ANNUAL MEDICAL/PHYSICAL PROCEDURE

As per our SOPs, all LMFD personnel are required to complete the following steps during the month of their birthday. Please remember that not getting a physical can result in not being eligible for incentives and possibly interior qualification. **Please note: work physicals WILL NOT be accepted as a replacement for the department physical unless other circumstances that have been discussed and approved already.**

Step 1: Receive email with this paperwork and physical packet to fill out

Step 2: Schedule an appointment

Firefighters and fire police shall schedule their appointments for all tests and physical exams at health works. Phone # 610-402-9285 option#1. When scheduling please let them know you are with the **LOWER MACUNGIE FIRE DEPARTMENT and that it is the ANNUAL TESTING.** Health works Allentown is located at 1243 S. Cedar Crest Blvd 1st floor, Allentown PA 18103.

Step 3: Arrival to your appointment with all paperwork.

It is unknown exactly how long it could take but on the safe side I would side with 2 hours for everything but hope it is less.

If you have any issues or problems, please Contact Andrew Miller 951-295-0727.

Lehigh Valley Health Network
Your health deserves a partner.

Welcome to HealthWorks
REGISTRATION FORM

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 Fire Dept.	958 Brookside Rd. Wescosville, PA 18106 POBox 3002 Wescosville, PA 18106-mailing	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
(610) 395 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
LEHIGH VALLEY HOSPITAL-HAZLETON
LEHIGH VALLEY HOSPITAL-POCONO
LEHIGH VALLEY HOSPITAL-SCHUYLKILL
LVHN SURGERY CENTER-TILGHMAN
LVHN CHILDREN'S SURGERY CENTER
LEHIGH VALLEY PHYSICIAN GROUP (All Practices)
LVHN-EAST STROUDSBURG AMBULATORY SURGERY CENTER
LEHIGH VALLEY HOSPITAL-COORDINATED HEALTH ALLENTOWN
LEHIGH VALLEY HOSPITAL-COORDINATED HEALTH BETHLEHEM
LEHIGH VALLEY HEALTH NETWORK REHABILITATION CENTER-SCHUYLKILL
LVHN COORDINATED PROFESSIONAL PRACTICE (All Practices)

LEHIGH VALLEY HEALTH NETWORK CONSENT FOR TREATMENT

PLACE PATIENT LABEL HERE

9.) TELEPHONE CONSENT: I agree to allow LVHN, its agents, and vendors to use pre-recorded or artificial voice messages, or an automatic telephone dialing system, to contact me at the phone numbers that I provided and are on file (including wireless or cell phone numbers), and to leave voice mail messages at these phone numbers and include in any such messages information (including information required by law) about experience outreach and amounts I owe. **IF YOU REFUSE TO PROVIDE TELEPHONE CONSENT, PLEASE CHECK THIS BOX** ☐ Please note that this provision does not affect the ability of LVHN providers to leave messages regarding appointment reminders or treatment information.

10.) ELECTRONIC PRESCRIBING: I understand that LVHN medical practices and offices may use an electronic prescription system which allows prescriptions and relates information to be electronically sent between my LVHN providers and my pharmacy. I have been informed and understand that LVHN providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my LVHN providers to see this health information.

11.) IMMUNIZATION REGISTRY: I understand that LVHN participates in the Pennsylvania Department of Health's statewide immunization registry that collects vaccination history and information to serve the public health goal of preventing the spread of vaccine preventable diseases. The registry complies with federal health information privacy laws.

In addition to the Terms and Conditions set forth in Paragraphs 1 through 11 above, the following also applies to services rendered at, or rendered virtually by, LVHN Hospitals:

AUTHORITY TO RELEASE LOCATION AND GENERAL CONDITION: As a patient, I have the option to be listed in the LVHN public information directory. If I elect not to be listed ("Do NotAnnounce") my 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 the patient's room, or at the bedside, including those valuables that may be brought to the patient by other persons.

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 a patient's information is to be used for a research study, patient may be asked to sign additional authorization at that time.

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 & Patient Safety at: jointcommission.org/resources/patient-safety-topics report-a-patient-safety-event or Fax: 630-792-5636 if I want to report concerns about patient safety and quality of care. I understand that I may have a copy of the patient rights upon request.

In addition to the Terms and Conditions set forth in Paragraphs 1 through 11 above, the following also applies to services rendered at, or rendered virtually by, Lehigh Valley Physician Group (LVPG) and LVHN Coordinated Professional Practice (LCPP) practices:

LVHN EMPLOYEE IMMUNIZATION RELEASE: If you are employed by an LVHN subsidiary, I agree that vaccination documentation can be transmitted to LVHN Employee Health to facilitate any healthcare I may receive regarding occupational exposures or injuries and to verify that I meet vaccination requirements.

RELEASE OF RESPONSIBILITY FOR PERSONAL VALUABLES: I have been made aware and understand that all LVPG and LCPP medical practices and offices provide no facilities for safekeeping of valuables. I do hereby release LVPG/ LCPP from any responsibility due to loss or damage of any valuables that I, or anyone accompanying me, may bring to a medical practice, office or facility.

PERMISSION TO FAX CHILDHOOD IMMUNIZATION RECORD TO SCHOOLS: I do hereby grant permission for LVPG/ LCPP to send or fax childhood immunization records to schools, upon request.

ACKNOWLEDGMENT FORM: I certify that I have read this document, that it has been fully explained to me if requested and that I understand its contents, and hereby agree to all terms and conditions set forth in the paragraphs above and acknowledge receipt of a copy if requested.

Signature of Patient	Date	Time
Signature of Authorized Agent / Representative	Date	Time
Relationship to Patient		
Witness	Date	Time

LEHIGH VALLEY HOSPITAL
LEHIGH VALLEY HOSPITAL-HAZLETON
LEHIGH VALLEY HOSPITAL-POCONO
LEHIGH VALLEY HOSPITAL-SCHUYLKILL
LVHN SURGERY CENTER-TILGHMAN
LVHN CHILDREN'S SURGERY CENTER
LEHIGH VALLEY PHYSICIAN GROUP (All Practices)
LVHN-EAST STROUDSBURG AMBULATORY SURGERY CENTER
LEHIGH VALLEY HOSPITAL-COORDINATED HEALTH ALLENTOWN
LEHIGH VALLEY HOSPITAL-COORDINATED HEALTH BETHLEHEM
LEHIGH VALLEY HEALTH NETWORK REHABILITATION CENTER-SCHUYLKILL
LVHN COORDINATED PROFESSIONAL PRACTICE (All Practices)

0 0 1

PLACE PATIENT LABEL HERE

LEHIGH VALLEY HEALTH NETWORK CONSENT FOR TREATMENT

Please note that this consent applies to services rendered at, or rendered virtually by, the following Lehigh Valley Health Network (LVHN) entities: Lehigh Valley Hospital, LVHN Surgery Center-Tilghman, LVHN Children's Surgery Center, LVHN-East Stroudsburg Ambulatory Surgery Center, Lehigh Valley Hospital-Hazleton, Lehigh Valley Hospital-Pocono, Lehigh Valley Hospital- Schuylkill, Lehigh Valley Hospital-Coordinated Health Allentown, Lehigh Valley Hospital-Coordinated Health Bethlehem, Lehigh Valley Health Network Rehabilitation Center-Schuylkill, Lehigh Valley Physician Group and LVHN Coordinated Professional Practice and all its medical practices.

1.) **CONSENT FOR TREATMENT:** I grant authorization to 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 judgment of the medical provider. I understand that I am responsible for providing complete and accurate information concerning my medical history and current condition to my physician(s) and other health care providers. 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 LVHN, or otherwise. I realize that I have the right to refuse any drugs, treatment, procedures or photographs to the extent permitted by law.

2.) **PAYMENT GUARANTEE:** I do hereby guarantee payment of all fees and charges incurred by and for the named patient from the date of admission/service, including services provided virtually. 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.

3.) **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 LVHN. In the event benefits are paid, LVHN shall credit all payments to the patient's 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. In the event that it is necessary to appeal an insurance payment decision, I authorize LVHN to appeal on my behalf.

4.) **INSURANCE COVERAGE NOTICE:** I acknowledge that LVHN will perform a search for active insurance coverage on all self-pay patients unless specifically requested otherwise with LVHN staff. This search will take place post-discharge, if named patient's bill remains unpaid for a defined period of time.

5.) **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 treating 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.

6.) **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 an 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 CHECK THIS BOX** ☐

7.) **PRIVACY NOTICE:** I acknowledge receipt of the Health Information Privacy Notice for LVHN and the LVHN Medical Staffs on or after April 14, 2003, and as amended from time to time.

8.) **MEDICAL ASSISTANCE VERIFICATION:** I certify 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.

Lehigh Valley Health Network

2 5 9

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: Lower Macungie Fire Dept. Company/Employer

Address: PO Box 3002 Fax#:
Wescosville, PA 18106

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
☐ 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)
■ Other (specify) Drug collection, Breath Alcohol, Immunizations, Venipuncture, Audiogram, PFT, Respirator Fit Test, Lab Test Results, Vision Testing, History & Physical Exam

☐ **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
Your health deserves a partner

MEDICAL HISTORY

HealthWorks

Name_____ **Date of Birth**_____ **Date**_____

Company _____ **Job position**_____

Yes	No		Yes	No	
☐	☐	Head/brain injuries, disorders, or illness	☐	☐	Joint pain/swelling, osteoarthritis
☐	☐	Seizures or epilepsy	☐	☐	Rheumatoid arthritis, lupus, other autoimmune diseases (multiple sclerosis, etc.)
☐	☐	Stroke, TIA, or paralysis	☐	☐	Infectious disease (HIV, tuberculosis, etc.)
☐	☐	Spinal injury to the back or neck	☐	☐	Cancer, leukemia, or lymphoma
☐	☐	Numbness or tingling of arms, legs, hands, or feet	☐	☐	Psychiatric disorders (anxiety, depression, bipolar disorder, ADHD/ADD, OCD, etc.)
☐	☐	Eye disease, eye injury, or vision loss (except glasses or contacts)	☐	☐	Alcohol use – if yes, how much _____
☐	☐	Ear disorders, loss of hearing or balance	☐	☐	Tobacco use/vaping – if yes what/how much _____
☐	☐	Heart disease, heart attack, pacemaker, defibrillator, irregular heartbeat, stents	☐	☐	Narcotic or habit-forming drug use – if yes, describe_____
☐	☐	High blood pressure	☐	☐	Certified to use medical marijuana
☐	☐	Bleeding or clotting disorder, DVT, pulmonary embolism	☐	☐	Other medical problems/injuries not previously mentioned _____ _____ _____
☐	☐	Lung disease (emphysema, asthma, chronic bronchitis, COPD, etc.)			
☐	☐	Sleep disorders, daytime sleepiness, loud snoring, sleep apnea	☐	☐	Any prior work-related injuries or motor vehicle accidents? _____ _____
☐	☐	Digestive disease (GERD, ulcers, Crohn's, IBS, gastritis, etc.)			
☐	☐	Kidney disease, dialysis	☐	☐	Any exposure to hazardous chemicals, loud noise, excessive vibration or radiation? Describe: _____ _____
☐	☐	Liver disease, hepatitis			
☐	☐	Diabetes or elevated blood sugar	☐	☐	What types of jobs have you done in the past? _____ _____
☐	☐	Muscular disease, carpal tunnel syndrome, tendonitis			
☐	☐	Chronic or ongoing lower back pain	☐	☐	Do you have any hobbies? Please list: _____

Explain any YES answers here: _____

_____

List medications: _____

_____

List allergies (drugs, food, latex, etc.): _____

List past surgeries (operations):_____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND TRUE. I UNDERSTAND THAT FALSE OR MISSING INFORMATION MAY VOID THE EXAM.

Employee Signature_____ Date_____

Provider use only:_____

_____

_____

_____

_____ Provider initials:_____

Lehigh Valley Health Network
A PASSION FOR BETTER MEDICINE

HealthWorks

PHYSICAL EXAMINATION

Name_____ **Date of Birth**_____ **Date**_____

Height		Weight (lbs)	BP	Pulse	Temp	SpO2
ft	in		BP			

Vision

Far RT 20/___ LT 20/___ Both 20/___ ☐ w/glasses / corrective lenses

Near RT 20/___ LT 20/___ Both 20/___ ☐ w/glasses / corrective lenses

Color Vision: Pass / Fail **Depth Perception**_____% **Peripheral Vision**: RT_____ LT_____

Hearing

Whisper RT_____ft LT_____ft

☐ See audiogram

Urine Dip

Specific gravity _____ pH _____

Sugar _____ Blood _____ Protein _____

Above completed by: Sign/Date/Time: _____

	Normal	Abnormal	Comments		Normal	Abnormal	Comments
Skin				Lungs			
Head				Heart			
Eyes				Abdomen			
Ears				Hernia	No	Yes	
Nose				Back			
Throat				Extremities			
Teeth				Nervous System			
Neck				Other			

Findings / Recommendations / Comments:

_____

_____

_____

_____

_____

_____

_____

Medical Examiner Signature **Medical Examiner Name** **Date**

Lehigh Valley Health Network
A PASSION FOR BETTER MEDICINE

HealthWorks

MEDICAL ASSESSMENT FOR WORK

Name of Applicant: _____

Name of Company: _____

Date of Medical Examination: _____

Applicant Job Title: _____

Medical Assessment:

_____ ***Applicant has no specific medical limitations or restrictions recommended for job position. If a pre-work screen was requested, refer to results noted below to determine if this applicant meets employer's overall requirements for this position.***

_____ ***Restrictions and/or limitations concerning job activities are recommended:***

_____

_____

Pre-Work Screen* ____Met employer screen ____Did not meet screen (Not qualified for position)

____Not Applicable

**Pre-work screens are developed with the input of the employer and are conducted as a separate assessment by Rehabilitation Services. They are only performed at the request of the employer.*

_____ _____

Physician/Clinician 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 accommodations for those with any limitations or restrictions. If there are 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

Resp. Question.

Lehigh Valley Health Network
A PASSION FOR BETTER MEDICINE

HealthWorks

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 *pushinga* 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 FIT TEST FORM

NAME _____ **DOB**_____

FIT TEST PERFORMED BY _____

PROTOCOL FOLLOWED

IRRITANT SMOKE	BANANA OIL	SACCHARIN
BITREX	QUANTITATIVE FIT TEST	

TYPE OF RESPIRATOR

NORTH	MSA	SURVIVAIR	DISPOSABLE
3M	WILLSON	MODEL # _____	

SIZE

SMALL	MEDIUM	LARGE

CARTRIDGE COLOR

BROWN	WHITE	BLACK	YELLOW
GREEN	HEPA	WHITE	PURPLE

FIT TEST REQUIREMENTS

Y	N	FACIAL HAIR DOES NOT INTERFERE WITH PROPER FIT
Y	N	FITS SNUGGLY AGAINST EMPLOYEE'S FACE
Y	N	BREATHS COMFORTABLE WITH RESPIRATOR DONNED
Y	N	SAFETY GLASSES DO NOT INTERFERE WITH FIT
Y	N	NO PHYSICAL IMPAIRMENT INHIBITS FIT

FIT TEST RESULTS

_____PASS _____FAIL – Reason:_____

_____ _____

Signature of Employee Date

❑ 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

Lehigh Valley Health Network
A PASSION FOR BETTER MEDICINE

HealthWorks

RESPIRATOR FITNESS / MEDICAL CLEARANCE

Employee Name: _____ DOB: ____/____/____

Company: _____

_____

Based on: ☐ review of the OSHA Respiratory Questionnaire ☐ Medical exam

_____

☐ 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).

☐ Not medically fit for respirator use as of this evaluation

Recommendations including re-evaluation: ☐ Annual ☐ Biannual

_____

_____

☐ 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

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.		

Lehigh Valley Health Network
A PASSION FOR BETTER MEDICINE

HealthWorks

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