TAMPA ELECTRIC COMPANY
MEDICAL EXAMINATION PROGRAM

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PURPOSE

The purpose of the Medical Examination Program is to provide guidance for the provision of medical examinations (physicals) to prospective employees, to define medical clearance for assigned responsibilities and to meet specific medical surveillance requirements as established by OSHA.

INTRODUCTION

The Medical Examination Program represents the company's commitment to establish baseline physical examination parameters, comply with regulatory requirements, and provide a mechanism for promoting health and wellness for all Tampa Electric Company employees.

The written program contains the following elements:

- Roles and Responsibilities
- Employee Education & Training
- Medical Examination Requirements
- Medical Evaluation Criteria, Content, and Frequency
- Procedural Requirements
- Recordkeeping Requirements
- Glossary
- Forms

SCOPE

This program applies to all prospective Tampa Electric Company employees including those positions requiring; the use of respirators, and / or assignment as HAZMAT responders. This program also applies to Tampa Electric employees whose job descriptions require; the use of respirators or assignment as HAZMAT responders.

ROLES AND RESPONSIBILITIES

Medical Director - COMBI

COMBI (Comprehensive Occupational Medicine for Business and Industry) is the preferred provider for all physical examinations covered by this program. COMBI provides Tampa Electric with comprehensive medical services including the provision of the company Medical Director. The Medical Director is responsible for reviewing the information gathered, determining the capability of each examined individual to perform work assignments within their respective positions, and completing the Medical Clearance Form (Appendix E). The Medical Director will review examination data obtained both at COMBI, as well as any other medical service provider. The Medical Director also provides supervisory and advisory services to the Tampa Electric Energy Supply nursing staff including the Nurse Practitioner. Offers of employment in Energy Supply should not be finalized with anyone without the approval of the Medical Director.

Tampa Electric Energy Supply Nurse Practitioner and Nursing Staff

The Nurse Practitioner is responsible for performing quality checks and reviews of the medical examination documentation for each prospective Energy Supply employee.

The Nurse Practitioner will provide the medical examinations and updates as needed.

For prospective employees, the Nurse Practitioner will communicate medical restrictions based upon the results of the medical examination to Tampa Electric Human Resources Recruiting and Staffing Group.

The Nursing Support Staff and Nurse Practitioner will maintain medical records in locked file cabinets at each of the plant locations, update record retention databases, and administer Pulmonary Function Testing, Audiograms, and Medical Questionnaires as needed for all employees requiring medical examinations.

Tampa Electric - Managers, Safety & Health Roles:

The Managers of Safety and Industrial Health for Tampa Electric Company Energy Supply and Energy Delivery are responsible for providing guidance and interpretation of the Medical Examination Program, as well as maintaining and updating the written Medical Examination Program as necessary.

ROLES AND RESPONSIBILITIES cont'd

Tampa Electric Human Resource / Recruitment and Staffing Roles:

The Recruitment and Staffing group within Human Resources will coordinate the offer-contingent baseline medical examination for all prospective employees with COMBI or other appropriate health care facility.

If the medical examination is conducted at a facility other than COMBI, the Recruitment and Staffing group within Human Resources will forward the specific completed Job Analysis form to the health care facility so that an appropriate medical evaluation can be made.

The Recruitment and Staffing group within Human Resources is responsible for ensuring that all medical examination forms and documentation are forwarded to COMBI and have been reviewed and approved by the Medical Director and Nurse Practitioner, prior to finalizing the offer of employment.

The Recruitment and Staffing group within Human Resources is responsible for maintaining a copy of the Medical Clearance Form (Appendix E) in the employees personnel file.

The Recruitment and Staffing group within Human Resources is also responsible for archiving all supporting medical examination forms and documentation if the prospective employee is not hired.

Tampa Electric Employees

Each employee covered by this program is responsible for scheduling and obtaining their required medical examinations.

EMPLOYEE EDUCATION & TRAINING

Target Audience - All Tampa Electric employees covered by this program. All employees covered by the roles and responsibilities section of this program.

Frequency – Information as to the content and specifics of this program shall be provided within six months of the effective date of this program to current employees. Newly hired employees shall be informed of the elements of this program during their orientation.

Methods – Education of employees shall be accomplished through in-person presentations, handouts, or by any other means determined adequate by the Energy Supply and Energy Delivery Safety and Industrial Health groups.

Documentation – Documentation of this training is not required.

MEDICAL EXAMINATIONS

All prospective Tampa Electric employees will be provided with a post-offer / pre-placement medical examination. Specific elements of the exam shall be based on the specific job requirements and duties for the position at the time of hire and are outlined in this program.

Periodic medical examinations are required for certain employees, based on their current or potential exposures and/or their specific job requirements.

Medical Examination requirements have been identified by the Tampa Electric Medical Director and are grouped into three specific categories based on job duties and/or requirements. Employees shall receive additional testing if their job requires the use of respirators.

All Medical examinations will be provided by qualified and licensed medical personnel. The final evaluation concerning clearance for job requirements will be made by the Tampa Electric Medical Director. A Medical Clearance Form (Appendix E) shall be completed for each employee.

Medical Evaluation Content and Criteria

The medical evaluations begin with a **Baseline Medical Examination** for all new hires. Two additional levels of screening are required as based upon various job position requirements. These levels include **Physical Worker**, and **HAZMAT Responder**. Any employee that may be required to use a respirator as part of their job assignment shall receive the additional **Respirator User** screening as part of their medical examination.

Baseline Medical Examination

The elements of the baseline medical requirements are to be provided for all new hires at Tampa Electric regardless of the position applied for.

- Review of an occupational and medical history (Medical Questionnaire Appendix B)
- Vital Signs (Blood Pressure, Pulse, Respirations and Temperature)
- Audiogram (performed in sound proof booth, testing for 7 frequencies, and is OSHA compliant)
- Vision Screen (far, fields and color)
- Medical Examination Form Completed (Appendix C)
- Dip Stick Urinalysis
- Examination by a Health Care Provider
- A Baseline Chest X-ray
- Medical Clearance Form (Appendix E)

Baseline Medical Examination cont'd

Energy Supply
All positions not specified for other examinations will receive this level of examination. Administrative staff will only receive this examination.

Energy Delivery
All positions not specified for other examinations will receive this level of examination. Administrative staff will only receive this examination.

Employees covered by the Tampa Electric hearing conservation program will receive an annual audiogram.

Physical Worker Medical Examination

Employees whose jobs include occasionally or frequent strenuous physical work shall receive an examination that includes the baseline physical, as well as the following components:

- A Back and Functional Examination
- Comprehensive Metabolic Profile with Lipids Laboratory Evaluation
- Electrocardiogram with Interpretation
- Evaluation of Tetanus Status and update as needed

Energy Supply
Individuals receiving this examination within Energy Supply include; Heavy Labor/Power Plants including; Maintenance Personnel, Auxiliary Operators, Boiler Turbine Operators, and Special Utility Workers, Mechanized Vehicle Operators (cranes, forklifts, trucks), Warehouse staff, Air Services Staff and Incipient Fire Response personnel.

Energy Delivery
Individuals receiving this examination within Energy Delivery include; Electricians, Linemen, Patrolmen, Troublemen, Groundmen, Servicemen, Repairmen, Cable Splicers, Materials Specialists, Field Inspectors, Materials Specialists, Materials Processors, Garage Mechanics, Substation Technicians, Meter Mechanics, Meter Workers, Meter Servicemen, Paint & Body Specialists, Special Equipment Operators, Special Utility Workers.

HAZMAT Responder Medical Examination

Employees whose jobs include responsibilities of HAZMAT Responder shall receive an bi-annual examination that includes the baseline physical, the physical worker physical, as well as the following components:

- A Chest X-ray (Every 5 Years)
- A Stress Test (Every 5 Years or more often as indicated by Medical Director)
- A "Work Trial" Evaluation (Only as indicated by Medical Director) (Appendix D)
- A Complete Blood Count including metabolic profile and lipid profile (Every Two Years)
- Evaluation of Hepatitis B Status

Energy Supply
Employees receiving these physicals include the designated HAZMAT responders at Big Bend, and all Diesel Generation Specialists (Philips), Combined Cycle Specialists (Bayside), and IGCC Process Specialists (Polk).

Energy Delivery
Employees in Energy Delivery do not receive this examination.

Respirator User Screening

Employees whose jobs require respirator use shall receive an annual examination that includes the Physical Worker or Hazmat Responder Examination, as well as the following components:

- The OSHA Respirator Questionnaire (Appendix F) (Annual Requirement)
- A Pulmonary Function Screening Test (Annual Requirement)

Energy Supply
Individuals receiving this examination include; Engineering and Technical Staff, including Co-op's in these areas; Supervisory and Management Staff (where respirator use is required for the job), all non-administrative Station Employees.

Energy Delivery
Individuals receiving this examination include; Cable Splicers, and Paint and Body Specialists.

PROCEDURAL GUIDELINES

Evaluation by a Medical Practitioner and Examination Cost

All medical examinations, evaluations and procedures must be performed by licensed occupational medicine practitioners under the supervision of a licensed physician knowledgeable in occupational medicine. Medical practitioners that may perform evaluations include Physicians, Nurse Practitioners and Physician Assistants.

The physicians of COMBI will provide supervisory and advisory services for the medical practitioners and medical evaluations. The Medical Director or designee provided by COMBI will determine the employee's medical clearance status. The medical clearance will be provided to the appropriate staff for confirmation of clearance prior to finalizing the offer of employment or transfer.

Medical examinations will be provided to all prospective employees and employees in designated roles without cost as part of the pre-employment process. The type of physical examination that will be required and provided is based on the job description elements.

Employees who require periodic examinations will not incur loss of pay and will have examinations during the normal workday. The facility where the employee works is responsible for the cost of the medical examination.

Employee medical examinations may be conducted at COMBI or any of the following energy supply locations; Big Bend Power Station, Bayside Power Station, Polk Power Station, or Sebring Power Station.

Pre-Employment Medical Examinations

The Recruitment and Staffing group within Human Resources will coordinate the employment-contingent baseline medical examination for all prospective employees with the appropriate health care facility (preferably COMBI). If the prospective employee is from an area outside of Tampa and chooses to obtain a physical at a location other than COMBI, it is Recruitment and Staffing's responsibility to provide the appropriate guidelines and forms to the medical facility performing the examination (Appendices B, C, E & F), and to ensure that the information collected at those examinations is forwarded to the Tampa Electric Medical Director, and the Energy Supply Nurse Practitioner.

If the medical examination is conducted at a facility other than COMBI, the Recruitment and Staffing group within Human Resources will forward the specific completed Job Analysis form to the health care facility so that an appropriate medical evaluation can be made.

Pre-Employment Medical Examinations cont'd

Any concerns or questions related to the type or nature of the medical examination that is required should be discussed with the respective Manager of Safety & Health in Energy Supply or Energy Delivery, or the Nurse Practitioner.

The medical history section of the Medical Questionnaire (Appendix B) is to be completed by the prospective employee prior to seeing the health care provider. The responses will be reviewed by the health practitioner at the time of the physical examination.

During the examination, the Medical Examination Form (Appendix C) will be completed and signed by the health care provider.

The Medical Clearance Form (Appendix E) will be completed by the health practitioner providing the medical examination. The health practitioner will determine medical clearance status based on job requirements including job duties.

If the physical examination is provided by a medical facility other than the preferred provider (COMBI), Recruitment and Staffing shall make sure all appropriate testing has been accomplished at that health care facility. If all the appropriate testing cannot be completed, the Energy Supply Nurse Practitioner should be notified, so that other arrangements can be made to complete the testing requirements prior to the extension of a job offer or the employee beginning work in Energy Supply at Tampa Electric.

All medical examination forms and documentation shall be forwarded to COMBI and must be reviewed by the Medical Director and in the case of Energy Supply Employees, the Nurse Practitioner, prior to finalizing the offer of employment.

After receiving the physical examination results, the supporting paperwork, and applicable test documents (i.e. chest x-ray films, audiometric test readings, lab results, etc.) will be sent to the Energy Supply Nurse Practitioner, who will perform a quality check and review of the documentation. The Nurse Practitioner will sign-off on the Medical Clearance Form and return it to Recruitment and Staffing, thereby, completing the physical examination portion of the hiring process. If the prospective employee is not hired, all supporting medical examination forms and documentation will be forwarded to Recruiting and Staffing for archiving.

Human Resources shall maintain a copy of the Medical Clearance Form (Appendix E) in the employees personnel file. For Energy Delivery, the original copy of the Medical Clearance form and all other paperwork related to the physical examination will be forwarded to the ED Manager of Safety and Industrial Health. For Energy Supply, the original copy of the Medical Clearance form and all other paperwork related to the physical examination will be forwarded to the Nurse Practitioner at the Bayside Power Station.

Pre-Employment Medical Examinations cont'd

The OSHA respirator questionnaire is to be completed annually by every employee that will be required to use a respirator (Appendix F). Additionally, a PFT will be performed annually for these employees. Potential new hires or regular employees who receive annual evaluations should complete the form prior to seeing the health care practitioner and prior to pulmonary function testing. The health care practitioner will review the questionnaire with each individual employee.

After evaluation of the respirator clearance requirements, the respiratory clearance section of the Medical Clearance form (Appendix E) will be completed. A copy will be kept in the employees chart and a copy of the clearance will be provided to the employee.

Record Keeping Process and Requirements

In Energy Supply, the sites' nursing staff is responsible for insuring that all medical records are retained in the on-site employee medical file. The medical records are maintained in locked file cabinets at all times.

The Energy Supply's Safety and Health Coordinators with assistance from the nursing staff will ensure that annual medical clearance evaluations are maintained and kept in the employee medical record throughout employment.

When the Energy Supply employee terminates employment with Tampa Electric Company, the medical records will be forwarded to the Records Retention Department and will be maintained for 30 years from the end date of employment.

In Energy Delivery, the Manager of Safety & Industrial Health is responsible for insuring that all medical records are retained in each employee's medical file.

When the Energy Delivery employee terminates employment with Tampa Electric Company, the medical records will be forwarded to the Records Retention Department and will be maintained for 30 years from the end date of employment.

APPENDIX A
GLOSSARY

Audiogram - A graphic record of hearing ability for various sound frequencies that is used to measure hearing loss.

COMBI (Comprehensive Occupational Medicine for Business and Industry) – COMBI is the preferred provider for medical examinations as well as the provider of the Energy Supply Medical Director. COMBI has locations at 9210 Florida Palm Drive, Tampa, Florida, and 3810 Drane Field Road, Unit 15, Lakeland, Florida 33811

Hazardous Materials (HazMat) Technicians - Individuals who respond to conditions or releases or potential releases of hazardous materials for the purpose of stopping or controlling the release for either on-site or off-site emergency responses.

IDLH – Immediately dangerous to life and health.

OSHA (Occupational Safety & Health Administration) - A branch of the US Department of Labor responsible for establishing and enforcing safety and health standards in the workplace.

PFT (Pulmonary Function Test) - Any of several breathing tests that measure the function of the lungs, including the rate of air flow and the volume of exhaled air, performed to assess lung function and to detect the presence of respiratory disease

PPE (Personal Protective Equipment) – This refers to protective clothing, helmets, goggles, gloves, shoes, respirators, or other gear designed to protect the wearer's body or clothing from injury or damage.

Work Trial Evaluation – A means of assessing work capacity and respirator tolerance in individuals by monitoring their pulse rate and blood pressure as they perform exercises while wearing respirators.

Appendix B (Page 1 of 4)

MEDICAL QUESTIONNAIRE AND EXAMINATION FORM

Name:	DOB:	Date:

Job Title: _____ Supervisor:_____ Start Date: _____

Employee of: (Check company & department)

_____ Tampa Electric Co.

_____ Energy Supply
_____ Energy Delivery
_____ Support Services

_____ TWG TECO Wholesale Generation

_____ TECO Energy

_____ PGS – Peoples Gas

Type of Physical Exam Required
Please Check One Required Exam(s):

_____ Baseline Exam
_____ Physical Worker Exam
_____ Hazmat Responder Exam

Will Employee be required to wear a respirator?
☐ Yes ☐ No

If yes, respirator exam is required.

_____ Respirator Exam

IBEW / OPEIU Employee _____ Yes _____ No

Plant/Work Location: _____

1. **Please complete pages 1 – 4 before reporting to physician's office.**
2. **Sign and date page 4**
3. **Fill in name and DOB where requested**

ADDRESS _____
Street or PO Box

_____
City State Zip

HOME TELEPHONE (___) _____ ALTERNATE (___) _____

SOCIAL SECURITY NUMBER _____-____-_____ DATE OF BIRTH_____

All prospective new hires must complete and sign pages of form where indicated. When a physical is required, take this completed form to the assigned health care facility. TECO uses Comprehensive Occupational Medicine for Business and Industry (COMBI) as its preferred health care facility. When a physical is required, this completed form will be reviewed and signed by the COMBI health care provider. When a physical is performed by a non-COMBI facility, the completed form will be forwarded to the COMBI Medical Director for review.

R&S will distribute the completed form to the designated company representative responsible for keeping that department's medical records

MEDICAL QUESTIONNAIRE AND EXAMINATION FORM

Name:	DOB:	Date:

PREVIOUS EMPLOYMENT:

EMPLOYER	JOB TITLE	JOB DUTIES	HAZARDS OR CHEMICALS

SYMPTONS / REVIEW OF SYSTEMS / PAST MEDICAL HISTORY

Do you have any of the following symptoms at the present time or have you ever had them?

General:	**YES**	**NO**	**Gastrointestinal:**	**YES**	**NO**
Fatigue or loss of sleep	☐	☐	Nausea/vomiting	☐	☐
Fevers	☐	☐	Colitis, Crohn's, Inflammatory Bowel Disease, Diverticulosis	☐	☐
Marked change in weight	☐	☐			
Change in appetite	☐	☐	Diarrhea/Constipation	☐	☐
Excessive thirst	☐	☐	Vomiting blood	☐	☐
Senses & sense organs:			Passing blood in stools	☐	☐
Difficulties with vision or eyes	☐	☐	Hernia	☐	☐
Difficulties with hearing or ears	☐	☐	**Musculoskeletal:**		
Difficulties with smelling	☐	☐	Back or neck pain	☐	☐
Difficulties maintaining balance	☐	☐	Shoulder, elbow, wrist, hand pain	☐	☐
Numbness	☐	☐	Hip, knee, ankle, foot pain	☐	☐
Respiratory:			Knee(s) giving away	☐	☐
Shortness of breath	☐	☐	Trick or locked knee(s)	☐	☐
Excessive coughing	☐	☐	Restricted movement in any joint	☐	☐
Productive cough	☐	☐	Amputation	☐	☐
Hoarseness	☐	☐	**Neurological:**		
Nasal congestion or drainage	☐	☐	Loss of consciousness	☐	☐
Cardiovascular:			Headaches/Migraines	☐	☐
Irregular heartbeat/arrhythmias	☐	☐	Dizziness or vertigo	☐	☐
Chest pain/tightness	☐	☐	Faintness/lightheadedness	☐	☐
Swelling of extremities	☐	☐	Numbness, tingling, shooting pain	☐	☐
Urinary:			Seizures/Fits/Epilepsy/Convulsions	☐	☐
Painful/burning urination	☐	☐	Hallucinations	☐	☐
Blood in urine	☐	☐	Excessive sleepiness	☐	☐
Frequent urination	☐	☐	Difficulty walking	☐	☐
Kidney Stones	☐	☐	Difficulty speaking	☐	☐
Dermatological:			**Psychiatric:**		
Itching	☐	☐	Depression, feeling "blue"	☐	☐
Hives	☐	☐	Anxiety/Nerve problems	☐	☐
Rashes	☐	☐	Panic attacks	☐	☐
Skin Disorders	☐	☐	Nervous breakdown	☐	☐
			Eating disorder/bulimia/anorexia	☐	☐

Notes/Comments:

MEDICAL QUESTIONNAIRE AND EXAMINATION FORM

Name:	DOB:	Date:

Have you ever had any injury or illness for which you received medical treatment or surgery?
No ☐ Yes ☐ If yes, please explain:
Back Injury ☐
Other ☐ _____

_____

Have you ever been admitted to the hospital for any reason? No ☐ Yes ☐ If yes, please explain:

_____

Have you ever undergone any surgical procedures (inpatient or outpatient)? No ☐ Yes ☐ If yes, please explain:

_____

Have you ever been diagnosed with any significant psychological, emotional, or psychiatric disorder? No ☐ Yes ☐ If yes, please explain:

_____

Have you ever routinely used illicit drugs, or been treated for addiction to any drug? No ☐ Yes ☐ If yes, please explain:

_____

Have you ever been diagnosed, evaluated for or treated for any medical condition? (Check ALL that apply)

	YES	NO		YES	NO
Heart attack or coronary artery disease, e.g. stent or bypass	☐	☐	Connective tissue disease	☐	☐
High blood pressure	☐	☐	Liver disease	☐	☐
Asthma	☐	☐	Kidney disease	☐	☐
Chronic lung disease	☐	☐	Bladder problems	☐	☐
Stroke	☐	☐	Arthritis or joint disease	☐	☐
Diabetes	☐	☐	Any disability or impairment	☐	☐
Stomach disorder, e.g. ulcers	☐	☐	Rheumatic Fever/Heart Murmur	☐	☐
Eye Disorders/Injuries	☐	☐	Other:_____	☐	☐
Have you ever had any significant infectious disease?			**FAMILY HISTORY**		
Tuberculosis (active disease)	☐	☐	Heart Disease: heart attack,	☐	☐
Positive skin test for TB	☐	☐	coronary artery disease		
Meningitis	☐	☐	High Blood Pressure/Stroke	☐	☐
Sepsis	☐	☐	Kidney Disease	☐	☐
Hepatitis	☐	☐	Diabetes	☐	☐
If yes, which type: A☐ B☐ C☐, Unknown ☐			Seizures	☐	☐

MEDICAL QUESTIONNAIRE AND EXAMINATION FORM

Name:	DOB:	Date:

Do you have any medication allergies or intolerances? No ☐ Yes ☐ If yes, what are you allergic to?

_____

Do you have any environmental allergies or intolerances? No ☐ Yes ☐ If yes, what are you allergic to?

_____

Are you currently using any prescription or non-prescription (over-the-counter) supplements or herbs for health purposes? No ☐ Yes ☐ If yes, please list: _____

_____

_____

Do you routinely exercise at least 30 minutes a day, 5 or more days a week? No ☐ Yes ☐

Tobacco Use:	**YES**	**NO**
Do you use tobacco now?	☐	☐
Have you ever used tobacco?	☐	☐

If you quit, when did you quit? _____
How long did/have you used? _____
On average, how much did/do you use?
Cigarettes: _____ packs/per day
Cigars: _____ per day/week/month/year
Chewing: _____ per day/week/month/year
Pipe: _____ per day/week/month/year
Snuff: _____ per day/week/month/year

Alcohol Use:	**YES**	**NO**
Do you use alcohol now?	☐	☐
Have you ever used alcohol?	☐	☐

If you quit, when did you quit? _____
How long did/have you used? _____
On average, how much did/do you use?
Beer: _____ per day/week/month/year
Wine: _____ per day/week/month/year
Liquor: _____ per day/week/month/year

Immunization Status:	**YES**	**NO**
Did you complete your "school shots" or at least have 3 tetanus shots in your life?	☐	☐
Year of last tetanus booster: _____		
	☐	☐
Have you had 3 Hepatitis B shots? _____		
Have you had 2 Hepatitis A shots? _____	☐	☐

Other Immunizations, please list:_____

_____

I, _____ (Print Name), affirm that I have answered the questions fully and truthfully. I hereby authorize COMBI to release my history and physical exam results to TECO. I understand that TECO will be billed. I also understand as per Florida law, my work related medical records will be released to TECO if requested.

_____ _____
Examinee Signature **Date**

_____ _____
History reviewed by **Date**

MEDICAL PHYSICAL EXAMINATION

Name:	DOB:	Date:

BP:	/	HR:		RR:		T:		HT:		WT:	

If BP > 160/90 then repeat:

BP:	/	/

HANDED: Right ☐ Left ☐

VISION TEST

	UNCORRECTED			CORRECTED		
	LEFT	RIGHT	BOTH	LEFT	RIGHT	BOTH
FAR	20/	20/	20/	20/	20/	20/
NEAR	20/	20/	20/	20/	20/	20/
Horizontal Fields	0	0		0	0	

Color Test ☐ Titmus ☐ Ishihara Depth:_____

AUDIO TEST

	500	1000	2000	3000	4000	6000	8000
Left Ear							
Right Ear							

URINALYSIS (dip) SG10

Glucose	_____	pH	_____	Glucometer:	_____
Bilirubin	_____	Protein	_____	(If indicated)	
Ketones	_____	Urobilinogen	_____		
Spec. Grav.	_____	Nitrite	_____	Performed by:	_____
Blood	_____	Leukocytes	_____		

TB Skin Test

Type _____ Reading: _____ mm Pos/Neg

Lot#: _____ Date: _____

Exp: _____ Read by: _____

Patient instructed to return to clinic for reading

Comments: _____

_____

Medical Examiner: _____ **Date:** _____

Physician Review: _____ **Date:** _____

MEDICAL PHYSICAL EXAMINATION

Name:	DOB:	Date:

LIMITED FUNCTIONAL EXERCISE

Hamstring Flexibility		
☐ Good (80-110)	☐ Marginal (60-80)	☐ Poor (<60)
Back and Hamstring Flexibility		
☐ Good (fingertips to toes)	☐ Marginal (3 inches from toes)	☐ Poor (>3 inches from toes)
Bilateral Leg Lifts		
☐ Good (hold for 10 secs.)	☐ Marginal (hold for 5-9 secs.)	☐ Poor (hold for <5 secs.)
Crunches (abdominal strength)		
☐ Good (>5, hands behind head)	☐ Marginal (1-4, hands towards knees)	☐ Poor (0)
Push-ups		
☐ Good (10+)	☐ Marginal (5-10)	☐ Poor (<5)
Back Extensor Muscle Strength		
☐ Good (10+ secs.)	☐ Marginal (<10 secs.)	☐ Poor (unable to assume position)
Quadriceps Strength		
☐ Good (25+ secs.)	☐ Marginal (10-24 secs.)	☐ Poor (<10 secs.)

Weight Lifting: Load = 55.5 pounds (25.22 kg). Patient instructed in proper lifting technique prior to this component.

YES		NO
☐	Able to lift from floor to shelf 10 times	☐
☐	Able to slide six feet 10 times	☐
☐	Able to step up then down from step stool while carrying/holding crate 10 times	☐

One leg hop for distance normal ☐ abnormal ☐

Duck walk normal ☐ abnormal ☐

Grip Strength (measured in Kilograms (kg)

Left Hand
1:_____ 2. _____ 3. _____

Right Hand
1. _____ 2. _____ 3. _____

Recumbent Exercise Module

Pre-exercise Heart Rate: _____ Post Exercise Heart Rate: _____

Comments:_____

_____

Examiner Signature:_____ **Date:**_____

Appendix C (Page 3 of 4)

MEDICAL PHYSICAL EXAMINATION

Name:	DOB:	Date:

THIS SECTION IS RESERVED FOR EXAMINER/PHYSICIAN

System	Normal	Abnormal	Not Examined	System	Normal	Abnormal	Not Examined
General Appearance				Abdomen			
Skin/Hair/Nails				Inguinal (hernias)			
Head				Genitalia			
Eyes				Anal/Rectum			
Ears				Spine			
Nose				Forward Flexion (finger misses floor by ____")			
Mouth				Upper Extremities			
Teeth				Varicosities			
Throat				Feet			
Neck				Peripheral			
Chest				Neurological			
Lungs				Emotional Status			
Breasts				Optional: Prostate			
Heart							

Comments: _____

_____

_____

_____

Medical Examiner: _____ **Date:** _____

MEDICAL PHYSICAL EXAMINATION

Name:	DOB:	Date:

BACK EXAMINATION

Gait: Normal ☐ Abnormal ☐
Positive, Standing Normal ☐ Abnormal ☐
Pelvic Tilt Normal ☐ Abnormal ☐

Forward Flexion (90° normal) _____ degrees Misses Floor by _____ inches

Extension (30° normal) _____ degrees

	Left	Right
Lateral Bend (45° normal)	_____	_____
Rotation (30° normal)	_____	_____
Deep Tendon Reflexes		
Patellar	_____	_____
Achilles	_____	_____
Straight Leg Raising		
Measured in degrees	_____	_____
Radicular Patterns	_____	_____

Result of Functional Exercise: ☐ Pass ☐ Pass with conditional limits:_____
☐ Fail

AUDIOGRAM Normal ☐ Abnormal ☐ Date last conducted: _____
COMMENTS:_____

BLOOD Normal ☐ Abnormal ☐ Date last conducted: _____
COMMENTS: _____

EKG Normal ☐ Abnormal ☐ Date last conducted: _____
COMMENTS: _____

SPIROMETRY Normal ☐ Abnormal ☐ Date last conducted: _____
COMMENTS: _____

STRESS TEST Normal ☐ Abnormal ☐ Date last conducted: _____
COMMENTS: _____

_____

Examiner Signature:_____ **Date:**_____

Physician Review:_____ **Date:**_____

Appendix D (Page 1 of 1)

MEDICAL PHYSICAL EXAMINATION

Name:	DOB:	Date:

WORK TRIAL EVALUATION (to be completed by TECO)

Participation Consent

I, _____ (print name), consent to participating in the Work Trial Evaluation, which consists of donning respirator equipment and completing several physical activities.

The participant will climb stairs two to three times and stop for pulse and blood pressure check. The same exercise will be repeated with a weight (not to exceed 50 lbs with respirator). The participant will stop for pulse and blood pressure check. The participant will remove gear quickly and stop for pulse and blood pressure check. This will complete the Work Trial Evaluation.

Employee Signature: _____ Date: _____

Stop testing if any of the following occurs: BP > 220 systolic; HR > 85% maximum predicted; patient is symptomatic.
85% maximum predicted heart rate = (220 – age X .85) = _____

Pre-test (Resting)

BLOOD PRESSURE	PULSE

Put on gear (at minimum typical respirator and pants)

Exercise 3 minutes, STOP…		→	Exercise 3 minutes, STOP…		→	
BLOOD PRESSURE	PULSE		BLOOD PRESSURE	PULSE		Remove gear quickly – 2 minutes or less

Post-test

BLOOD PRESSURE	PULSE

☐ Passed or completed Work Trial Evaluation without problem
☐ Failed, explain: _____
☐ Further evaluation needed, explain: _____
_____

ARNP/Examiner Signature: _____ Date: _____

Physician Review: _____ Date: _____

COMMENTS:
_____

Appendix E

MEDICAL CLEARANCE STATUS

Name:	Employee number:	Date:
This is a Medical Clearance for Duty Evaluation: (Mark all that apply) ☐ HAZWOPER Team ☐ Respirator Use ☐ Physical Worker ☐ Other:		

MEDICAL CLEARANCE

Based on the essential job functions as stated in the company job description(s), the employee is:

- ☐ Full Duty with – NO RESTRICTIONS
- ☐ Restricted Duty – WITH RESTRICTIONS AS LISTED BELOW
- ☐ NOT Cleared for _____ Duty.
- ☐ UNABLE TO DETERMINE – Additional evaluation or records are needed.

RESTRICTIONS (Define)

- ☐ Temporary _____
- ☐ Permanent _____

RESPIRATOR USE

- ☐ May use respiratory protection with limitations. ☐ None ☐ Restrictions Below
- ☐ May use respiratory protection for escape purposes or self rescue only.
- ☐ May not use respiratory protection.
- ☐ May only use the following respirators (circle all that apply); **ALL; or Non-cartridge Disposable; Half Face Negative Pressure; Full Face Negative Pressure; PAPR; Supplied Air, SCBA.**

I have reviewed all available medical records and patient history and conducted the physical examination if indicated. My opinion regarding clearance for duty is based on the available information at the time of the examination.

_____ _____
Examiner's signature Date

_____
Print name

I have been informed by the above medical practitioner of the results of the medical evaluation and any other medical conditions which require further examination or treatment. Furthermore, I have been informed that my medical records are available for my access regarding any follow-up or evaluation by my personal physician.

_____ _____
Examinee's signature Date

_____
Print name

Reviewed by:_____

OSHA RESPIRATOR QUESTIONNAIRE

Can you read (check one): ☐ Yes ☐ No

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 (check 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 (check 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 (check one): ☐ Yes ☐ No

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

    _____

OSHA RESPIRATOR QUESTIONNAIRE

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 check "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 (fits): ☐ 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

OSHA RESPIRATOR QUESTIONNAIRE

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
f.	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 (fits):	☐ 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

OSHA RESPIRATOR QUESTIONNAIRE

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: _____
   _____
   _____

OSHA RESPIRATOR QUESTIONNAIRE

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) (check "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

OSHA RESPIRATOR QUESTIONNAIRE

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):
    _____
    _____

OSHA RESPIRATOR QUESTIONNAIRE

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):
_____
_____