CorpOHS
an Affiliate of Frederick Regional Health System

Hours: Monday-Friday 7:00 am-5:00 pm
490-L Prospect Boulevard • Weis Festival Plaza
Frederick, Maryland 21701
240-566-3001
Fax: 240-566-3003
info@corpohs.com

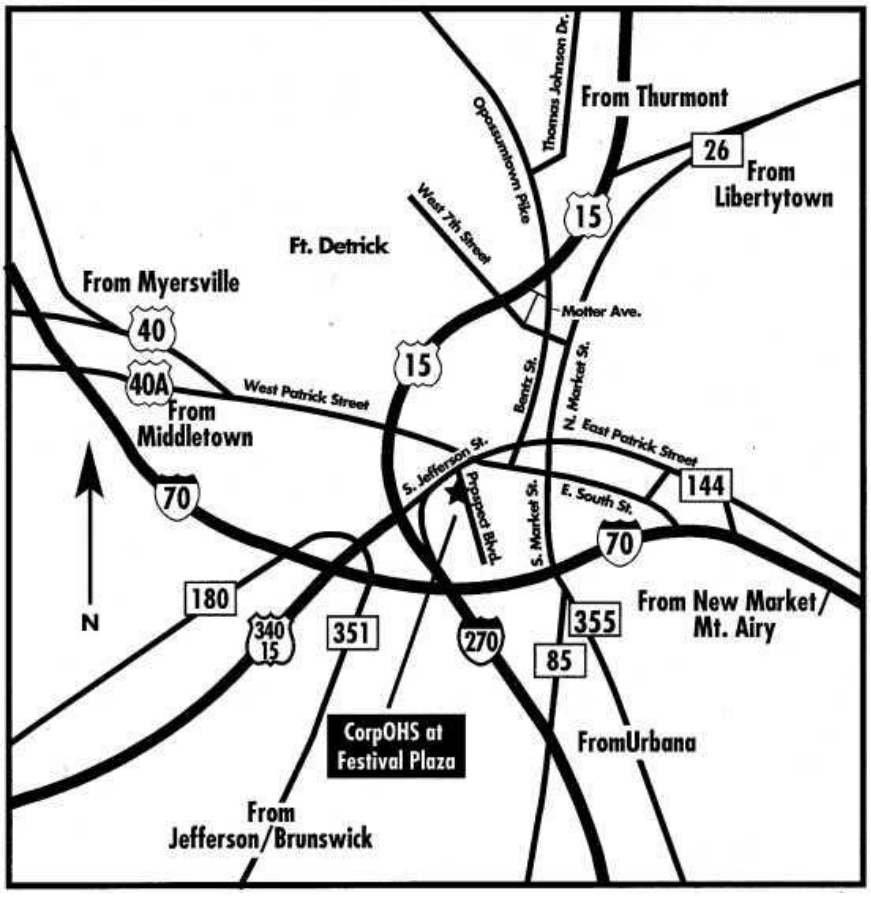
DIRECTIONS

• From Points North of Frederick:

Take 15 South to 15/340 (Leesburg/Charleston) exit. Stay in left lane on exit ramp. Turn left at light onto Jefferson Street. Turn right at second light onto Prospect Blvd. Turn right into Weis Festival Plaza. CorpOHS-Frederick is the last office in the first building on the right.

• From Points South of Frederick:

From 15 North, exit at Jefferson Street. Take a right at first light onto Prospect Blvd. Turn right into Weis Festival Plaza. CorpOHS-Frederick is the last office in the first building on the right.



Medical History - Healthcare Workers

Frederick Memorial Hospital Employees

Allergies: Latex: _____ Yes _____ No
Medication Allergies: _____
Other Allergies: _____
Last Tetanus booster: _____
Current Medications: _____
Current Physician: _____
Medical Illnesses (check all that apply):
___ High Blood Pressure ___ Heart Disease ___ Lung Disease ___ Diabetes
___ Anemia ___ Kidney Disease ___ Seizures ___ Cancer
___ Stomach or Bowel Disorders: _____
___ Sleep Apnea
___ Fractures & Joint Injuries: _____
___ Other: _____
Surgeries: _____
Social History (Check all that apply):
___ Tobacco use ___ Cigarettes: ___ packs/day ___ years
___ Cigars: ___ per day ___ years
___ Pipe: ___ years
___ Chew/Snuff: ___ years
___ Alcohol use ___ Drinks per week

Place an X on the line if you have any of the conditions below now or in the past:
(Caregivers: please comment on positive responses)

Vision
__ 1. Do you use glasses?
__ For reading
__ For distant vision
__ Contacts
__ 2. Are you color blind?
3. Do you have:
__ Retinal disease
__ Cataracts
__ Glaucoma
__ 4. Do you use eye medicine?
__ 5. Have you had eye surgery?
__ 6. Have you had laser exposure?

Hearing
Do you have:
__ 7. Difficulty hearing
__ 8. Ear disease
__ 9. Ringing in the ears
__10. Abnormal hearing test
__11. Do you use a hearing aid?
__12. Have you had ear surgery?
__13. Ruptured ear drum?
__14. Exposure to gunfire?
__15. Wear hearing protection?

Heart/Vascular
Do you have:
__16. Chest pain on effort
__17. High blood pressure
__18. Shortness of breath
__19. Swelling of ankles
__20. Heart murmur
Have you had:
__21. Heart attack
__22. Stroke
__23. Rheumatic fever
__24. Heart failure
__25. Heart surgery/Stent/Pacemaker

Respiratory
Do you have:
__26. Chronic cough
__27. Asthma
__28. Bronchitis
__29. Hay fever
__30. Emphysema/COPD
Have you had:
__31. Tuberculosis
__32. Lung cancer
__33. Lung surgery
__34. Silicosis
__35. Asbestos
__36. Black lung

Liver or Gastrointestinal
Do you have or have you had:
__37. Hepatitis
__38. Cirrhosis
__39. Jaundice
__40. Frequent indigestion
__41. Ulcer disease
__42. Colitis
__43. Other intestinal problems
__44. Do you have a hernia?
__45. Have you had hernia surgery?

Genitourinary
Do you or have you had:
__46. Kidney trouble
__47. Bladder trouble
__48. Kidney stones

Skin
__49. Do you have eczema?
__50. Do you have psoriasis?
__51. Any other skin conditions

Neurologic
__52. Tremors
__53. Dizzy spells
__54. Convulsions
__55. Paralysis
__56. Nerve damage
__57. Serious head injury
__58. Brain surgery
__59. Nervous breakdown
Are you taking medication for:
__60. Anxiety or depression
__61. Epilepsy
__62. Parkinson's disease

Blood, Endocrine
Have you had:
__63. Anemia
__64. Bleeding problems
__65. Hormone problems
__66. Diabetes
__67. Thyroid problem

Musculoskeletal
Have you had or do you have:
__68. Back trouble
__69. Disc problems/surgery
__70. Shoulder problems/surgery
__71. Arm problems/surgery
__72. Wrist problems/surgery
__73. Hand problems/surgery
__74. Hip problems/surgery
__75. Leg problems/surgery
__76. Knee problems/surgery
__77. Ankle problems/surgery
__78. Foot problems/surgery
__79. Broken bones
__80. Numbness, tingling, and/or pain in hands or arms

Communicable Diseases:
Have you had:
__81. Chicken pox
__82. Measles
__83. German Measles
__84. Mumps
__85. Hepatitis A
__86. Hepatitis B
__87. Hepatitis C

Vaccine Dates: MMR #1: _____ MMR #2: _____
Tetanus: _____
Hepatitis B 1st: _____ 2nd: _____ 3rd: _____
HepB Antibody Testing: _____ [ ] Positive [ ] Negative
Tuberculin (TB) skin test reactor: _____ yes _____ no
If yes, year of conversion: _____
If positive, Preventive Drug Treatment: _____ yes _____ no
If yes, how long did you take medicine: _____
Last chest x-ray: _____
Have you ever been injured at work? _____ yes _____ no
If yes, year and type of injury for each injury: _____
_____
Have you ever received worker's compensation: _____ yes _____ no
If yes, give details: _____
_____

_____ _____
Employee Signature Date

_____ _____
Reviewed By Date
f-hxhlth

OSHA Mandatory Respiratory Medical Evaluation Questionnaire
29 CFR 1910.134

Frederick Memorial Hospital Employees

Can you read: [ ] yes [ ] no
Your employer must allow you to answer the questionnaire during normal working hours, or at a time 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: _____ 4. Leave Blank _____
5. Your Job Title: _____
6. Your Date of Birth: ___/___/_____
7. Sex [ ] Male [ ] Female 8. Your Height: ___ feet ___ inches
9. Your Weight: ____ lbs.
10. Phone # where you can be reached to discuss your answers:(____) ___-_____
11. The best time to call you at this number: _____ [ ] a.m. [ ] p.m.
12. Has your employer told you how to contact the health care professional who will review this questionnaire? [ ] yes [ ] no
13. 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).
14. Have you worn a respirator? [ ] 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.

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. Trouble smelling odors:	[ ] yes	[ ] no
d. Claustrophobia (fear of closed-in places)	[ ] yes	[ ] no
e. Allergic reaction that interfere with your breathing?	[ ] 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 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. Swelling in your legs and feet (not caused by walking) [ ] yes [ ] no
   e. Heart Failure [ ] yes [ ] no
   f. Heart arrhythmia (irregular heart beat) [ ] 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 the 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 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 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 box and go to question
   [ ] Never Used
   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

_____ _____
Employee Signature Date

OSHA Mandatory Respirator Medical Evaluation Questionnaire Reviewed by:

_____ _____
PLHCP Signature Date

N-95 Medical Clearance Form

Frederick Memorial Hospital Employees

Please check Type(s) of Respirator(s) to be used:

[ ] Atmosphere-supplying respirator	[ ] Continuous-flow respirator
[ ] Open-circuit SCBA	[ ] Closed circuit SCBA
[ ] Supplied-air respirator	[ ] Combination air-lined and SCBA
[ ] Air-purifying (non-powered): N-95 Mask	[ ] Air-purifying (powered)

Level of Work Effort: [ ] Light [ ] Moderate [ ] Heavy [ ] Strenuous

Extent of Usage:
[ ] On a daily basis
[ ] Occasionally - but more than once a week
[ ] Rarely - or for emergency situations only

Length of Time of Anticipated Effort in Hours: _____

Special Work Considerations: (i.e. high places, temperature, hazardous material, protective clothing, etc.)

_____

_____

_____

_____ _____
Company Safety Representative Telephone Number

Health Care Provider's Evaluation

_____

_____

_____

Class (check one):
[ ] No restrictions on respirator use
[ ] Some specific use restrictions: Medically cleared for N-95 respirator only
[ ] No respirator use permitted
[ ] Need special frames for glasses if required to wear full-face respirator
[ ] No contact lenses

Restrictions:

_____

_____

[ ] FIT TEST TECHNICIAN HAS CONFIRMED THAT FACIAL HAIR IS NOT PRESENT ACROSS RESPIRATOR SEAL AREAS AT THE TIME OF TESTING (OSHA REG 29 CFR 1910.134)

_____ _____
Health Care Provider Signature Date

f-rclfmh

RESPIRATOR FIT QUANTITATIVE

Frederick Memorial Hospital Employees

Quantitative Respirator Fit Testing will not be performed without a signed Respirator Clearance Form as per OSHA Standard 29 CFR 1910 and 1926.

OHS TECH (initial to verify the following):

_____ Respirator Medical Clearance Report signed by an OHS Caregiver

MEDICAL HISTORY

Please place a check by any of the following that a doctor has ever told you that you have or had:

_____ Claustrophobia _____ Heart Disease _____ Emphysema
_____ Asthma _____ Other Lung Disease

Please explain any of the above that you have checked: _____
_____

Smoking History: _____ Smoker _____ Ex-Smoker _____ Non-Smoker

REVIEW OF SYMPTOMS (Circle Yes or No)

Do you get short of breath at rest? Yes No
Do you get chest pain? Yes No
Do you have medical problems that might interfere with respirator use?
Yes No
If you answered "Yes" to any of the above, please explain:_____
_____

Are you currently taking any medication: Yes No (If yes, list them)
_____

I have been instructed on the Quantitative Fit Testing process.
_____

Employee Signature: _____ Date: ___/___/_____

FIT TESTING RESULTS:

- Respirator: Brand and Model Number: 3M#1860 Type: N95
  Size: ___ Regular ___ Small
  Alternate Brand: Brand and Model Number: _____ Type: _____

- Respirator Fit Test Passed: _____ yes _____ no
  ___ Instructed on donning, removal, and storage

- Reason Fit Test Not Passed: Beard: _____ Other: _____

If not approved for N95 Respirator, then fit test on:
___ Powered Air Purifying Respirator (PAPR) instructions and fitting completed

OHS Tech Signature:_____ Date: ___/___/_____

Copy form for OHS chart Original form for employer

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