ATTACHMENT 5

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Employer Medical Examination Report As Required By OSHA

Name of Employee:	Medical Record/Social Security Number:	OH Number:

A. Notification: The employee was informed of all significant abnormal findings (EHS consultants: please note that it is your responsibility to notify employee).

B. Overall Results: The following abnormalities may be related to the employee's occupational exposure to chemical, physical and/or biologic agents:

Abnormality

☐ Hearing Loss
☐ Elevated Lead Level

Recommendations

Hearing Conservation Program
☐ Other _____

_____

C. Specific Results

	EMPLOYEE RESULTS	WITHIN NORMAL LIMITS
Lead Level	_____MCG/DL	Yes ☐ No ☐
ZPP Level	_____MCG/DL	Yes ☐ No ☐
Plasma Cholinesterase	_____U/L	Yes ☐ No ☐
RBC Cholinesterase	_____U/L	Yes ☐ No ☐
Other	_____	Yes ☐ No ☐

D. Hearing Results (See enclosed Audiometric Record):

☐ Normal
☐ Abnormal

Baseline Audiogram date: Both ears _____/_____/_____
Baseline Audiogram date: Left ear _____/_____/_____ ☐ No Baseline Available
Baseline Audiogram date: Right ear _____/_____/_____

Left Ear STS ☐ Yes ☐ No If STS, confirmed on ____/____/____ Recordable? ☐ Yes ☐ No
Right Ear STS ☐ Yes ☐ No If STS, confirmed on ____/____/____ Recordable? ☐ Yes ☐ No

E. Respirator Use and Special Program Certification

☐ Found fit to use the following respirators:
☐ Found unfit to use respirators

Certified for: ☐ 1 year ☐ 2 years ☐ 3 years

☐ Filter Respirator (Dust Mask Type)
☐ Cartridge/Cannister Respirator (M17)
☐ PAPR
☐ Supplied Air Respirator
☐ SCBA
☐ All of the Above

Recommend the following consultation/testing prior to respirator certification:
☐ Stress test for SCBA use
☐ Other

_____

Cleared for:
☐ CERT/Crisis Intervention/ Unarmed Defensive Tactics
☐ Firefighting
☐ Confined Space Work

F. Asbestos Report

☐ The employee has increased risk of developing medical problems associated with asbestos exposure for the following reasons(s):
☐ Demonstrated pulmonary dysfunction
☐ Hobbies increase risk
☐ Smokes (advised of increased risk of lung cancer)
☐ Other_____

Recommendations:

☐ Suspend asbestos exposure activities
☐ Reexamine in ☐ 1 year ☐ 6 months ☐ 3 months
☐ Consult pulmonary specialist

B-Reading CXR Results:
☐ Negative for asbestos-related pathology
☐ Pos. _____

Examining Physician/PA/NP	Date	Reviewed by (initial)

ATTACHMENT 6

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Preplacement Examination Determination

CANDIDATE'S NAME:	SOC. SEC. #
ADDRESS:	EXAM DATE:
	JOB TITLE:
	AGENCY:

I have examined the above-named candidate and certify that he/she meets the physical/medical standards for this job title. For candidates who require clearance to wear a respirator, I certify that the candidate is fit to use:

☐ Negative Pressure Respirators

☐ Positive Air Purifying Respirator

Signed _____Date_____

I have examined the above candidate and certify that he/she does not meet the physical/medical standards for this job title. Specifically, the candidate did not meet the following standard(s) below:

Please list the **number** of the standard, **why** the standard was not met, and **what action**, if any, must be taken to meet the standard. For example:
[Standard 5 - Cardiovascular - Abnormal EKG - Needs cardiac work-up & clearance for unrestricted work]

_____

_____

Signed _____Date_____

EHS PHYSICIAN REVIEW: ☐ QUALIFIED

☐ DISQUALIFIED REMEDIABLE

Signed _____Date_____

COMMENTS: _____

_____

_____

ATTACHMENT 7

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Medical History Questionnaire for Occupational Health Examination Form

Name	***EHS Acct. No.***	***Date***

Personal Privacy Protection Law Notification

The information you are providing on this questionnaire is being requested for the principal purpose of conducting an evaluation of your health with reference to a confidential profile of your medical history. It is being collected and maintained as a result of your voluntary request for an examination or pursuant to Section 50 of the Civil Service Law. This information will be used in accordance with Section 96(1) of the Personal Privacy Protection Law. Failure to provide this information may prevent the Employee Health Service from making such an evaluation. This information will be maintained by the Administrator, Employee Health Service, NYS Department of Civil Service, 55 Mohawk Street – Suite 201, Cohoes, NY 12047. For further information relating only to the Personal Privacy Protection Law, call (518) 457-9375. If you have a question regarding this form, please call (518) 233-3100.

REASONS FOR EXAM

☐ Firefighting ☐ Weapons Training Officer ☐ SCUBA Diver
☐ Confined Space Work ☐ Toxic Chemical Exposure ☐ Respirator Clearance
☐ Noise exposure ☐ Other

AGENCY/JOB TITLE

_____

WORK INJURIES Please list all work injuries (e.g., back, neck, hand):

Injury	Date	Injury	Date

SOCIAL HISTORY

Have you ever smoked cigarettes? ☐ ***YES*** ☐ ***NO*** If ***YES***, packs per day? _____ Years smoked? _____

If ***YES,*** do you currently smoke cigarettes? ☐ ***YES*** ☐ ***NO*** If ***NO***, year quit _____

Do you smoke cigars and/or a pipe? ☐ ***YES*** ☐ ***NO***

MEDICAL HISTORY

Do you have any existing medical problem that would interfere with your ability to perform the essential duties of the position(s) listed above? If ***YES***, describe briefly. ☐ ***YES*** ☐ ***NO***

_____

Have you ever had any of the following conditions?

Seizures	☐ ***YES***	☐ ***NO***	Allergic reactions that interfere with your breathing	☐ ***YES***	☐ ***NO***
Diabetes	☐ ***YES***	☐ ***NO***	Claustrophobia (fear of closed-in places)	☐ ***YES***	☐ ***NO***
Trouble smelling odors	☐ ***YES***	☐ ***NO***	High cholesterol and/or Triglycerides	☐ ***YES***	☐ ***NO***
Arthritis	☐ ***YES***	☐ ***NO***	Cancer or Blood Disease	☐ ***YES***	☐ ***NO***
GI or Liver Disease	☐ ***YES***	☐ ***NO***	Kidney or Urologic Disease	☐ ***YES***	☐ ***NO***
Neurologic Disorder	☐ ***YES***	☐ ***NO***	Psychiatric Disorder	☐ ***YES***	☐ ***NO***

Have you ever had any of the following pulmonary (lung) or cardiovascular (heart) conditions?

Asbestosis/Silicosis	☐ ***YES***	☐ ***NO***	Chronic Bronchitis/Emphysema	☐ ***YES***	☐ ***NO***
Asthma	☐ ***YES***	☐ ***NO***	Pneumothorax (collapsed lung)	☐ ***YES***	☐ ***NO***
Pneumonia	☐ ***YES***	☐ ***NO***	Any chest injuries or surgeries (broken ribs)	☐ ***YES***	☐ ***NO***

Lung cancer	☐ *YES*	☐ *NO*	Pulmonary embolus or DVT (blood clot in lungs or legs)	☐ *YES*	☐ *NO*
Tuberculosis	☐ *YES*	☐ *NO*			
Heart Attack	☐ *YES*	☐ *NO*	Leg ulcers	☐ *YES*	☐ *NO*
Stroke (TIA)	☐ *YES*	☐ *NO*	Heart arrhythmia (heart beating irregularly)	☐ *YES*	☐ *NO*
Angina (Chest pain)	☐ *YES*	☐ *NO*	High blood pressure	☐ *YES*	☐ *NO*
Heart failure	☐ *YES*	☐ *NO*	Abnormal electrocardiogram	☐ *YES*	☐ *NO*
Syncope (passing out)	☐ *YES*	☐ *NO*			

Do you currently have any of the following symptoms of pulmonary (lung) or cardiovascular (heart) illness?

Shortness of breath at rest or during the night	☐ *YES*	☐ *NO*
Shortness of breath when walking at an ordinary pace on level ground (need to stop to catch your breath)	☐ *YES*	☐ *NO*
Shortness of breath when walking fast on level ground or walking up a slight hill or incline	☐ *YES*	☐ *NO*
Shortness of breath when lying down (relieved by getting up or using several pillows)	☐ *YES*	☐ *NO*
Coughing that produces phlegm (thick sputum)	☐ *YES*	☐ *NO*
Frequent or severe coughing spells (except with a cold) or coughing up blood	☐ *YES*	☐ *NO*
Wheezing	☐ *YES*	☐ *NO*
Chest pain when you breathe deeply	☐ *YES*	☐ *NO*
Chest pain with exertion or at rest	☐ *YES*	☐ *NO*
Heartburn or indigestion that is not related to eating	☐ *YES*	☐ *NO*
Irregular heart beat (skipping beats) or rapid heart beat	☐ *YES*	☐ *NO*
Cramps in the calves when walking	☐ *YES*	☐ *NO*
Swelling in the ankles/feet	☐ *YES*	☐ *NO*

Do you currently have any of the following vision problems?

Wear contact lenses or glasses	☐ *YES*	☐ *NO*	Lost vision in either eye	☐ *YES*	☐ *NO*
Color blind	☐ *YES*	☐ *NO*	Any other eye or vision problem	☐ *YES*	☐ *NO*

Do you currently have any of the following hearing problems?

Difficulty hearing	☐ *YES*	☐ *NO*	History of injury to your ears	☐ *YES*	☐ *NO*
Wear a hearing aid	☐ *YES*	☐ *NO*	Any other hearing or ear problem	☐ *YES*	☐ *NO*

Have you ever had a back injury? ☐ *YES* ☐ *NO*

Do you currently have any of the following musculoskeletal or neurological problems?

Weakness or numbness in any of your arms, hands, legs or feet	☐ *YES*	☐ *NO*
Back/neck pain	☐ *YES*	☐ *NO*
Difficulty fully moving your arms and legs or walking/running	☐ *YES*	☐ *NO*
Any other musculoskeletal or neurological problem	☐ *YES*	☐ *NO*

If you answered ***YES*** to any questions under ***MEDICAL HISTORY***, please explain _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

MEDICATIONS Please list all medications (including over-the-counter) that you take:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SURGERY HISTORY Please list all surgeries that you have ever had:

Type of Surgery	Date	Type of Surgery	Date
_____	_____	_____	_____
_____	_____	_____	_____

EXPOSURE HISTORY Have you had workplace exposure to the following:

Asbestos	☐ ***YES*** ☐ ***NO***	Petroleum products	☐ ***YES*** ☐ ***NO***	***Please list other exposures:***
Lead	☐ ***YES*** ☐ ***NO***	Pesticides	☐ ***YES*** ☐ ***NO***	_____
Solvents	☐ ***YES*** ☐ ***NO***	PCBs	☐ ***YES*** ☐ ***NO***	_____
Human Blood	☐ ***YES*** ☐ ***NO***	Noise	☐ ***YES*** ☐ ***NO***	

RESPIRATOR USE

Have you ever used a respirator before? ☐ ***YES*** ☐ ***NO***

If ***YES***, have you ever had any of the following problems while using a respirator?

Eye irritation	☐ ***YES*** ☐ ***NO***	Anxiety	☐ ***YES*** ☐ ***NO***
Skin allergies or rashes	☐ ***YES*** ☐ ***NO***	Any other hearing or ear problem	☐ ***YES*** ☐ ***NO***
Any other problem that interferes with your use of a respirator			☐ ***YES*** ☐ ***NO***

If ***YES***, please explain any conditions that you checked above:_____

Signature:_____ ***Date:_____***

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

RESPIRATORY QUESTIONNAIRE

Client's Name _____

SS# or EHS# _____ **Date** _____

Personal Privacy Protection Notification

The information you provide on this form is being requested for the principal purpose of conducting a pulmonary examination. The information will be used in accordance with Section 96(1) of the Personal Privacy Protection law, particularly subdivisions (b), (e) and (f). Failure to provide this information may interfere with our ability to conduct such examination. This information will be maintained by the Administrator of Employee Health Service, NYS Department of Civil Service, 55 Mohawk Street – Suite 201, Cohoes, NY 12047. For further information concerning the Personal Privacy Protection Law, call (518) 457-9375. If you have questions concerning this form, please call (518) 233-3100.

YES	NO	
		Have you had major surgery (including eye surgery) in the last six weeks? If yes, what type of surgery? _____ Date _____ (Clearance required.)
		Do you have high blood pressure? If yes, list medications taken for blood pressure: _____ (Clearance required if systolic BP ≥ 180 and/or diastolic BP ≥ 110.)
		Are you under a physician's care for a heart condition? If yes, list medications taken for heart condition: _____ (Clearance required if current chest pain, shortness of breath.)
		Have you ever smoked (cigarettes, cigars, pipe)?
		If yes, do you currently smoke?
		If yes, have you smoked within the last one hour? (If yes, delay test for one hour.)
		Have you eaten a full meal within the last one hour? (If yes, delay test for one hour.)
		Have you had a respiratory infection (flu, chest cold, pneumonia, bronchitis) within the last three weeks? (Test, if possible; otherwise reschedule in three weeks.)
		Do you have a history of allergies or asthma?
		If yes, list medications taken for lung condition: _____
		If yes, have you used an inhaled bronchodilator within the last one hour? (If yes, delay test one hour.)
		Are you wearing any tight or restrictive clothing or vests?
		Do you have dentures?

Height: _____ Feet _____ Inches Weight: _____ Pounds

Technician's Assessment

Questionnaire Review:
- ☐ No contraindication to testing.
- ☐ Testing canceled; needs to be rescheduled in _____ weeks.
- ☐ Physician/PA clearance required

Cleared by: _____ MD/PA

Client's Performance:
- ☐ Good effort; valid test
- ☐ Satisfactory effort; valid test
- ☐ Poor effort
- ☐ Unable to obtain three valid tests

Reason: _____ Technician's Initials: _____

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Public Health Roentgenographic Interpretation Form

Reset Form

CHEST RADIOGRAPH CLASSIFICATION

FEDERAL MINE SAFETY AND HEALTH ACT OF 1977
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL & PREVENTION

Coal Workers' Health Surveillance Program
National Institute for Occupational Safety and Health
1095 Willowdale Road, MS LB208
Morgantown, WV 26505
FAX: 304-285-6058

OMB No.: 0920-0020
CDC/NIOSH (M) 2.8
REV. 01/2015

DATE OF RADIOGRAPH (mm-dd-yyyy) ☐☐-☐☐-☐☐☐☐

EXAMINEE'S Social Security Number ☐☐☐-☐☐-☐☐☐☐

Full SSN is optional, last 4 digits are required.

TYPE OF READING A ☐ B ☐ F ☐

FACILITY Number - Unit Number ☐☐☐☐☐-☐☐☐

Note: Please record your interpretation of a single radiograph by placing an "x" in the appropriate boxes on this form. Classify all appearances described in the ILO International Classification of Radiographs of Pneumoconiosis or Illustrated by the ILO Standard Radiographs. Use symbols and record comments as appropriate.

1. IMAGE QUALITY ☐ 1 ☐ 2 ☐ 3 ☐ 1/- (If not Grade 1, mark all boxes that apply)

☐ Overexposed (dark) ☐ Underexposed (light) ☐ Artifacts ☐ Improper position ☐ Poor contrast ☐ Poor processing ☐ Underinflation ☐ Mottle ☐ Other (please specify)

2A. ANY CLASSIFIABLE PARENCHYMAL ABNORMALITIES? YES ☐ Complete Sections 2B and 2C NO ☐ Proceed to Section 3A

2B. SMALL OPACITIES

a. SHAPE/SIZE — PRIMARY: p q r; SECONDARY: s t u

b. ZONES — R L: UPPER ☐☐ MIDDLE ☐☐ LOWER ☐☐

c. PROFUSION: 0/- 0/0 0/1 / 1/0 1/1 1/2 / 2/1 2/2 2/3 / 3/2 3/3 3/+

2C. LARGE OPACITIES SIZE O A B C — Proceed to Section 3A

3A. ANY CLASSIFIABLE PLEURAL ABNORMALITIES? YES ☐ Complete Sections 3B, 3C NO ☐ Proceed to Section 4A

3B. PLEURAL PLAQUES *(mark site, calcification, extent, and width)*

Chest wall	Site	Calcification	Extent (chest wall; combined for in profile and face on)	Width (in profile only) (3mm minimum width required)
In profile	O R L	O R L	O R 1 2 3 / O L 1 2 3	O R a b c / O L a b c
Face on	O R L	O R L		
Diaphragm	O R L	O R L		
Other site(s)	O R L	O R L		

Up to 1/4 of lateral chest wall = 1; 1/4 to 1/2 of lateral chest wall = 2; > 1/2 of lateral chest wall = 3

3 to 5 mm = a; 5 to 10 mm = b; > 10 mm = c

3C. COSTOPHRENIC ANGLE OBLITERATION R L Proceed to Section 3D NO ☐ Proceed to Section 4A

3D. DIFFUSE PLEURAL THICKENING *(mark site, calcification, extent, and width)*

Chest wall	Site	Calcification	Extent (chest wall; combined for in profile and face on)	Width (in profile only) (3mm minimum width required)
In profile	O R L	O R L	O R 1 2 3 / O L 1 2 3	O R a b c / O L a b c
Face on	O R L	O R L		

Up to 1/4 of lateral chest wall = 1; 1/4 to 1/2 of lateral chest wall = 2; > 1/2 of lateral chest wall = 3

3 to 5 mm = a; 5 to 10 mm = b; > 10 mm = c

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Public Health Roentgenographic Interpretation Form

4A. ANY OTHER ABNORMALITIES? YES ☐ Complete Sections 4B, 4C, 4D, 4E NO ☐ Complete physician info and sign form.

5. PHYSICIAN'S Social Security Number* | **READER'S INITIALS** | **DATE OF READING (mm-dd-yyyy)**

Full SSN is optional, last 4 digits are required.

SIGNATURE | PRINTED NAME (LAST, FIRST MIDDLE)

STREET ADDRESS | CITY | STATE | ZIP CODE

4B. OTHER SYMBOLS (OBLIGATORY)

aa	at	ax	bu	ca	cg	cn	co	cp	cv	di	ef	em	es	fr	hi	ho	id	ih	kl	me	pa	pb	pi	px	ra	rp	tb
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

aa	atherosclerotic aorta
at	significant apical pleural thickening
ax	coalescence of small opacities - with margins of the small opacities remaining visible, whereas a large opacity demonstrates a homogeneous opaque appearance - may be recorded either in the presence or in the absence of large opacities
bu	bulla(e)
ca	cancer, thoracic malignancies excluding mesothelioma
cg	calcified non-pneumoconiotic nodules (e.g. granuloma) or nodes
cn	calcification in small pneumoconiotic opacities
co	abnormality of cardiac size or shape
cp	cor pulmonale
cv	cavity
di	marked distortion of an intrathoracic structure
ef	pleural effusion
em	emphysema
es	eggshell calcification of hilar or mediastinal lymph nodes
fr	fractured rib(s) (acute or healed)
hi	enlargement of non-calcified hilar or mediastinal lymph nodes
ho	honeycomb lung
id	ill-defined diaphragm border - should be recorded only if more than one-third of one hemidiaphragm is affected
ih	ill-defined heart border - should be recorded only if the length of the heart border affected, whether on the right or on the left side, is more than one-third of the length of the left heart border
kl	septal (Kerley) lines
me	mesothelioma
pa	plate atelectasis
pb	parenchymal bands - significant parenchymal fibrotic stands in continuity with the pleura
pi	pleural thickening of an interlobar fissure
px	pneumothorax
ra	rounded atelectasis
rp	rheumatoid pneumoconiosis
tb	tuberculosis

4C. MARK ALL BOXES THAT APPLY: (Use of this list is intended to reduce handwritten comments and is optional)

Abnormalities of the Diaphragm
- ☐ Eventration
- ☐ Hiatal hernia

Airway Disorders
- ☐ Bronchovascular markings, heavy or increased
- ☐ Hyperinflation

Bony Abnormalities
- ☐ Bony chest cage abnormality
- ☐ Fracture, healed (non-rib)
- ☐ Fracture, not healed (non-rib)
- ☐ Scoliosis
- ☐ Vertebral column abnormality

Lung Parenchymal Abnormalities
- ☐ Azygos lobe
- ☐ Density, lung
- ☐ Infiltrate
- ☐ Nodule, nodular lesion

Miscellaneous Abnormalities
- ☐ Foreign body
- ☐ Post-surgical changes/sternal wire
- ☐ Cyst

Vascular Disorders
- ☐ Aorta, anomaly of
- ☐ Vascular abnormality

Date Physician or Worker notified? (mm-dd-yyyy)

4D. Should worker see personal physician because of findings? YES ☐ NO ☐

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Public Health Roentgenographic Interpretation Form

4E. OTHER COMMENTS

Save Form Print

Public reporting burden of this collection of information is estimated to average 3 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection information, including suggestings for reducing this burden to CDC, Project Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0020). Do not send the completed form to this address.

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Consultant Examination Request and Authorization

Reference #_____ We can be reached at: (518) 233-3100 General Info: (518) 233-3131 Fax

EHS Referring Physician	**Signature**	**Date**
Consultant/Vendor	**Location**	
Appointment Date	**Appointment Time**	**Vendor EHS Account Number**
Examinee's Name	**Social Security Number**	
Job Title		
Agency	**Agency Code**	**Cost Center Code**
Agency Payment Coordinator's Name, Address and Telephone Number		

TYPE OF MEDICAL EXAMINATION

☐ **AGENCY REFERRAL**

***Report Should Address*:**

- **Degree of impairment, disability, permanency and impact on usual occupation**
- **Response to the specific inquiries in agency letter to EHS;**
- **Capability of performing full duties of position according to job description; and**
- **If unable to perform full duties, existing limitations and expected duration.**

Comments

☐ **OCCUPATIONAL HEALTH**

Certification:

☐ Asbestos ☐ Hazardous Waste ☐ PCB
☐ Lead ☐ Organic Solvents ☐ Welding Fumes
☐ Herbicides/ Pesticides ☐ Noise ☐ Biologic Agents_____
☐ Other_____

Respirator

☐ Filter or Dust Mask ☐ Supplied Air
☐ Cartridge ☐ SCBA
☐ PAPR ☐ All of the Above

☐ **PREPLACEMENT (See Physical/Medical Standards or Job Descriptions)**

☐ **MANDATORY HEALTH FOR**_____
(Position)

☐ **ANTICIPATED SERVICES**

☐ Comp. Office Consultation/GP
☐ Limited Office Consultation/GP
☐ Psychiatric Consultation
☐ Psychology Consultation (including psychologic testing)
☐ Cardiology Consultation
☐ Audiometry
☐ CXR.B Reading (per Table 2 OSHA standard)
☐ CXR.PA
☐ ECG (Required for SCBA use if age ≥ 40)
☐ Ishihara Color Vision
☐ Breathalyzer/BAC
☐ Blood Alcohol Level with confirmation/chain of custody
☐ Urine Drug Screen/Confirm/Chain of Custody
☐ Lead Serum/ZPP and OSHA Questionnaire
☐ Cholinesterase Serum/RBC
☐ Occult Blood
☐ Complete lab Profile/Urine

NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

Consultant Examination Request and Authorization

- ☐ Pulmonary Consultation
- ☐ Neurology Consultation
- ☐ Orthopedic Consultation
- ☐ Hx and Physical (OH, Preemploy, and Mandatory)
- ☐ Other:_____
- ☐ MMPI
- ☐ Respirator Certification
- ☐ Spirometry
- ☐ Vision
- ☐ Chemistry
- ☐ Hematology
- ☐ Urinalysis
- ☐ Other Diagnostic Tests:_____

OCCUPATIONAL HEALTH EXAMINATION COMPONENTS

	Comprehensive History	Special History Form	Physical Exam	Vital Signs	Audiogram	Vision	EKG	Pulmonary Function	Chest X-ray	Colorectal Screen	Complete Laboratory Profile	Other Services
Noise (29 CFR 1910.95)	No	Required	No	No	Required	No	No	No	No	No	No	STS Calculation
Inorganic Lead (29 CFR 1910.1025)	No	Required	No	No	No	No	No	No	No	No	No	Serum Lead ZPP
Welding Fumes (29 CFR 1910.134) (29 CFR 1910.1025)	Required	Required (OSHA-Lead)	Required	Required	No	No	If Indicated	Required	If Indicated	No	Required	Serum Lead ZPP Fit Testing
Herbicides (29 CFR 1910.134)	Required	No	Required	Required	No	No	If Indicated	If Indicated	If Indicated	Recommended	Required	Fit Testing
Pesticides (29 CFR 1910.134)	Required	No	Required	Required	No	No	If Indicated	If Indicated	If Indicated	Recommended	Required	Serum & RBC Cholinesterase Fit Testing
Asbestos-initial (CFR 1910.1001)	Required	Required	Required	Required	No	No	If Indicated	Required	Required	If Indicated	Required	Fit Testing B-Reading
Asbestos-Follow-Up (CFR 1910.1001)	Required	Required	Required	Required	No	No	If Indicated	Required	If Indicated	If Indicated	Required	Fit Reading B Testing
Silica-Initial (29 CFR 1910.1000)	Required	Required	Required	Required	No	No	If Indicated	Required	Required	Recommended	Required	Fit Testing B-Reading Mantoux
Silica-Follow-Up (29 CFR 1910.1000)	Required	Required	Required	Required	No	No	If Indicated	Required	If Indicated	Recommended	Required	Fit Testing B-Reading
Organic Solvents (29 CFR 1910.1028)	Required		Required	Required	No	No	If Indicated	Required	If Indicated	Recommended	Required	Fit Testing
Respiratory Protection (29 CFR 1910.134)	Required		Required	Required	No	No	If Indicated	Required	If Indicated	Recommended	Required	Fit Testing
Laboratory Workers	Required		Required	Required	No	No	If Indicated	If Indicated	If Indicated	Recommended	Required	Fit Testing

Required - This is a basic component in every medical evaluation.
No - This component is not included in the medical evaluation.
If Indicated - This component is only provided when required by regulation, or with medical justification.
Recommended - Not required for certification but can potentially yield clinically significant results.
Done only with employee consent.