above \$400 will be for the new employee's account. However, if required immunizations result in the total exam cost to exceed \$400, the cost of required immunizations will be for IODP's account. In addition, charges for procedures not required by IODP will be for the new employee's account. If an employee does not pass the physical exam and pursues further testing/treatment in order to pass, he/she will be responsible for the expense of these tests or treatment. If the employee fails the physical exam, the total cost of the exam will be for his/her account. The hiring supervisor will inform the new employee of this expense responsibility. The employment offer may be withdrawn from a new employee who fails the physical exam.

## **MEDICAL HISTORY RECORDS**

New employees are required to provide copies of medical history records for immunizations and blood type. If no records are provided or records are incomplete, immunizations and blood typing will be done as part of the new employee exam. IODP will cover the costs of these procedures.

Texas A&M University/International Ocean Discovery Program

Medical History Questionnaire

-To Be Completed By Patient-

Attachment 1

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Your Present Job Title: \_\_\_\_\_

How would you rate your physical condition?

Poor     Fair     Good     Excellent

**Please read and sign the below statement.**

I certify that the answers given by me on this questionnaire are true, complete, and correct to the best of my knowledge and are made in good faith. I understand that false statements or omissions may void this physical exam and may result in the withdrawal of an offer of employment or denial of sea duty participation. I agree that prior to participating on an IODP expedition I will undergo a complete, comprehensive examination by a duly licensed physician and that all of the required medical examination forms and test results will be submitted to the assigned IODP official who will in turn forward these documents to the shipboard doctor. I agree that if the physician performing said evaluation has reservations, in any way whatsoever, the assigned IODP official shall make the final determination as to my eligibility for shipboard service. I further agree that the assigned IODP official's decision shall be final. Successful completion (passing) of this exam does not in anyway obligate the International Ocean Discovery Program. I agree that I am responsible for providing all medication including psychotropic medication and medical supplies which I may need for the treatment of existing conditions for the duration of the expedition. I understand that my medical information will be kept confidential; however, if an injury, abnormality, or illness is discovered such that my fitness for sea duty is in question, I understand that it may be necessary to inform my manager and/or supervisor so that staffing decisions can be made. I further agree that if I am subjected to injury or illness after the date of my physical examination and prior to the beginning of the expedition I will notify the assigned IODP official so that eligibility for shipboard service may be determined.

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Expedition

Have you been ill, injured, hospitalized, or under the care of a physician within the past six months? If yes, please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you been treated for or under the care of a physician/psychologist for depression, mental illness, and/or emotional problems in the last 12 months? If yes, please explain providing details including dates, medication prescribed for condition, and prognosis.

(See Attachment 4 for additional exam requirements)

\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you presently taking any medication, including psychotropic medication?  YES  NO  
Please describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Blood Type: \_\_\_\_\_

(Please attach copy of medical record indicating blood type, such as blood donor card, previous blood type results, or physician statement of your blood type.)

**Dates of latest immunizations:**

Tetanus \_\_\_\_\_

Polio \_\_\_\_\_

Diphtheria \_\_\_\_\_

Hepatitis B \_\_\_\_\_

Measles, mumps, rubella \_\_\_\_\_

Haemophilus influenzae b (Hib) \_\_\_\_\_

**New employees are required to attach a copy of records of immunization history to this form.**

**To the best of your knowledge, have you ever had or now have symptoms or a diagnosis of any of the following? Please check all that apply.**

- Hernia, skin disorder, or fungus infections.
- Problems with the stomach, intestine, throat, esophagus, ulcers, or digestive disorder.
- Gallbladder disease, hepatitis, jaundice, or other liver disease.
- Asthma, allergies, bronchitis, pneumonia, emphysema, sinus, nasal, tonsils, adenoids, bronchi, trachea, lung, or other respiratory symptoms.
- Abnormal growth or function of thyroid, pancreas, adrenal, or lymph glands.
- Diabetes, anemia, or other blood disorders.

**Diabetic participants are required to submit an ophthalmologist report annually.**

- Problems with the kidneys, bladder, prostate, reproductive organs, menstrual disturbance, or other male/female disorder.
- Arthritis, rheumatism, polio, rheumatic fever.
- Cancer, leukemia, Hodgkin's disease, or Kaposi' Sarcoma.
- Injury or problem with the back, muscle, bone, joint, spine, neck; fracture or deformity.
- Tumor, cyst, or growth (benign/malignant); disease or lump(s) in breast.
- Impairment of sight or hearing, cataracts, or ear infections.
- Gain or loss of more than 10-15 pounds in the past year or obesity.
- Any past or present complications of pregnancy (prior history of miscarriage, infertility, toxemia, c-section) or is any person now pregnant?
- Any other medical or surgical advice, treatment, or hospitalization.
- Any chronic or recurring minor ailments, injuries, or other departures from good health, regardless of whether or not a practioner was consulted.
- High or low blood pressure, stroke, heart trouble, heart defect, murmur, or other circulatory impairment of blood, arteries.



Please check if any of the following factors have been or are present in your history:

- Smoker, if so # of packs a day \_\_\_\_\_
- High blood pressure
- Elevated cholesterol levels
- Sedentary lifestyle coupled with a physically demanding job
- History of heart attack or sudden cardiac death in a first degree relative less than 60 years of age.

For those questions you checked, please describe the medical or surgical care advised or performed, the date of illness or treatment and your present condition, in the space provided below.

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Do you have any special dietary needs (i.e., vegetarian, etc.)? There is no guarantee your request can be accommodated but if we know about them 30 days or more before the expedition starts, notification to the ship's operator can be made.  Yes  No

Please Explain: \_\_\_\_\_  
\_\_\_\_\_

Do you have a history of sea sickness or other types of motion sickness?  Yes  No

Please explain: \_\_\_\_\_  
\_\_\_\_\_

**PARTICIPANT**

Please return this entire package (Medical History Questionnaire, Blood Test Results, Audiograms, Chest X-Ray Reports, Pulmonary Function Reports, etc.) to:

<p>Human Resources/Insurance Services  <b>CONFIDENTIAL</b>          International Ocean Discovery Program          1000 Discovery Drive          College Station, Texas 77845 USA</p>
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# TYPICAL PHYSICAL REQUIREMENTS OF IODP EMPLOYEES

To be reviewed by examining physician

Attachment 2

I. On the job, the employee must perform the following:

<u>Activity</u>	<u>Per Work Day</u>
Bend, Climb; Push/Pull; Sit; Stand; Walk	Frequently
Reach above shoulder level	Frequently
Handle objects; Fine finger movement	Frequently
Squat, Kneel	Occasionally
Crawl	Rarely

II. On the job, this employee must be able to lift:

Up to 10 pounds	Frequently
11-50 pounds	Frequently
51-74 pounds	Occasionally
75-100 pounds; over 100 pounds	Only with assistance

III. On the job, the employee:

Operates foot controls	Occasionally
Is around moving machinery	Frequently
Is exposed to marked changes in temperature and/or humidity	Frequently
Drives automotive equipment in port	Occasionally
Is exposed to dust, fumes and gases	Frequently
Works in confined quarters	Frequently

## Seagoing Physical Requirements Statement

To be reviewed by examining physician

The duties of this position involve fine motor skills for delicate tasks as well as frequent strenuous physical activity including, but not limited to, moving, lifting, and carrying objects weighing as much as 50 pounds and occasionally more. This work is performed in port and at sea on a research vessel, working 12 hours per day, 7 days per week for up to two months without a break. The ship does not return to port during a two-month expedition. The work also requires reaching, standing long hours, walking, bending, and maintaining balance on a moving ship while carrying a load. Walking up and down several flights of stairs many times during day is required. The work is performed under confined conditions, with frequent exposure to noise, vibration, and potential allergens; also with occasional exposure to outdoor, extreme environments. Rarely, exposure to toxic gases requires donning full body protective gear and breathing apparatus while performing other duties as listed above. Medical evacuation (medivac) by helicopter or alternate vessel is only available within a certain distance from a port and the research vessel most commonly operates outside of this distance. In the event of an emergency, 5 or more days travel by sea are commonly required to reach port. Escape during an emergency may require navigating several flights of stairs and water tight doors.

## MEDICAL EXAM REQUIREMENTS

To Be Reviewed by Examining Physician

Attachment 3

The following indicated tests should be completed for the annual exam.

<b>TESTS:</b>	<b>REQUIRED:</b>
<b>Complete Blood Count</b>	Yes (Fasting)
<b>Blood Chemistry Profile</b>	Yes (Fasting)
<b>Audiogram</b>	Yes
<b>HgbA1C</b>	Yes, for individuals with diabetes
<b>Bruce Protocol Stress Test</b>	Males over the age of 40 <b>with one or more risk factors</b> should undergo treadmill stress testing according to the Bruce Protocol. Women over 50 should be likewise tested. The Bruce Protocol Stress Test should not be conducted more often than once every FOUR years, unless indicated by symptoms or changes in cardiac medical history.

Date of previous stress test:

\_\_\_\_\_

Risk factors for the purpose of the Bruce stress test are:

- 1) Cholesterol greater than 240 mg/dl;
- 2) Smoking;
- 3) Diabetes Mellitus;
- 4) Systolic blood pressure greater than 140 mm Hg or diastolic blood pressure greater than 90 mm Hg;
- 5) History of heart attack or sudden cardiac death in a first-degree relative less than 60 years of age.

<b>TB Skin Test</b>	Yes, unless received BCG inoculation* in the past. If individual is symptomatic or if TB skin test results are "positive," then perform <b>Chest X-rays</b> (PA and lateral). * If individual received BCG in past, physician statement indicating the individual has had a BCG inoculation and a <b>Chest X-ray</b> is required.
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## MEDICAL EXAM REQUIREMENTS CONTINUED

Attachment3a

The following inoculations should be completed for IODP Expedition 372 departing from Fremantle, Australia, and returning to Wellington, New Zealand.

<b>IMMUNIZATIONS:</b>	<b>REQUIRED:</b>
Tetanus	Yes, if more than 10 years since last immunization
Cholera	No
Yellow Fever	No
Typhoid/Typhus	Recommended
Anti-Malaria Precaution	No
Polio	Recommended
Diphtheria	Recommended
Measles, Mumps, Rubella	Recommended
Hepatitis A, Hepatitis B	Recommended

**Any immunization indicated as not completed on Medical History Sheet** Yes

**TO BE COMPLETED BY EXAMINING PHYSICIAN**

Attachment3b

The information requested herein is required for participation on a research expedition aboard the research drillship JOIDES Resolution. Please note that although a licensed M.D. accompanies all expeditions, medical facilities on board are limited. In an emergency, it could require five days or more to reach a port. Although emergency transportation can be arranged, it may not be immediate. Please bear the aforementioned in mind in evaluating your patient's ability to withstand eight weeks at sea working 12 hours per day, 7 days per week. The purpose of this examination is to protect the health and safety of this employee, his/her fellow employees, and the scientific objectives of the expedition. To assist you in this evaluation and in determining what immunizations are required, please refer to the description of physical exam requirements for this participant (Attachment 3). Please refer to Attachment 2 for further information regarding typical physical requirements for expedition participants.

Physician, please indicate whether observations/results are within normal limits. If not within normal limits, please provide an explanation (attach additional page if needed).

Pulse Character	<input type="text"/>	Hands and Arms	<input type="text"/>
Temperature (F)	<input type="text"/>	Skin	<input type="text"/>
Eyes	<input type="text"/>	Lungs	<input type="text"/>
Ears *	<input type="text"/>	Cardiac Sounds	<input type="text"/>
Speech	<input type="text"/>	Cardiac Size	<input type="text"/>
Teeth	<input type="text"/>	Abdomen	<input type="text"/>
Gums	<input type="text"/>	Varicocele	<input type="text"/>
Throat	<input type="text"/>	Hydrocele	<input type="text"/>
Nasal Passages	<input type="text"/>	Hemorrhoids	<input type="text"/>
Head	<input type="text"/>	Hernia	<input type="text"/>
Neck	<input type="text"/>	Legs	<input type="text"/>
Glands	<input type="text"/>	Feet	<input type="text"/>
		Varicose Veins	<input type="text"/>

\* Does the employee have perforated/ruptured ear drum(s)?  YES  NO

Please explain: \_\_\_\_\_  
 \_\_\_\_\_

**TO BE COMPLETED BY EXAMINING PHYSICIAN CONTINUED**

Attachment3c

HEIGHT	
cms	ft

WEIGHT	
kgs	lbs

PULSE

Blood Pressure

Complete Blood Count  
Blood Chemistry Profile

	*
	*

TB Skin Test  
Audiogram

	*
	*

Bruce Protocol Stress Test

**As required on Attachment 3 \***

HgbA1C

**As required on Attachment 3 \***

Chest X-Rays (PA and Lateral)

**As required on Attachment 3 \***

**\* All Laboratory results must be attached and returned with exam for these tests.**

Comments regarding above items (please attach extra page if needed):

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Treatment/Immunizations:

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**PHYSICIAN, Please check one:**

- IT IS MY OPINION THAT THIS PATIENT IS PHYSICALLY CAPABLE OF PERFORMING HIS/HER DUTIES.
- THIS PATIENT IS NOT PHYSICALLY CAPABLE OF PERFORMING HIS/HER DUTIES. Please explain below:
- THIS PATIENT IS NOT CLEARED TO SAIL PENDING (tests, further review) Please explain below:

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This judgement is based on the examination and based on the review of medical questionnaire and the typical physical requirements. I performed this physical exam and hereby certify that I am a duly licensed physician.

**Please print or type:**

_____ M.D. _____	
Signature of Examining Physician	Date
Physician Name: _____	
Physician Address: _____	
Office Telephone Number: _____	
Fax Number: _____	

PHYSICIAN: The PARTICIPANT must return this entire package (Medical History Questionnaire, Actual Test Results for Blood, Audiogram, Bruce Protocol Stress Test, TB Skin Test, and all other tests performed to:

Human Resources/Insurance Services <b>CONFIDENTIAL</b> International Ocean Discovery Program 1000 Discovery Drive College Station, Texas 77845 Phone# (979) 845-2583 Fax# (979) 845-1026
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# International Ocean Discovery Program Emergency Contact Form

Employee Name \_\_\_\_\_

Home Address \_\_\_\_\_

Home Phone \_\_\_\_\_

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**I authorize the IODP Human Resources Department to use the information below in an emergency situation:**

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

or

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_





# Hearing History Questionnaire

(Please print. All information must be completed.)

Today's Date: \_\_\_\_\_ Company: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: Male or Female

- 1) Do you use any of the following Hearing Protection when in noise?
 

a) Ear Plugs:	Yes _____ No _____	% of time used when required: _____%
b) Ear Muffs:	Yes _____ No _____	% of time used when required: _____%
c) Canal Caps:	Yes _____ No _____	% of time used when required: _____%
d) Combination:	Yes _____ No _____	% of time used when required: _____%
  
- 2) Last date of Hearing Protection Device training: \_\_\_\_/\_\_\_\_/\_\_\_\_ a) No training received: \_\_\_\_\_
- 3) 8-hour time weighted average noise exposure level: \_\_\_\_\_
- 4) When was your last exposure to noise? \_\_\_\_\_
- 5) Do you have a family member who had hearing loss before age 50? Yes \_\_\_\_\_ No \_\_\_\_\_
- 6) Do you have difficulty hearing? Yes \_\_\_\_\_ No \_\_\_\_\_
 

a) If yes, in which ear? Rt \_\_\_\_\_ Lt: \_\_\_\_\_ Both: \_\_\_\_\_
- 7) Do you wear a hearing aid? Yes \_\_\_\_\_ No \_\_\_\_\_
- 8) Do you have ringing in your ears? Yes \_\_\_\_\_ No \_\_\_\_\_
- 9) Do you have frequent allergy problems? Yes \_\_\_\_\_ No \_\_\_\_\_
- 10) Do you experience frequent or severe dizziness? Yes \_\_\_\_\_ No \_\_\_\_\_
- 11) Have you had a cold or the flu in the last two weeks? Yes \_\_\_\_\_ No \_\_\_\_\_
- 12) Have you ever had measles? Yes \_\_\_\_\_ No \_\_\_\_\_
- 13) Have you ever had scarlet fever? Yes \_\_\_\_\_ No \_\_\_\_\_
- 14) Have you ever had diabetes? Yes \_\_\_\_\_ No \_\_\_\_\_
- 15) Have you ever had mumps? Yes \_\_\_\_\_ No \_\_\_\_\_
- 16) Have you ever had meningitis? Yes \_\_\_\_\_ No \_\_\_\_\_
- 17) Have you ever had high blood pressure? Yes \_\_\_\_\_ No \_\_\_\_\_
- 18) Have you taken any medications or antibiotics in the last month? Yes \_\_\_\_\_ No \_\_\_\_\_
 

a) If yes, what? \_\_\_\_\_
- 19) Have you had an ear infection, ear drainage, or an earache within the last month? Yes \_\_\_\_\_ No \_\_\_\_\_
- 20) Are you under a physician's care for ear problems? Yes \_\_\_\_\_ No \_\_\_\_\_
- 21) Have you had ear infections, earaches, or ear drainage in the past? Yes \_\_\_\_\_ No \_\_\_\_\_

**TURN OVER ↓**

- 22) Have you previously had ear surgery? Yes \_\_\_ No \_\_\_  
 a) If yes, which ear? Rt. \_\_\_ Lt. \_\_\_ Both \_\_\_
- 23) Have you ever been exposed to a loud explosion? Yes \_\_\_ No \_\_\_
- 24) Have you ever had a head injury that caused unconsciousness? Yes \_\_\_ No \_\_\_
- 25) Have you ever shot firearms - sport or military? Yes \_\_\_ No \_\_\_
- 26) Do you listen to loud music or play in a band? Yes \_\_\_ No \_\_\_
- 27) Do you participate in any loud hobbies (motorcycles, power tools, racing)? Yes \_\_\_ No \_\_\_
- 28) Have you ever operated power-driven farm equipment? Yes \_\_\_ No \_\_\_
- 29) Have you ever operated construction equipment? Yes \_\_\_ No \_\_\_
- 30) Did you work in a noisy environment at any of your previous jobs? Yes \_\_\_ No \_\_\_
- 31) Do you have a second job that is noisy? Yes \_\_\_ No \_\_\_

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**AUDIOMETRIC TEST (To be completed by person administering the test)**

Audiometer Make/Model: HT Wizard Serial No.: 01021046  
 Last electronic calibration: 11/09/2012 Last biological calibration: \_\_\_\_\_

Was test performed in room which complies with background noise levels in Appendix D of "Audiometer Test Rooms" of Occupational Noise Standard (29 CFR 1910.95)? Yes  No \_\_\_

Type of Test: \_\_\_ Pre-Hire \_\_\_ Annual Surveillance \_\_\_ Retest \_\_\_ Health Evaluation \_\_\_ Other \_\_\_ Exit

Hearing Test Data (dB HL)							
Ear	500 Hz	1000Hz	2000Hz	3000Hz	4000Hz	6000Hz	8000Hz
Left							
Right							

EG= Frequency not tested ED= No response at 95dB maximum EF= No threshold clearly established EE= No response at 90dB maximum

**Left Ear Average:** \_\_\_\_\_ **Right Ear Average:** \_\_\_\_\_

**Examiner's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Comments:** \_\_\_\_\_

St. Joseph Regional Health Center  
Bryan, TX

**TUBERCULIN SKIN TEST  
QUESTIONNAIRE AND CONSENT**

PATIENT NAME: \_\_\_\_\_

COMPANY / DEPT: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

SUPERVISOR: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

**PLEASE ANSWER THE QUESTIONS BELOW:**

YES NO **HAVE YOU EVER HAD A POSITIVE TB SKIN TEST** IN THE PAST, HAVE BEEN SENT FOR A CHEST XRAY OR PUT ON MEDICATION BECAUSE OF A TB TEST? IF YES, DATE OF LAST CXR \_\_\_\_\_

YES NO IN THE PAST 30 DAYS, HAVE YOU BEEN VACCINATED FOR **MMR, POLIO, VARICELLA OR YELLOW FEVER?**

YES NO HAVE YOU EVER HAD A BCG VACCINATION? (A VACCINE FOR TUBERCULOSIS, NOT OFFERED IN THE UNITED STATES)

YES NO ARE YOU CURRENTLY PREGNANT OR BREASTFEEDING?

YES NO HAVE YOU RECEIVED **CHEMOTHERAPY** OR **STEROIDS** WITHIN THE LAST 6 WEEKS?

I HAVE ANSWERED THE QUESTIONS ABOVE TO THE BEST OF MY KNOWLEDGE AND GIVE MY CONSENT TO HAVE THE TB SKIN TEST ADMINISTERED.

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

**SIGNATURE OF PARENT/GUARDIAN IF PATIENT IS UNDER 18:** \_\_\_\_\_

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**TB ADMINISTRATION DOCUMENTATION (TO BE COMPLETED BY TRAINED PERSONNEL ADMINISTERING TEST)**

**TB TEST GIVEN**

DATE SKIN TEST APPLIED: \_\_\_\_\_

TIME APPLIED: \_\_\_\_\_

ADMINISTERED BY: \_\_\_\_\_

MANUFACTURER: \_\_\_\_\_

LOT#: \_\_\_\_\_ EXP DATE: \_\_\_\_\_

SITE (FOREARM) (CIRCLE ONE):    **R**    **L**

**TB SKIN TEST INTERPRETATION**

DATE OF INTERPRETATION: \_\_\_\_\_

TIME READ: \_\_\_\_\_

INTERPRETED BY: \_\_\_\_\_

RESULTS: \_\_\_\_\_mm    SENT FOR CXR: \_\_\_\_\_

**>10MM IS POSITIVE FOR ALL HEALTHCARE WORKERS**

Brazos County Health Dept PKT Complete \_\_\_\_\_  
Employee Injury Report Completed \_\_\_\_\_  
Entered into shared drive spreadsheet \_\_\_\_\_



## Consent for Treatment

I understand that I am seeking employee health services at/from a St. Joseph Health System Facility (the "Clinic") and give my voluntary consent to the attending practitioner or his/her designee(s), including other practitioners, facility personnel, and students, to perform and/or administer all screenings, examinations, diagnostic testing (laboratory, radiology, pulmonary function, FIT testing), immunizations, and treatment, which have been requested by \_\_\_\_\_, my prospective or current Employer.

I understand that Texas law provides that if any healthcare worker is exposed to my blood or other bodily fluid, my blood or other bodily fluid will be tested by this facility to determine the presence of any communicable disease, including but not limited to Hepatitis, Human Immunodeficiency Virus(which is the causative agent of AIDS), and Syphilis. I understand such testing is necessary to protect those who will be caring from me while I am receiving medical services at this facility. I understand that the results of the tests taken under these circumstances do not become part of my medical record.

\_\_\_\_\_ PATIENT'S RIGHTS AND RESPONSIBILITIES: I acknowledge receipt of the statement "Patients' Rights."

\_\_\_\_\_ NOTICE OF PRIVACY PRACTICES: I acknowledge receipt of the St. Joseph *Notice of Privacy Practices*.

This form has been fully explained to me and I certify that I understand its contents.

\_\_\_\_\_  
Signature of Patient (or Patient Representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient (or Patient Representative)

\_\_\_\_\_  
Authority of Representative to Act for Patient  
(Relationship to Patient)



## Patient Authorization for Release of Health Records – Testing or Treatment at Request of Employer

1. I authorize St. Joseph Health System to disclose information from the health records of:

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

2. The information is to be disclosed to Patient’s prospective or current employer as identified below (“Employer”):

Name of Employer: International Ocean Discovery Program

Address: 1000 Discovery Drive, College Station, TX 77845

Contact Person: Ollie Berka

I authorize this information to be disclosed in the following ways (initial below):

\_\_\_\_\_ **Written/Photocopy/Paper**

\_\_\_\_\_ **Verbal**

\_\_\_\_\_ **Fax** at the following fax number: \_\_\_\_\_

\_\_\_\_\_ **Electronic Mail** at the following email address: \_\_\_\_\_

3. **Date(s) of Treatment:** \_\_\_\_\_

4. I authorize St. Joseph to disclose to Employer the results of all screenings, examinations, diagnostic testing (laboratory, radiology, pulmonary function, FIT testing), immunizations, and treatment provided to Patient at the request of Employer.

5. I understand that I may withdraw or revoke this authorization at any time. However, any disclosures already made pursuant to this authorization are unable to be taken back. I may revoke this authorization by notifying St. Joseph Health System in writing.

6. My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by Employer and may no longer be protected by Federal or Texas privacy regulations.

7. Unless revoked earlier, this authorization expires in one year unless I specify another time: \_\_\_\_\_.

8. I release St. Joseph Health System, its affiliates, and their employees and agents from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

\_\_\_\_\_  
Signature of Patient (or Patient Representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient (or Patient Representative)

\_\_\_\_\_  
Authority of Representative to Act for Patient  
(Relationship to Patient)

**Additional Physical Exam Requirements for Participants with Depression, Mental Illness, and/or Emotional Problems**

Attachment 4

It is IODP's policy to request additional information if a participant indicates he/she has been treated for or under the care of a physician/psychologist for depression, mental illness, and/or emotional problems in the last 12 months. Two additional items are required. A statement from the physician who performs the physical indicating that he/she is aware that you are/were being treated for mental illness, depression, and/or emotional problems and in his/her professional opinion that you can sail for two months. Second, IODP also requires a statement from the physician that was/is treating you for depression, mental illness, and/or emotional problems. Please provide the letter in Attachment 4a to your physician or please contact IODP's Human Resources and we can fax the letter to your physician. This letter explains the working conditions and environment on the ship. In addition, the letter requests the physician's professional opinion on how sailing for two months may affect your recent depression, mental illness, and/or emotional problems and his/her opinion on your fitness for sea duty in regards to your depression, mental illness, and/or emotional problems.

**Until this information is received and is reviewed, a decision can not be made regarding your fitness for sea duty.**

Please feel free to call me at 979/845-2583 if you have any questions regarding this matter.

June 30, 2017

To Whom It May Concern:

\_\_\_\_\_ is scheduled to sail aboard the *JOIDES* Resolution for two months  
(Name)  
starting in November 2017. \_\_\_\_\_ indicated on the medical history of his/her  
(Name)  
seagoing physical examination that he/she is being/was treated for depression, mental illness, and/or  
emotional problems.

The location of the ship will be several days from the nearest port. The ship is a closed environment with close quarters and shared accommodations and in an industrial environment. His/Her work will involve 12 hour shifts, seven days a week for the entire deployment (~60) days. IODP is concerned about this participant sailing due to his/her treatment for depression, mental illness, and/or emotional problems in relation to shipboard conditions.

Please provide a statement indicating your professional opinion regarding the impact shipboard conditions may have on this participant in relation to their condition and your opinion on his/her fitness to participate in a two-month expedition. You can fax this statement to me at 979-845-1026.

IODP is requesting this statement to ensure that this participant or others are not going to be put at risk if he/she is allowed to sail.

Sincerely,

Human Resources Representative

## INTERNATIONAL OCEAN DISCOVERY PROGRAM PHYSICAL EXAM REIMBURSEMENT FORM

To: Human Resources Representative Date \_\_\_\_\_

From: \_\_\_\_\_ Expedition \_\_\_\_\_

*Exam Expense:*

In order for ASPP employees to be reimbursed for the physical exam expenses, employees are required to submit proof of payment for expenses incurred. All exams must be paid by the employee before submitting a reimbursement form. **Payment cannot be made to the provider.** All claims *must* have an itemized statement of charges for processing funds of reimbursement or claim will be held until such required information is provided. **Attach all receipts to this form.**

Charge to Cost Center: \_\_\_\_\_ Sub Code: \_\_\_\_\_

Make Check Payable to: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Total Due Claimant: \$ \_\_\_\_\_

I certify that the expenses listed above were incurred for the physical medical exam requested by the International Ocean Discovery Program as a sea-going participant.

\_\_\_\_\_  
Claimant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Department Head or Delegate

\_\_\_\_\_  
Date



NAME \_\_\_\_\_

This employee may be required to take mandatory training which includes marine fire-fighting, wearing full-face breathing apparatus, survival at sea, hazardous materials emergency response and general radiological safety training. If required to take this training, Attachment 6: OSHA Respirator Medical Evaluation Questionnaire will be completed. After reviewing the questionnaire, please complete below. If you need additional information regarding the training, please contact Ollie Berka at (979) 845-2583.

PHYSICIAN, Please check one:

\_\_\_\_\_ Yes, it is my opinion that this patient is fit to take the mandatory training.

\_\_\_\_\_ No, it is my opinion that this patient is not physically fit to take the mandatory training. Please explain below:

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Physician's Signature

Date

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**Appendix C to Sec. 1910.134: OSHA Respirator Medical Evaluation Questionnaire (Mandatory)**

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

To the employee:

Can you read (circle one): Yes/No

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Part A. Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Today's date: \_\_\_\_\_

2. Your name: \_\_\_\_\_

3. Your age (to nearest year): \_\_\_\_\_

4. Sex (circle one): Male/Female

5. Your height: \_\_\_\_\_ ft. \_\_\_\_\_ in.

6. Your weight: \_\_\_\_\_ lbs.

7. Your job title: \_\_\_\_\_

8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): \_\_\_\_\_

9. The best time to phone you at this number: \_\_\_\_\_

10. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes/No **Tom Powell/St. Joseph Occup. Health Clinic, 979-821-7373**

11. Check the type of respirator you will use (you can check more than one category):
- a. \_\_\_\_\_ N, R, or P disposable respirator (filter-mask, non- cartridge type only).
  - b.  Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

12. Have you worn a respirator (circle one): Yes/No

If "yes," what type(s): \_\_\_\_\_

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Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please circle "yes" or "no").

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 (fits): Yes/No
- b. Diabetes (sugar disease): Yes/No
- c. Allergic reactions that interfere with your breathing: Yes/No
- d. Claustrophobia (fear of closed-in places): 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. Pneumothorax (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 that you've been told about: 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 an 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 when you are lying 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 that you think may be related to lung problems: Yes/No

5. Have you **ever had** any of the following 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 that you've been told about: Yes/No

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. Heartburn or indigestion that is not related to eating: Yes/ No
- f. Any other symptoms that 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 used a respirator, have you **ever had** any of the following problems? (If you've never used a respirator, check the following space and go to question 9:)

- 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 to this questionnaire: Yes/No

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. Have you **ever lost** vision in either eye (temporarily or permanently): Yes/No

11. Do you **currently** have any of the following vision problems?

- a. Wear contact lenses: Yes/No
- b. Wear glasses: Yes/No
- c. Color blind: Yes/No
- d. Any other eye or vision problem: Yes/No

12. Have you **ever had** an injury to your ears, including a broken ear drum: Yes/No

13. Do you **currently** have any of the following hearing problems?

- a. Difficulty hearing: Yes/No
- b. Wear a hearing aid: Yes/No
- c. Any other hearing or ear problem: Yes/No

14. Have you **ever had** a back injury: Yes/No

15. Do you **currently** have any of the following musculoskeletal problems?

- a. Weakness in any of your arms, hands, legs, or feet: Yes/No
- b. Back pain: Yes/No
- c. Difficulty fully moving your arms and legs: Yes/No
- d. Pain or stiffness when you lean forward or backward at the waist: Yes/No
- e. Difficulty fully moving your head up or down: Yes/No
- f. Difficulty fully moving your head side to side: Yes/No
- g. Difficulty bending at your knees: Yes/No
- h. Difficulty squatting to the ground: Yes/No
- i. Climbing a flight of stairs or a ladder carrying more than 25 lbs: Yes/No
- j. Any other muscle or skeletal problem that interferes with using a respirator: Yes/No

Part B Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen: Yes/No

If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions: Yes/No

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals: Yes/No

If "yes," name the chemicals if you know them: \_\_\_\_\_

\_\_\_\_\_

3. Have you ever worked with any of the materials, or under any of the conditions, listed below:

- a. Asbestos: Yes/No
- b. Silica (e.g., in sandblasting): Yes/No
- c. Tungsten/cobalt (e.g., grinding or welding this material): Yes/No
- d. Beryllium: Yes/No
- e. Aluminum: Yes/No
- f. Coal (for example, mining): Yes/No

- g. Iron: Yes/No
- h. Tin: Yes/No
- i. Dusty environments: Yes/No
- j. Any other hazardous exposures: Yes/No

If "yes," describe these exposures: \_\_\_\_\_

\_\_\_\_\_

4. List any second jobs or side businesses you have: \_\_\_\_\_

\_\_\_\_\_

5. List your previous occupations: \_\_\_\_\_

\_\_\_\_\_

6. List your current and previous hobbies: \_\_\_\_\_

\_\_\_\_\_

7. Have you been in the military services? Yes/No

If "yes," were you exposed to biological or chemical agents (either in training or combat):  
Yes/No

8. Have you ever worked on a HAZMAT team? Yes/No

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications): Yes/No

If "yes," name the medications if you know them: \_\_\_\_\_

10. Will you be using any of the following items with your respirator(s)?

- a. HEPA Filters: **NO**
- b. Canisters (for example, gas masks): **YES**
- c. Cartridges: **NO**

11. How often are you expected to use the respirator(s) (circle "yes" or "no" for all answers that apply to you):

- d. Escape only (no rescue): Yes/**NO**
- e. Emergency rescue: **YES**/No
- f. Less than 5 hours **per week**: **YES**/No
- g. Less than 2 hours **per day**: Yes/**NO**
- h. 2 to 4 hours per day: Yes/**NO**

i. Over 4 hours per day: Yes/**NO**

12. During the period you are using the respirator(s), is your work effort:

a. **Light** (less than 200 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift: \_\_\_\_\_ hrs. \_\_\_\_\_ mins.

Examples of a light work effort are **sitting** while writing, typing, drafting, or performing light assembly work; or **standing** while operating a drill press (1-3 lbs.) or controlling machines.

b. **Moderate** (200 to 350 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift: \_\_\_\_\_ hrs. \_\_\_\_\_ mins.

Examples of moderate work effort are **sitting** while nailing or filing; **driving** a truck or bus in urban traffic; **standing** while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; **walking** on a level surface about 2 mph or down a 5-degree grade about 3 mph; or **pushing** a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.

c. **Heavy** (above 350 kcal per hour): **Yes**/No

If "yes," how long does this period last during the average shift: \_\_\_\_\_ hrs. **30** mins. **(drills)**

Examples of heavy work are **lifting** a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; **shoveling**; **standing** while bricklaying or chipping castings; **walking** up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator: **Yes**/No

If "yes," describe this protective clothing and/or equipment: **Respirators can be worn over fire fighting coats and decontamination suits.**

14. Will you be working under hot conditions (temperature exceeding 77 deg. F): **Yes**/No

15. Will you be working under humid conditions: **Yes**/No

16. Describe the work you'll be doing while you're using your respirator(s): **Fire fighting, emergency rescue, and response to hazardous situations.**

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases): **Confines spaces, moving ship, hazardous materials, etc.**



18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):

Name of the first toxic substance: acids  
Estimated maximum exposure level per shift: emergency or training drills  
Duration of exposure per shift: one hour  
Name of the second toxic substance: bases  
Estimated maximum exposure level per shift: one hour  
Duration of exposure per shift: one hour  
Name of the third toxic substance: flammable solvent  
Estimated maximum exposure level per shift: one hour  
Duration of exposure per shift: one hour  
The name of any other toxic substances that you'll be exposed to while using your respirator:

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19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security):  
**rescue, neutralization and removal of hazardous material, clean up**

[63 FR 1152, Jan. 8, 1998; 63 FR 20098, April 23, 1998]

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Occupational Safety & Health Administration  
200 Constitution Avenue, NW  
Washington, DC 20210