Dear Lower Macungie Fire Department Member,

To speed up the medical physicals process, I have copied forms, which are the same ones that need to be filled out at the doctor's office. If you would like, you may fill them out prior to going to your appointment. Please be sure to keep these pages in the order that you receive them. It will make the process go faster and easier for the staff at Health Works and LVH Diagnostic. I hope this helps out and makes the whole medical physicals process easier for you all.

Please be sure to emphasize that you are with **Lower Macungie Fire Department (formerly Wescosville)** and that you will be getting the cholesterol screening. Not all of the call takers are aware of this and they also confuse us with Macungie Fire Department.

Sincerely,

*Andrew M. Miller*

Andrew M. Miller
EMS Coordinator
Lower Macungie Fire Department

# Lower Macungie Fire Department
# Annual Medical / Physical Procedure

Dear ,

As per our SOPs, all LMFD personnel are required to complete the following steps during the month of his/her birthday. Our records indicate that your birthday month, so your physical will be due by the end of the month. Please remember that if you do not get your physical by this time, you will not be able to use an air pack for the following year. You also will not be invested in the pension or incentive programs for that year. **Please note: work physicals <u>will not be accepted</u> as a replacement for the fire fighter medicals.**

## <u>Step 1</u>: Schedule an appointment at LVH Diagnostic Care Center

Firefighters and Fire Police shall report here for blood work, urinalysis, EKG and chest X-ray (if due).

Call (610) 402-8378 Option #1for English then option 4 for preadmission testing to schedule the appointment. Be sure to mention that you are a member of **Lower Macungie** FD (They tend to confuse us with Macungie FD) and a participant in the fire department Medical Surveillance program. Appointments may be scheduled for Tue, Wed, and Fri 0800-1500 and Thursday 10am- 1800. This is a fasting blood work so you can't have anything to eat or drink 10-12 hrs. prior to blood work, so morning would probably be best if you can. These are the **only** times available so try to schedule your appointment appropriately. LVH requests that appointments be scheduled at least 2 days in advance. Allow about 30-45 minutes to complete the check-in and testing.
Enter through the main lobby of LVH Cedar Crest & I-78. Turn left and follow the signs for the Jandl Pavilion. Once in the Jandl Pavilion, report to the Diagnostic Care center on the first floor, past the elevators, and register with the receptionist.

## <u>Step 2</u>: Schedule an appointment at Health Works (Affinity).

Firefighters and Fire Police shall schedule their physical exam, pulmonary spironetry, and audiometry at Health Works (Affinity) 14 days after their laboratory testing.

Call (610) 402-9285 to schedule the appointment. Be sure to mention that you are a member of LMFD and a participant in the Fire Department Medical Surveillance program. Appointments may be scheduled Monday through Friday between 07:30 and 17:30 hours.

Report to Health Works (Affinity) at 1243 South Cedar Crest Blvd. 1st Floor.

**If you have any questions or problems, please contact Andrew Miller at (951)295-0727 (Cell).**

Lehigh Valley Health Network
A PASSION FOR BETTER MEDICINE

# Welcome to HealthWorks

##

## REGISTRATION FORM

- ☐ Healthworks Allentown
- ☐ HealthWorks Bethlehem
- ☐ HealthWorks Easton
- ☐ HealthWorks Trexlertown

**Please print in blocks below questions. Thank you.**

### PATIENT INFORMATION

| Last name: | First: | MI: |
|---|---|---|
| | | |

| Is this your legal name? | If not, what is your legal name? | (Former name): | Birth date: | Age: | Sex: |
|---|---|---|---|---|---|
| ☐ Yes ☐ No | | | / / | | ☐ M ☐ F |

| Home phone #: | Cell phone #: | Social Security #: |
|---|---|---|
| ( ) | ( ) | - - |

| Street address: | | |
|---|---|---|
| | | |
| **City:** | **State:** | **ZIP Code:** |
| | | |

### EMPLOYER INFORMATION

*****Please list the Employer who requested that you come to HealthWorks. If a Temporary Agency sent you, list them as the Employer. If paying for services yourself, leave employer information blank. *****

| Company/Employer Name: | Employer address: | Name of Company Contact: |
|---|---|---|
| Lower Macungie FD | 958 Brookside Rd. Wescosville, PA 18106 | Andrew Miller |

| Employer phone #: | If working for a temporary employment agency, list where you will be working, if known. | Job Title: | Shift- 1st, 2nd, 3rd |
|---|---|---|---|
| (951) 295-0727 | | | N/A |

### IN CASE OF EMERGENCY

| Name of relative or friend to be called in case of an emergency: | Relationship to patient: | Cell phone #: | Work or Home phone #: |
|---|---|---|---|
| | | ( ) | ( ) |

☐ Check this box if your emergency contact's address is the same as yours.
If different, please record their address below.

| Street address: | City: | State: | ZIP Code: |
|---|---|---|---|
| | | | |

LEHIGH VALLEY HOSPITAL
ALLENTOWN, PA

LEHIGH VALLEY HOSPITAL – MUHLENBERG
BETHLEHEM, PA

FAIRGROUNDS SURGICAL CENTER
LVHN SURGERY CENTER – TILGHMAN
LVHN CHILDREN'S SURGERY CENTER
ALLENTOWN, PA

0 0 1

Name:_____

Date of Birth:_____

# CONSENT FOR TREATMENT

**CONSENT FOR TREATMENT:** I grant authorization to Lehigh Valley Health Network (LVHN) and all its physicians and staff whether employed directly by LVHN or brought in on a consulting basis, for all such treatment and procedures as may be necessary for the patient herein named in accordance with the judgement of the attending physician. I understand that LVHN utilizes telehealth/telemedicine technologies including digital photography, interactive audio and/or video, cloud-based storage and other types of secure HIPAA compliant technologies. Photographs, interactive video, and/or audio may be taken and/or utilized during my stay for treatment reasons or for monitoring my safety. Photographs may become part of my medical record, as appropriate. I acknowledge that no guarantees have been made as to the results of treatments or examinations in the LVHN, or otherwise. I realize that I have the right to refuse any drugs, treatment, procedures or photographs to the extent permitted by law.

**AUTHORITY TO REVIEW AND RELEASE RECORDS AND INFORMATION:** Healthcare providers require access to patient medical information whenever or wherever a patient presents for care to assure safety, quality, and to coordinate patient care across the provider network, avoiding duplication of services. LVHN has a system-wide electronic medical record that is available to caregivers, on a "need to know" basis, to share information about patient care provided in the hospital, outpatient or physician office settings. Confidentiality of records including those reflecting treatment for behavioral health issues, HIV/AIDS or drug or alcohol problems is maintained per relevant governmental and regulatory standards. Patient care summaries are automatically sent to designated Lehigh Valley Physician Group and other community primary care/family/referring physicians, as well as to physicians who are consulted by the attending physician for coordination of care. LVHN and/or the attending physician can furnish and release to federal and state healthcare oversight agencies or upon written request, to all insurance companies or their representatives any information with respect to treatment of the patient herein named including copies of the medical record.

**AUTHORITY TO RELEASE LOCATION AND GENERAL CONDITION:** As a patient, you have the option to be listed in the LVHN public information directory. If you elect not to be listed ("Do Not Announce") your presence will not be acknowledged and mail, telephone calls, flowers and visitors will be refused. Being listed in the public information directory means that your room number, telephone numbers and general condition can be released in matter of public record.

**RELEASE OF RESPONSIBILITY FOR PERSONAL VALUABLES:** I understand and have been made aware that the Hospital provides facilities for the safekeeping of valuables. I release the Hospital from any responsibility due to loss or damage of any valuables that the patient or the undersigned may keep in his possession in the room, or at the bedside, including those valuables that may be brought to him by other persons.

**PAYMENT GUARANTEE:** I do hereby guarantee payment of all fees and charges incurred by and for the named patient from the date admission/service. I agree to make payment in full immediately upon receipt of billings, whether interim or final billings. In the event that the undersigned fails to make payment as provided herein or agrees to alternate arrangements deemed satisfactory by LVHN, affirmative collection measures will be initiated. I agree to pay all costs of collection, including fifteen (15%) percent of the unpaid balance as a reasonable attorney's fees in the event that such indebtedness is turned over to an attorney for collection.

**DATA COMPILATION FOR RESEARCH:** The undersigned hereby grants authorization for the Hospital to use a patient's health information for the internal purpose of gathering and sorting data (or human tissue) by categories to be available for potential use in research studies. If your information is to be used for a research study, you may be asked to sign additional authorization at that time.

**ASSIGNMENT OF BENEFITS:** In the event the undersigned is entitled to insurance benefits of any type out of any program health benefit plan or policy of insurance covering the patient or any other party liable to the patient, then such benefits are hereby assigned to LVHN and may be paid directly to the LVHN. In the event benefits are paid, LVHN shall credit all payments to the patients' account; however, the patient and the undersigned, if not the patient, shall remain responsible for any portion of the LVHN bill not covered by this assignment.

**PRIVACY NOTICE:** I acknowledge receipt of the Health Information Privacy Notice for LVHN and the LVHN Medical Staff on or after April 14, 2003.

**PATIENT RIGHTS:** I hereby acknowledge receipt of information regarding Patient Rights and the complaint process. I understand that I may contact the Department of Health at 800-254-5164 or the Joint Commission, Office of Quality Monitoring at 800-994-6610 or complaint@jointcommission.org if I want to report concerns about patient safety and quality of care.

_____ I decline a copy of the patient rights.
(initials)

**HEALTH INFORMATION EXCHANGES:** LVHN may make your health information available electronically through a state, regional, or national Health Information Exchange (HIE) service or through *Care Everywhere*® Network to facilitate the secure exchange of your health information between and among several health care providers or other health care entities for your treatment, payment, or other healthcare operations purposes. This means we may share information we obtain or create about you with a HIE, which will be made available to outside entities (such as hospitals, doctors offices, pharmacies, or insurance companies) or we may receive information they create or obtain about you (such as medication history, medical history, or insurance information) so each entity can provide better treatment and coordination of your healthcare services. In cases where your specific consent or authorization is required to disclose certain health information to others, we will not disclose that health information without first obtaining your consent. Information that requires additional consent in order to be shared includes psychotherapy notes, treatment for substance or alcohol abuse, and records of tests or treatment for sexually transmitted diseases. **IF YOU ARE NOT INTERESTED IN HAVING YOUR HEALTH INFORMATION SHARED WITH OTHER HEALTH CARE PROVIDERS IN THE HIE, PLEASE INITIAL BELOW TO OPT OUT:**

_____ No, I request that my medical information be excluded from *Care Everywhere*®. I understand this means that other health care providers will not
(initials) be able to obtain my health information through *Care Everywhere*® but they may obtain it through other methods.

**ACKNOWLEDGEMENT FORM:** I certify that I have read this document, that it has been explained and that I understand its contents, and hereby agree to all terms and conditions set forth in paragraphs 1 through 9 set forth above and acknowledges that receipt of a copy if requested.

**MEDICAL ASSISTANCE VERIFICATION:** My signature certifies that I received a service or item on the date listed below. I understand that payment for this service or item will be from Federal and State funds, and that any false claims, statements or documents, or concealment of material may be prosecuted under applicable Federal and State laws.

| | | |
|---|---|---|
| Signature of Patient | Date | Time |
| Signature of Authorized Representative | Date | Time |
| Relationship to Patient | | |
| Witness | Date | Time |

## TB/Fall Risk/DV Questionnaire Interpreter ID:

**Patient Name:** _____ **DOB/MRN:** _____

*Please circle Yes or No for each question*

**Fall Risk**

1. Do you need anything to help you walk (cane, walker, etc.)? Yes No
2. Do you feel unsteady on your feet? Yes No
3. Have you fallen in the past year? Yes No

**TB**

*Please notify nurse or receptionist IMMEDIATELY if you answer "YES" to two or more of the following questions:*

1. Have you been sick with a cough for more than two weeks? Yes No
2. Have you had contact with anyone with tuberculosis or consumption? Yes No
3. Have you ever had tuberculosis or consumption? Yes No
4. Do you have night sweats? Yes No
5. Do you cough up blood? Yes No
6. Have you lost weight recently for no reason? Yes No

**DV Screening**

1. Do you feel safe in your current relationship? Yes No
2. Is someone making you feel bad about yourself? Yes No
3. Within the last year, have you been hit, kicked, punched or otherwise hurt by someone you know? If so, by whom? Yes No
4. Is there someone who is making you feel unsafe now? Yes No

---

***HealthWorks Staff complete below:**** *if YES must be assessed by Nursing Staff or Medical Provider*

*Fall Screening Complete:* _____ *Staff Initial* *Answered Yes to one or more questions: No YES **see documentation*

*TB Screening Complete:* _____ *Staff Initial* *Answered Yes to two or more questions: No YES ** see documentation*

*DV Screening Complete:* _____ *Staff Initial* *Answered No to #1 or Yes to questions #2-4 No YES ** see documentation*

*Disposition:* *Sign, Date & Time:* _____

*Scan into patient record, Media Manager labeled as TB Fall Risk Questionnaire*

Lehigh Valley Health Network

# Consent for Release of Protected Health Information

## Section 1: Patient Information

| | | | |
|---|---|---|---|
| X | PATIENT NAME | SOCIAL SECURITY NO. | DATE OF BIRTH |
| X | PATIENT ADDRESS STATE ZIP CODE | | TELEPHONE NO. |

## Section 2: Location(s) of Care

☐ Hospital * ☐ LVPG Physician Office ☐ Hospice ☐ Home Health
☒ Outpatient Clinic, Satellite location, or specified site ☐ Other Health Care Facility

Address Of LVPG Physician Office, Hospital Clinic, Satellite location(s), or Other Health Care Facility where you received care:

☒ HealthWorks ☐ Company Facility

*Includes Cedar Crest, Muhlenberg and 17th and Chew Hospital locations.

## Section 3: Release Records To:

I hereby consent to and authorize the above entities to release information from my medical record to:

Name of Doctor/Hospital/Insurance Company/Other Agency, Person, or Self: Company/Employer

Lower Macungie F.D.

Address: P.O. Box 3002 Wescosville, PA 18106 Fax#:

For the Purpose of: ☐ Continuation of Care ☐ Social Security/Disability ☐ Insurance Purposes

☐ Legal Purposes ☐ Personal Access ☒ Other: Company Request

Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule or other confidentiality laws.

## Section 4: Specific Information To Be Released

The Information to be released will cover the time period from _____ to _____.

SPECIFIC INFORMATION TO RELEASE:

☐ Record Summary*
☐ Office Notes/Visit Notes
☐ Immunizations
☐ Disability/FMLA Form
☐ Medication List
☐ Problem List
☐ Emergency Room Record
☐ History & Physical Exams
☒ Other (specify) Drug collection, Breath Alcohol, Immunizations, Venipuncture, Audiogram, PFT, Respirator Fit Test, Lab Test Results, Vision Testing, History & Physical Exam

☐ Discharge Summary
☐ Operation Reports
☐ Pathology Reports
☐ Consultation Reports
☐ Laboratory Results
☐ X-Ray Reports
☐ EKG, EEG, Stress Tests

☐ Physician Orders
☐ Diagnostic Films (x-rays, scans)
☐ Photographs
☐ Itemized Bills
☐ Catheterization Lab
☐ Entire Record (includes records from other facilities)

☐ Exception: I do not give permission to release (specify): _____

* For explanation of Record Summary, see Instructions for Completion.

# Consent for Release of Protected Health Information

**Section 5: Special Authorizations For Mental Health, Drug and Alcohol and HIV Records**

**ATTENTION PATIENT: IF APPLICABLE, PLEASE COMPLETE THIS SECTION**

I understand that my medical record may contain "protected information" related to the following categories. My signature next to these items acknowledges my awareness and my authorization to release "protected information" in the record.

_____ Signature — Drug or alcohol information, if drug or alcohol tests were ordered or treatment provided by my physician/provider. (Confidential Alcohol and Drug Abuse Patient Information 42 C.F.R. Part II)

_____ Signature — Psychiatric or psychological information, if psychiatric or psychological treatment was given by my physician/provider. (PA Mental Health Procedure Act).

_____ Signature — HIV related information, if HIV-related tests were ordered by my physician/provider. (Confidentiality of HIV-Related Information Act, PA Law Act 148).

Information is being disclosed from records whose confidentiality is protected by Federal Law [42 C.F.R. Part II] and PA State Statutes [Title 55 Pa. Code 5100.32 and 5100.34 (a) and (b) and DAACA, 71 P.S. 1690.108 (b) & (c)].

**Section 6: Authorization Signatures**

**AUTHORIZATION SIGNATURES**

I understand that in order to process this request for the reproduction of medical record information on a timely basis, Lehigh Valley Health Network may utilize a contracted medical record copying service, and I further authorize the release of my medical record information to such record service for this purpose. I understand that I do not have to sign this form in order to receive treatment at Lehigh Valley Health Network. **Even though the consent for release of information is valid for 90 days** I also understand that this consent may be revoked by me at any time by submitting a written revocation notice, except to the extent that any action that has already been taken as authorized by this form will remain in force in order to achieve the purposes for which it is given. I have a right to request a copy of this authorization. A copy of this authorization is as valid as the original.

Date Consent Expires:_____

X Patient Signature:_____ Date Signed:_____

Signature of Parent/Legal Guardian/Authorized Representative:_____

Printed Name of Parent/Legal Guardian/Authorized Representative:_____

Unable to sign because:_____

Witness signature:_____

☐ Attached is a copy of the appropriate legal document, which proves authority to act on behalf of the patient.

**CONTACT INFORMATION, MAILING/FAXING INSTRUCTIONS:**

Mail/fax the completed form to the appropriate LVHN location or other facility where you received care as follows:

Hospital, (Inpatient and Outpatient Visits) Records:
Lehigh Valley Health Network - Attn. Release of Information
Cedar Crest and I-78 Box 689
Allentown, PA 18105-1556
Phone: 610-402-8240 Mon.-Fri. 8:30AM to 4:00 PM
Fax: 484-884-3824

Home Care and Hospice Records:
2166 12th Street, Allentown, PA 18103
Phone: 610-969-0300
Fax: 610-969-0454

LVPG Physician Office Records and Satellite Locations:
Mail or fax to the physician office or satellite location where you received care. Please see http://www.lvpg.org for a listing of LVPG physician practice locations. Please see http://lvhn.org for a listing of satellite locations.

Other Facility:
_____
_____
_____

**For office use only:**

MRN#:_____ Encounter#:_____

Received:_____ Initial and Date ID Confirmed:_____ Initial and Date Completed :_____ Initial and Date

Lehigh Valley Health Network
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HealthWorks FF

# MEDICAL HISTORY

Name: _____ Date of Birth: _____

Position Applied For: _____ Company: _____

## APPLICANT/EMPLOYEE HEALTH HISTORY

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ☐ | ☐ | 1. Any illness or injury in last 5 years | ☐ | ☐ | 14. Spinal injury or disease |
| ☐ | ☐ | 2. Head/Brain injuries, fainting, seizures, loss of consciousness or stroke/paralysis | ☐ | ☐ | 15. Chronic or ongoing low back pain or neck pain |
| ☐ | ☐ | 3. Eye Disorders or impaired vision (except corrective lenses) | ☐ | ☐ | 16. Missing or impaired hand, arm, foot, leg, finger, or toe |
| ☐ | ☐ | 4. Ear disorders, loss of hearing or balance or exposure to loud noise | ☐ | ☐ | 17. Numbness or tingling of arms, legs, hands or feet |
| ☐ | ☐ | 5. Heart disease or heart attack; other cardiovascular condition. _____ | ☐ | ☐ | 18. Sleep disorders, pauses in breathing while asleep, daytime sleepiness or loud snoring |
| ☐ | ☐ | 6. Diabetes or elevated blood sugar. Controlled by: _____ | ☐ | ☐ | 20. Regular, frequent alcohol use _____ How much? _____ |
| ☐ | ☐ | 7. High Blood Pressure | ☐ | ☐ | 21. Any Narcotic or habit forming drug use? List: _____ |
| ☐ | ☐ | 8. Muscular disease/joint pain/carpal tunnel syndrome/tendonitis | ☐ | ☐ | 22. Tobacco use. If yes, how much: _____ |
| ☐ | ☐ | 9. Shortness of breath | ☐ | ☐ | 24. Any other complaints, disease or illness: _____ |
| ☐ | ☐ | 10. Lung disease such as emphysema, asthma, chronic bronchitis | ☐ | ☐ | 25. Do you have any hobbies? If Yes, please list: _____ |
| ☐ | ☐ | 11. Kidney disease and/ or dialysis | ☐ | ☐ | 26. Do you have a hernia or a lump in your groin? |
| ☐ | ☐ | 12. Nervous or psychiatric disorders (e.g. depression). _____ | | | 27. What jobs or types of work have you performed in the past? Please list: _____ _____ |
| ☐ | ☐ | 13. Digestive problems/ulcers/colitis or liver disease? | | | |

How much work time have you lost in the last 2 years due to illness or injury? _____

How much work have you missed due to a work injury or illness in the last 5 years? _____

Please list exposures you have had that may pose a health risk: _____

Please list any past surgeries (operations): _____

Please list any allergies: _____

Please list all medications including supplements: _____

I certify that the above information is complete and true. I understand that inaccurate, false, or missing information may invalidate the examination.

Signature _____ Date _____

## For Medical provider use only

Please explain all Yes answers, include any effects on job performance:

_____

Lehigh Valley Health Network
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HealthWorks

# PHYSICAL EXAMINATION

Name_____ Date_____

Height_____ Weight_____

Vision with/without correction  Far  RT_____ LT_____ Both_____

Safety glasses ❑Yes ❑ No  Near  RT_____ LT_____Both_____

Color_____

Depth Perception_____%

Peripheral RT_____ LT_____

Hearing:  Whisper RT_____Feet LT_____Feet
❑ See Audiogram

Blood Pressure_____ Repeat_____

Pulse_____

Urine Dip: Sugar_____ Specific Gravity_____ PH_____ Blood_____ Protein_____

***Above completed by: Sign/Date/Time:*** _____

| | Normal | Abnormal | Comments | | Normal | Abnormal | Comments |
|---|---|---|---|---|---|---|---|
| Skin | | | | Lungs | | | |
| Head | | | | Heart | | | |
| Eyes | | | | Abdomen | | | |
| Ears | | | | Genitourinary | | | |
| Nose | | | | Back | | | |
| Throat | | | | Extremities | | | |
| Teeth | | | | Nervous System | | | |
| Neck | | | | | | | |

Findings/Recommendations: Follow-up with personal health care provider for preventative, routine, and on-going evaluation and care.

_____

_____

_____

_____

**Medical Examiner (Print)**_____

**Signature** _____ **Date & Time**_____

Lehigh Valley Health Network
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# AUDIOMETRIC HISTORY

**Date:** _____

**Employee Name:** _____ **SSN:** _____ **DOB:** _____ **Sex:** _____

**Company Name:** _____ **Date of Hire:** _____ **Job Title:** _____

**How Do You Rate Your Hearing:**
- ❑ Good
- ❑ Fair
- ❑ Poor
- ❑ Difficult to Hear in Crowds
- ❑ Difficult to Hear Safety Alarms

**Current Hearing Protection Used:**
- ❑ None
- ❑ Ear Plugs
- ❑ Ear Muffs
- ❑ Both Plugs and Muffs
- ❑ Other: _____

**Reason For Test:**
- ❑ Pre-employment
- ❑ Annual
- ❑ Baseline
- ❑ Retest
- ❑ Exit

**Mark an "X" in the NOW, PAST, or NEVER box next to each item:**

| NOW | PAST | NEVER | |
|---|---|---|---|
| ❑ | ❑ | ❑ | Frequent Earaches |
| ❑ | ❑ | ❑ | Excessive Ear Ringing (Tinnitus) |
| ❑ | ❑ | ❑ | Excessive Dizziness (Vertigo) |
| ❑ | ❑ | ❑ | Head Injury (with unconsciousness) |
| ❑ | ❑ | ❑ | High Fever (Over 104° F) |
| ❑ | ❑ | ❑ | Ear Drainage |
| ❑ | ❑ | ❑ | Ear Surgery Specify: _____ |
| ❑ | ❑ | ❑ | Ear Injury Specify: _____ |
| ❑ | ❑ | ❑ | Sinus Trouble |
| ❑ | ❑ | ❑ | Allergies/Hay Fever |
| ❑ | ❑ | ❑ | Hearing Problems from Medication |
| ❑ | ❑ | ❑ | Ear Infections |
| ❑ | ❑ | ❑ | Bad Cold Today |
| ❑ | ❑ | ❑ | Frequent Asthma Attacks |
| ❑ | ❑ | ❑ | Trouble hearing in Right Ear |
| ❑ | ❑ | ❑ | Trouble hearing in Left Ear |
| ❑ | ❑ | ❑ | Hearing Aid: Right _____ Left _____ |

**NON-WORK EXPOSURE TO NOISE: Do/did you have significant exposure to any of the following without hearing protection outside of work? (Mark an "X" in the NOW, PAST, or NEVER box next to each item.**

| NOW | PAST | NEVER | |
|---|---|---|---|
| ❑ | ❑ | ❑ | Gun Fire |
| ❑ | ❑ | ❑ | Chainsaws/Power Tools |
| ❑ | ❑ | ❑ | Heavy Equipment |
| ❑ | ❑ | ❑ | Aircraft |
| ❑ | ❑ | ❑ | Hunting |
| ❑ | ❑ | ❑ | Loud Music |
| ❑ | ❑ | ❑ | Car Racing |
| ❑ | ❑ | ❑ | Engine Work/Tractor/Auto |
| ❑ | ❑ | ❑ | Pilot a Plane |

_____
**Employee Signature** **Date**

## OTOSCOPIC EXAMINATION

**TO BE COMPLETED BY PHYSICIAN/TECHNICIAN AT TIME OF OTOSCIPIC EXAMINATION.**
**HAS THE WORKER:**

| YES | NO | |
|---|---|---|
| ❑ | ❑ | Been working prior to examination? |
| ❑ | ❑ | Been exposed to noise 14 hours prior to test? If Yes, indicate the number of hours: _____ |
| ❑ | ❑ | Had an audiometric test in the last year? |
| ❑ | ❑ | Had an audiometric test over 1 year ago? |
| ❑ | ❑ | It is unknown whether an audiometric test had been performed. |

Check N (Normal) or A (Abnormal) for each. If A (Abnormal) is checked, describe the abnormality in the space provided.

| | RIGHT | LEFT | DESCRIBE ABNORMAL |
|---|---|---|---|
| External Ear | [N] [A] | [N] [A] | _____ |
| Ear Canal | [N] [A] | [N] [A] | _____ |
| Ear Drum | [N] [A] | [N] [A] | _____ |

**ATTACH AUDIOGRAM**

Lehigh Valley Health Network
A PASSION FOR BETTER MEDICINE

HealthWorks

# PFT Questionnaire

(Pulmonary Function Test)

| | | | |
|---|---|---|---|
| 1. | Have you smoked anything within the past one (1) hour? | Yes | No |
| 2. | Have you had a heavy meal within the past two (2) hours? | Yes | No |
| 3. | Do you wear dentures? | Yes | No |
| 4. | Have you used any aerosol for asthma, etc., within the past two (2) hour? | Yes | No |
| 5. | Have you had any flu or upper respiratory symptoms with in the past three (3) week? | Yes | No |
| 6. | Have you had any current or chronic ear infections? | Yes | No |
| 7. | Have you had surgery recently? | Yes | No |
| 8. | How do you feel today? | _____ | |
| 9. | Please remove restrictive clothing. | | |


☐ HealthWorks Allentown 1243 S. Cedar Crest Blvd., Allentown, PA 18103 ♦ Phone: 610-402-9230
☐ HealthWorks Trexlertown 6900 Hamilton Blvd, Trexlertown, PA 18087 ♦ Phone: 610-402-0047
☐ HealthWorks Bethlehem 1770 Bathgate Rd, Ste 200, Bethlehem, PA 18017 ♦ Phone: 484-884-2249
☐ HealthWorks Easton 2101 Emrick Boulevard, Bethlehem, PA 18020 ♦ Phone: 610-866-9675

**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: 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

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):_____
_____

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: 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

d. 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: 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: Yes/No

b. Canisters (for example, gas masks): Yes/No

c. Cartridges: Yes/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): Yes/No

b. Emergency rescue only: Yes/No

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

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

e. 2 to 4 hours per day: Yes/No

f. 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._____mins.

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:_____

_____

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):

_____

_____

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):

_____

_____

[63 FR 1152, Jan. 8, 1998; 63 FR 20098, April 23, 1998; 76 FR 33607, June 8, 2011; 77 FR 46949, Aug. 7, 2012]

Lehigh Valley Health Network
A PASSION FOR BETTER MEDICINE

HealthWorks

# RESPIRATOR FITNESS / MEDICAL CLEARANCE

Employee Name: _____ SS#: ____/____/____

Company: _____

☐ Medically Fit and Approved for All Respirator Use under any working Conditions

☐ Limited Respirator Use Only:

_____

_____

_____

☐ Not approved for negative pressure respirator but may use a Powered Air-Purifying Respirator (PAPR).

Recommendations including re-evaluation:

_____

_____

_____

☐ Not Medically Fit for Respirator Use

☐ A copy of this form has been given to the employee.

Licensed Healthcare Professional Signature: _____ Date: _____

Licensed Healthcare Professional Name: _____

_____


☐ HealthWorks Allentown 1243 S. Cedar Crest Blvd, Allentown, PA 18103 610-402-9230
☐ HealthWorks Trexlertown 6900 Hamilton Blvd, Trexlertown, PA 18087 610-402-0047
☐ HealthWorks Bethlehem 1770 Bathgate Rd, Bethlehem, PA 18017 484-884-2249
☐ HealthWorks Easton 2101 Emrick Boulevard, Bethlehem, PA 18020 610-866-9675

Lehigh Valley Health Network
A PASSION FOR BETTER MEDICINE

HealthWorks

# FIREFIGHTER PHYSICAL NOTIFICATION FORM

Firefighter's Name: _____ Date of Physical: _____

SS# _____ Title: _____

Firefighter Department Name: _____

Hazardous Material Team Member? _____ Yes _____ No

---

I have examined the above named: _____

_____ He/she is physically fit and cleared to perform assigned duties.

_____ He/she is not physically fit and cleared to perform assigned duties.

_____ He/she is unable to be cleared at this time due to lack of information.

_____ _____

Physician's Signature Date

---

Comments/follow up recommendations: _____

_____

_____

_____ _____

Physician's Signature Date

***The conclusions of this medical assessment are based, in part, on the assumptions that the medical history and any supplied job description or essential functions of the job are true and correct. The employer is responsible for employment decisions when considering accommodation for those with any limitations or restrictions. If there are any questions or concerns about an individual's abilities to perform tasks, please do not hesitate to contact a representative at HealthWorks.**

1243 S. Cedar Crest Blvd., Allentown, PA 18103 ♦ Phone: 610-402-9285 ♦ Fax: 610-402-9293
1770 Bathgate Dr. Suite 200, Bethlehem, PA 18017 ♦Phone: 484-884-2249 ♦Fax: 484-884-8034
2101 Emrick Boulevard, Bethlehem, PA 18020 ♦ Phone: 610-866-9675 ♦ Fax: 610-865-1472
6900 Hamilton Boulevard, Suite 145, Trexlertown, PA 18087 ♦ Phone: 610-402-0047 ♦ Fax: 610-402-0097