WORKNET
Occupational Medicine
managed by NovaCare

Paperwork given _____
Paperwork Received _____
Triaged into the rack/bin _____
Medical services start _____

Patient Registration

Please Print Clearly

Today's Date: _____/_____/_____ Social Security #:_____-_____-_____

First Name:_____ MI:_____ Last Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell/Mobile Phone:_____

Email:_____

Driver's License or State ID #: _____ Date of Birth:_____/_____/_____

Gender (circle): (●) Male ( ) Female

Employer/Potential Employer: _____

By signing below, I acknowledge the following:

1) I hereby give authorization to WORKNET Occupational Medicine to provide me with medical treatment for my work-related injury/illness and/or employment-related physical examination. I understand that employment-related physical examinations are not meant to replace routine health care as provided by my private physician. I also understand that an employment-related examination is often times not a complete evaluation and is being performed solely to evaluate my ability to safely perform the tasks required of me by the job I am applying for or the job I am currently performing.
2) I hereby give WORKNET Occupational Medicine authorization to release to my employer, insurance company, and their representatives any medical information, including any psychiatric and/or HIV related information, which is obtained as part of the treatment for this work related injury/illness, or employment-related physical examination.
3) I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
4) I understand that I may revoke this authorization at any time, except to the extent that action has been taken by WORKNET Occupational Medicine, by providing a written request to the Office where my care was provided.
5) I understand that I am not required to sign this form and medical treatment and/or substance abuse testing will not be withheld as a condition of signing this form.
6) I have been provided the WORKNET Occupational Medicine Notice of Privacy Practices.
7) If you are presenting **ONLY** for a Department of Transportation (DOT) drug and/or alcohol test, you are not required to sign below.

Patient Signature _____ Date_____

Witness_____ Date_____

Substance Abuse Testing

If you are here for substance abuse testing at the request of your employer or prospective employer, the results will be sent to the designated employer representative (DER) at the above-mentioned company. A refusal or failure to submit to the requested test(s) at this time may be viewed as a positive test result by your company policy.

Type of Test: ☑ Urine Drug Test ☐ Breath Alcohol ☐ Other_____

Reason for testing: ☐ Pre-employment ☐ Random ☐ Post Accident ☐ Reasonable Suspicion ☐ Return to Duty ☐ Follow Up ☐ Other _____

Office Use Only

Substance Abuse Test completed (Collector's Initials): Without incident _____ With Incident_____(Comment)

OSHA Respirator Medical Evaluation Questionnaire
(Appendix C to 29 CFR 1910.134)

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). Please answer all of the questions as completely and carefully as you can. If you do not understand any of the questions, contact a WORKNET Occupational Medicine representative.

1. Today's date:_____

2. Your name:_____ Social Security #_____

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 you employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes/No

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): No

    If "yes", what type(s):_____

    _____

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: No

2. Have you *ever had* any of the following conditions:

   a. Seizures (fits): No

   b. Diabetes (sugar disease): No

   c. Allergic reactions that interfere with your breathing: No

   d. Claustrophobia (fear of closed-in places): No

   e. Trouble smelling odors: No

3. Have you *ever had* any of the following pulmonary or lung problems?

   a. Asbestosis: No

   b. Asthma: No

   c. Chronic bronchitis: No

   d. Emphysema: No

   e. Pneumonia: No

   f. Tuberculosis: No

   g. Silicosis: No

   h. Pneumothorax (collapsed lung): No

   i. Lung cancer: No

   j. Broken ribs: No

   k. Any chest injuries or surgeries: No

   l. Any other lung problems that you've been told about: No

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

   a. Shortness of breath: No

   b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: No

   c. Shortness of breath when walking with other people at an ordinary pace on level ground: No

   d. Have to stop for breath when walking at your own pace on level ground: No

   e. Shortness of breath when washing or dressing yourself: No

   f. Shortness of breath that interferes with your job: No

   g. Coughing that produces phlegm (thick sputum): No

   h. Coughing that wakes you early in the morning: No

   i. Coughing that occurs mostly when you are lying down: No

   j. Coughing up blood in the last month: No

   k. Wheezing: No

   l. Wheezing that interferes with your job: No

   m. Chest pain when you breathe deeply: No

   n. Any other symptoms that you think may be related to lung problems: No

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

   a. Heart attack: No

   b. Stroke: No

   c. Angina: No

   d. Heart Failure: No

   e. Swelling in your legs or feet (not caused by walking): No

   f. Heart arrhythmia (heart beating irregularly): No

g. High blood pressure: No

h. Any other heart problem you've been told about: No

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

   a. Frequent pain or tightness in your chest: No

   b. Pain or tightness in your chest during physical activity: No

   c. Pain or tightness in your chest that interferes with your job: No

   d. In the past two years, have you noticed your heart skipping or missing a beat: No

   e. Heartburn or indigestion that is not related to eating: No

   f. Any other symptoms that you think may be related to heart or circulation problems: No

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

   a. Breathing or lung problems: No

   b. Hearth trouble: No

   c. Blood pressure: No

   d. Seizures: 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: No

   b. Skin allergies or rashes: No

   c. Anxiety: No

   d. General weakness or fatigue: No

   e. Any other problem that interferes with your use of a respirator: No

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

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

    a. Wear contact lenses: No

    b. Wear glasses: No

    c. Color blind: No

    d. Any other eye or vision problems: No

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

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

    a. Difficulty hearing: No

    b. Wear a hearing aid: No

    c. Any other hearing or ear problem: No

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

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

    a. Weakness in any of your arms, hands, legs, or feet: No

    b. Back pain: No

    c. Difficulty fully moving your arms or legs: No

    d. Pain or stiffness when you lean forward or backward at the waist: No

    e. Difficulty fully moving your head up or down: No

    f. Difficulty fully moving your head side to side: No

    g. Difficulty bending at your knees: No

h. Difficulty squatting to the ground: No

i. Climbing a flight of stairs or a ladder carrying more than 25 lbs: No

j. Any other muscle or skeletal problem that interferes with using a respirator: No

Part B.

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

   b. Silica (e.g., in sandblasting): No

   c. Tungsten/cobalt (e.g., grinding or welding this material): No

   d. Beryllium: No

   e. Aluminum: No

   f. Coal (for example, mining): No

   g. Iron: No

   h. Tin: No

   i. Dusty environments: No

j. Any other hazardous exposures: No

If "yes", describe these exposures:_____

_____

_____

4. List any second job or side business you have:_____

_____

5. List any previous occupations: _____

_____

6. List your current and previous hobbies:_____

_____

7. Have you been in the military services? No

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

8. Have you ever worked on a HAZMAT team? 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): 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): No

    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)?

    a. Escape only (no rescue): No

b. Emergency rescue only: No

c. Less than 5 hours *per week*: No

d. Less than 2 hours *per day*: No

e. 2 to 4 hours *per day*: No

f. Over 4 hours *per day*: 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 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. ____mins.

Examples of heavy work effort are *lifting* a heavy load (about 50 lbs.) form 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 respirator: No

If "yes", describe this protective clothing and/or equipment:_____

_____

14. Will you be working under hot conditions (temperature exceeding 77°F): No

15. Will you be working under humid conditions: No

16. Describe the work you'll be doing while you're using your respirator(s):_____

_____

_____

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

_____

_____

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:_____

Estimated maximum exposure level per shift:_____

Duration of exposure per shift:_____

Name of the second toxic substance:_____

Estimated maximum exposure level per shift:_____

Duration of exposure per shift:_____

Name of the third toxic substance:_____

Estimated maximum exposure level per shift:_____

Duration of exposure per shift:_____

The name of any other toxic substances that you'll be exposed to while using your respirator:

_____

_____

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):

_____

_____

April 2002

WORKNET
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Physician's Opinion Letter
Respirator

Employee:_____ **Company Name:** _____
SS#:_____ **Company Site:**_____
Job Title or Description:_____
Date of Examination:_____

Reason For Evaluation: Initial / Periodic
Type of Evaluation: Questionnaire Review Only / Questionnaire Review and Examination

Respirator:

☐ Medically approved for use of all respirator(s) including SCBA, subject to fit testing and respirator tolerance.

☐ Medically approved for use of only the following types of respirators, subject to fit testing and respirator tolerance:
- ☐ Dust Mask Respirator
- ☐ N Type HEPA Filters / TB Masks
- ☐ Negative Pressure Cartridge Type Respirator
- ☐ PAPR (Powered Air Pressurized Respirator)
- ☐ SAR (Supplied Air Respirator)
- ☐ SCBA (Self Contained Breathing Apparatus)

☐ Medically approved to perform all work functions and wear all types of personal protective equipment while wearing a respirator.

☐ Employee has been given a copy of the written opinion of the examination and has been informed of any medical conditions requiring further evaluation or treatment.

Comment:_____

_____

Recommended Time Period Until Next Respirator Evaluation*:

	Light to Mod Work	Strenuous Work or SCBA
Age<35	5 years ☐	3 years ☐
35-45y/o	2 years ☐	18months ☐
>45y/o	1 year ☐	1 year ☐

*ACOEM, NIOSH, ANSI recommendations on age based frequency of re-evaluation

Recommended Type of Evaluation at next Respirator Evaluation: Questionnaire Only ☐ Questionnaire and Examination ☐

Based on review of respiratory questionnaire, must come in for physical examination ☐

Printed Name of Health Care Provider:_____

Signature:_____ **Date:**_____

February 2013

WORKNET
Occupational Medicine
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Occupational Health Services

Medical & Physical Screening Examination Report

Name:_____ SSN:_____ Date of Examination:_____
Employer:_____ Job Title:_____
Job "Function"_____

Type of Examination: (Circle)
○Post-offer ○Annual ◉Periodic ○CDL ○Fitness for Duty ○Medical Surveillance ○Other: _____

Fitness Determination:
I have reviewed the occupation and /or health history and available laboratory data, and have examined the above named individual for determining the fitness for duty in the above listed job, and have determined that this person:

☐ is physically qualified for the job described above, based upon / (in the absence of) the description of essential functions for this job as provided by the employer.
☐ is physically qualified for the above job with the following restrictions, accommodations, or exceptions:_____
_____
☐ Based upon the high probability of substantial harm, this employee would pose a direct threat to self or others. The following accommodations might significantly decrease the magnitude of this threat:
_____
☐ is on Medical hold: waiting for additional data
☐ will require further testing to evaluate ability or risk
☐ needs to return in _____ days /weeks/ months for further testing / review prior to a fitness determination
☐ has NOT completed testing required for fitness determination within ten days of notification

☐ is medically qualified to serve as a healthcare worker / child-care worker (circle)
☐ is free of physical conditions or communicable disease that would endanger the health of clients or coworkers.
☐ has physical condition or disease that with proper protective measures, would not endanger the health of clients or coworkers.
☐ is medically qualified as a Pennsylvania School bus driver
☐ Tuberculosis screening has been conducted, the employee is determined to be free of tuberculosis disease, or has been adequately treated.
☐ Tuberculosis screening has been conducted, the employee is advised to return on ____/____/____ for the second stage PPD as recommended by the CDC.

ACIP Recommended Immunity for HealthCare /Child Care Workers:

☐ has adequate proof of immunity to Measles
☐ has adequate proof of immunity to Mumps
☐ has adequate proof of immunity to Rubella
☐ has adequate proof of immunity to Varicella
☐ has adequate proof of immunity to Hepatitis B
☐ Unable to provide proof of immunity
☐ Recommend serology testing for_____
☐ Recommend Vaccination for_____

Special Qualifications
☐ is medically qualified to wear a respirator (see attached certificate for type)
☐ has received a CDL Medical certificate expiring on ____/____/_____ (see attached)

Disposition
☐ has been referred to his or her family physician for follow-up, diagnosis, or treatment of conditions discovered
☐ has been provided information for discussion with his /her family physician related to immunity status
☐ has demonstrated on laboratory testing a condition which requires the following investigation and /or remediation:_____
☐ has been informed of the examination and laboratory findings, all recommendations and determinations
☐ Recommended re-evaluation interval_____
☐ Recommendations:_____
_____

Employee Signature: _____ Physician Signature: _____ Date: ___/___/___

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RESPIRATOR/HAZMAT POTENTIAL EXPOSURE DATA

Employer_____ Date_____
Safety Officer_____ Contact Telephone #_____
Job Title(s)_____

The hazardous materials for which a potential exposure exists include:

- ☐ Chemicals (List)_____
- ☐ Rarified Atmosphere (Less Than 19% Oxygen)
- ☐ Radiation ☐ Biologicals ☐ Products of Combustion ☐ Asbestos
- ☐ Cotton Dust ☐ Silica ☐ Other Dust ☐ Carbon Monoxide

Other risk factors include:

- ☐ High External/Ambient Heat
- ☐ High Humidity
- ☐ Level A or B Hazardous Materials Suites
- ☐ Other Special Clothing
- ☐ High/Low Ambient Pressure (Flying / Divining / Tunnel Building)
- ☐ Other (List)_____

Type of respirator anticipated:

- ☐ SCBA (Self Contained Breathing Apparatus)
- ☐ SAR (Supplied Air Respirator) ☐ Continuous Flow ☐ Pressure Demand
- ☐ PAPR (Powered Air Purifying Respirator)
- ☐ APR (Air Purifying Respirator, cartridge type)
- ☐ Dust Mask

Level of exertion:

- ☐ Light (20 pounds of force occasionally / 10 pounds of force frequently)
- ☐ Moderate (20-50 pounds of force occasionally / 10-25 pounds of force frequently)
- ☐ Heavy (50-100 pounds of force occasionally / 25-50 pounds of force frequently)
- ☐ Strenuous (More than 100 pounds of force occasionally / 50 pounds of force frequently)

Extent of usage:

☐ Daily ☐ Task Dependent (Occasionally) ☐ Rarely ☐ Emergency Use Only

Duration of usage per assignment:

- ☐ Full Shift (More Than 6 Hours Per Day) ☐ More Than 2 Hours Per Day
- ☐ More Than ½ Hour Per Day ☐ Less Than ½ Hour Per Day

Duration of assignment:

☐ As Needed, Less Than Monthly ☐ Weekly ☐ Daily For _____ Months Per Year

Signature of Person Completing Form_____
Name (Print)_____

April 2003

WORKNET
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Respiratory Fit Test

Mandatory Preparations and Requirements for testing

- ✓ Patient's face should be **clean-shaven** in the area where the mask must make a seal with the face. If facial hair is present, the patient will be turned away – per OSHA standards.
- ✓ Do not eat, chew gum, or smoke **15 minutes prior to the test**. The patient is permitted to drink plain water prior to the exam.
- ✓ Patient should bring **two (2)** ***types*** of Respirators in **two (2)** ***sizes*** to ensure proper fitting of a respirator on the patient.
- ✓ If possible, have the patient bring in the bag that the respirator was packaged in, as the instructor will review the proper cleaning methods for the respirator.
- ✓ Based on the type of solution used during the fit testing, the cartridges required for the test are particulate cartridges. Make sure the employee/patient brings with them **two (2) particulate cartridges** for the fit test. (3-M – Filter # 2097)
- ✓ OSHA Respiratory questionnaire **must be completed** and approved by the physician prior to the start of the respirator fit test/instruction.
- ✓ Based on the information provided on the respiratory questionnaire listed above, the **physician may require that a medical exam be performed** before the fit test begins.
- ✓ Educate the patient/your employee **on the potential exposures in the workplace** that warrant a respirator to be worn. OSHA requires that the employee has some knowledge as to why he/she will need to wear a respirator and therefore, be fit tested.
- ✓ Typically, the subject should have already been instructed on how to don the mask before the fit test.