EASTERNMED

Your Health And Safety Source

PATIENT NAME_____ **DATE** _____

PATIENT ADDRESS_____ **CITY**_____ **ZIP CODE**_____

DOB_____ **PHONE**_____

EMPLOYER NAME_____

MEDICAL SURVEILLANCE

19A PHYSICAL
DOT PHYSICAL
FIRE DEPT PHYSICAL
PHYSICAL
POLICE/ROAD PATROL PHYSICAL
MASK FIT/CLEARANCE
RESPIRATOR WRITTEN OPINION
SCBA FIT TEST
AUDIOGRAM
PFT
EKG
VISUAL ACUITY
PULSE OXIMETRY
ASBESTOS
HAZMAT

TESTING

BLOOD COLLECTION
HAIR/FINGERNAIL
BREATH ETOH
DOT/NIDA COLLECT & TEST
SAP5 COLLECT & TEST
SAP 10 COLLECT & TEST

IMMUNIZATIONS

TETANUS
PPD
HEP B #_____
HEP A
MMR
FLU/PNEUMONIA

LABORATORY

CBC
CHOLESTEROL
HEPATITIS SCREEN
HIV SCREEN
LIPID PANEL
MMR TITER
GLUCOMETER FINGER STICK
HEP B TITER
ZPP
SERUM LEAD
CHEST X RAY 1 VIEW/2 VIEW
URINALYSIS
PSA
OTHER _____

WORKERS COMPENSATION

NEW PATIENT

99201 E/M LEVEL 1
99202 E/M LEVEL 2
99203 E/M LEVEL 3
99204 E/M LEVEL 4
99205 E/M LEVEL5

ESTABLISHED PATIENT

99211 E/M LEVEL 1
99212 E/M LEVEL 2
99213 E/M LEVEL 3
99214 E/M LEVEL 4
99215 E/M LEVEL 5

DIAGNOSIS

INTERNAL NOTES:_____

_____

_____

_____

_____

_____

_____

SIGNATURE – MEDICAL PROVIDER

EASTERN MED, LLC
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CONSENT FOR TREATMENT & RELEASE OF INFORMATION

I consent to receiving treatment and/or a physical examination to be performed by the physician, nurse practitioner and/or professional staff at the Occupational Health Center. I permit the physician, nurse practitioner, and or staff of Eastern Med, LLC to treat me in ways they judge beneficial to me or have been requested by my employer or prospective employer. I understand that this care may include tests, physical examinations, immunizations and the drawing of my blood.

I further consent that the medical information and results of such test or treatment that is related to my job / job functions may be released to the guarantor (Example: The company authorizing and paying for the medical services or their agents).

PERMISSION TO CONTACT YOUR MEDICAL PROVIDER(S)
&
PRIVACY STATEMENT / HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

During the completion of your medical exam, significant findings may be identified which could have an impact on the performance of your work related duties. Further information from your medical provider(s) may be necessary to clear you for the employment or volunteer position you currently seek.

Please sign below if you agree to allow us to contact your medical provider(s) regarding significant medical findings, and / or additional information to clear you for your duties.

Furthermore, you also acknowledge that you have read and understand Eastern Med's HIPAA policy regarding the use of disclosure of protected health information, which is made in accordance with Federal Law (electronic version is available at www.easternmed.com/resources.php).

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

The patient is unable to give consent because: _____

Signature: _____ Date: _____

Relationship: _____

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FIREFIGHTERS
NFPA Medical Clearance Program

PLEASE COMPLETE THE FOLLOWING INFORMATION

FIRE COMPANY: _____

NAME: _____

DATE OF BIRTH: _____ DATE OF EXAM: _____

HOME ADDRESS: _____

HOME PHONE: _____

FAMILY PHYSICIAN: _____

FAMILY PHYSICIAN'S ADDRESS: _____

WHICH CATEGORY BELOW BEST DESCRIBES YOUR CURRENT CATEGORY OF FIREFIGHTER ACTIVITY?
CIRCLE ONE CATEGORY

CATEGORY A	CATEGORY B	CATEGORY C	CATEGORY D
INTERIOR FIREFIGHTER	**EXTERIOR FIREFIGHTER EMERGENCY USE OF SCBA**	**EXTERIOR SUPPORT ACTIVITIES NO RESPIRATOR USE**	**ADMINISTRATIVE ACTIVITIES**

If you are medically qualified would you wish to be upgraded to a higher firefighter category?

Please Circle 'YES or NO'

Please turn to the next page and complete medical history

DO NOT WRITE IN THIS BOX FOR MEDICAL PROVIDERS ONLY

CLEARANCE CATEGORY **A** **B** **C** **D**

☐ FIREFIGHTER COMPLETE EXAM ☐ FIREFIGHTER BRIEF ASSESSMENT

PFT	☐ NORMAL	☐ OBSTRUCTIVE	☐ RESTRICTIVE	☐ N/A
EKG	☐ NORMAL	☐ ABNORMAL		☐ N/A
AUDIOMETRY	☐ ACCEPTABLE	☐ ABNORMAL		☐ N/A
WHISPER	☐ ACCEPTABLE	☐ ABNORMAL		☐ N/A

☐ FIT TEST ☐ SCBA ☐ N95

SIZE: **S** **M** **L** **XL** **STANDARD** **ONE SIZE** **COMFORT SEAL**

☐ URINALYSIS ☐ NORMAL ☐ ABNORMAL

☐ HEP B TITER

VACCINE ☐ HEP B ☐ PPD ☐ FLU

☐ YES ☐ NO Temporarily Disqualified pending receipt and review of requested clearance letter.
☐ YES ☐ NO Recertification delayed pending receipt of requested clearance letter. Firefighter may remain active for duration of current card.
☐ YES ☐ NO Appropriate for firefighter level requested by the firefighter? If "NO" please indicate reason below.

COMMENT: _____

_____

_____

_____

_____

Physician's Name [print] _____

Physician's Signature _____ **DATE** ___/___/_____

NAME_____ DATE_____

FIRE DEPARTMENT_____ AGE_____

BLOOD PRESSURE _____/_____ PULSE_____ [Regular / Irregular] HEIGHT_____ [in] WEIGHT_____ [lbs]

CORRECTIVE LENSES	YES _____	NO_____

BMI_____

VISION	OD [right]	OS [left]	OU [both]
DISTANCE	20/	20/	20/
DISTANCE W/O CORRECTIVE LENSES			20/
NEAR			20/
PERIPHERAL			
COLOR(TRAFFIC SIGNALS)	NORMAL	ABNORMAL	

HEARING

Hertz	AD	AS
500		
1000		
2000		
3000		

PHYSICAL EXAM	NORMAL	ABNORMAL	COMMENTS
1. EYES			
2. EARS			
3. MOUTH/THROAT			
4. NECK			
5. LUNGS			
6. HEART			
7. ABDOMEN			
8. MUSCULOSKELETAL			
9. NEUOROLOGIC			
10. SKIN			

I CERTIFY THAT I HAVE REVIEWED THE EXAMINATION FORM AND PERFORMED A PHYSICAL EXAMINATION ON THIS PATIENT.

- EXAMINER'S SIGNATURE_____

During our examination concern was raised regarding _____

A referral has been made for further evaluation to _____

Additional information on #1-10_____

_____

_____

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

FIREFIGHTERS: ***Please note, we also utilize this document as a medical history form. Please fill out all pertinent information.***

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: _____

*For all **Yes** or **No** questions please **circle** the best answer that pertains to you*

Yes / No 10. Has your employer told you how to contact the health care professional who will review this questionnaire

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).

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b. _____ Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

Yes / No 12. Have you worn a respirator

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").

Yes / No **1. Do you *currently* smoke tobacco, or have you smoked tobacco in the last month**

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

Yes / No 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

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

Yes / No 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

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

Yes / No 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

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

Yes / No 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

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

Yes / No 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

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

Yes / No a. Breathing or lung problems

Yes / No b. Heart trouble

Yes / No c. Blood pressure

Yes / No d. Seizures

8. If you've used a respirator, have you *ever had* any of the following problems? (If you've never used a respirator go to question 9:)

Yes / No 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

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.

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

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

Yes / No 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

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

Yes / No 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

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

Yes / No 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

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.

Yes / No **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**

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:

Yes / No 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

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: _____

_____

Yes / No **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)**

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

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

Yes / No a. HEPA Filters

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

Yes / No c. Cartridges

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

Yes / No 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

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

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

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.

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

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.

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

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.).

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

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

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

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

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, and 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]

SURGICAL HISTORY

Surgical Procedure	Date
Surgical Procedure	Date
Surgical Procedure	Date
Surgical Procedure	Date

MEDICATION LIST

Please list any medications that you are currently taking:

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

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Hepatitis B Vaccination Declination Statement

The following statement of declination of hepatitis B vaccination must be signed by an employee who chooses not to accept the vaccine. The statement can only be signed by the employee following appropriate training regarding hepatitis B, hepatitis B vaccination, and the efficacy, safety, method of administration, and benefits of vaccination, and that the vaccine and vaccination are provided free of charge to the employee. The statement is not a waiver; employees can request and receive the hepatitis B vaccination at a later date if they remain occupationally at risk for hepatitis B.

Employee Name: _____

Organization: _____

Declination Statement

I understand that due to occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to me; however, I decline hepatitis B vaccination at this time for the following reason;

_____ I would like to receive the Hepatitis B vaccination series.

_____ I decline because I have completed the series
_____ I decline due to documented immunity
_____ I decline due to non-responder status (3 shots x2 without positive titer)
_____ I decline for personal reasons.

Eastern Med personnel only:
Initial to acknowledge form review: _____

I understand that by declining this vaccine I continue to be at risk of acquiring hepatitis B, a serious disease. If, in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Employee Signature: _____

Date: _____

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Authorization for Release of Confidential Medical Information

Patient Name: _____ Date: _____

Address: _____

Phone: _____ Date of Birth: _____

I, the undersigned, hereby authorize and request _____ to release all confidential medical information regarding my condition for the period of the time specified below. This authorization includes physical forms, progress notes, consultation, laboratory tests, x-ray reports, diagnostic studies, telephone messages, medication and health flow maintenance flow sheets, immunization records, and discharge summaries.

Disclosure information to:

_____

Employer / Facility / Physician Name

_____

Address / Phone number

_____

Reason for this release of information

_____

Nature of condition (be as specific as possible)

***Date of Service*: From**: _____ **To**: _____

I understand that I can decide to at any time to cancel this release in writing but, that letter will not apply to records already sent.

Time during which release is authorized (*Please check one*):

◯ *1 year* or

◯ From: _____ To: _____

_____ _____

Signature **Date**

_____

Relationship if other than patient

Information release from Eastern Med

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