Attachment #1
Table of Contents
T2609-Medical Examinations, Testing and Services
Bid Solicitation # 22DPP00676

MEDICAL DEFICIENCY REPORT

Name:_____
(LAST, FIRST, M.I.)

Social Security #:_____

The above Correction Officer Recruit candidate, upon examination, was found to have the following deficiency(ies) which will require the indicated correction(s) or follow-up in order to be considered medically fit to participate in the Police Training Commission's Physical Conditioning Training Program.

_____

_____

_____

_____

_____

_____

_____

_____ _____
Physician's Signature Date

CRU 7-96

POLICE AND FIREMEN'S RETIREMENT SYSTEM

The following report must be completed by a physician representing the employing agency and attached to the employee's enrollment application.

REPORT OF EXAMINING PHYSICIAN

Applicant _____ Social Security No. _____

Name of Employer _____ _____
Municipality County

State Agency _____ _____
Department Division

Height _____ Weight _____ History _____
(operations, diseases, nervous disorders, disability awards, etc.)

_____

_____

_____

_____

Teeth _____ Mouth _____ Nose _____ Throat _____ Hearing _____ Vision _____

Color Test _____ Chest _____ Lungs _____ Heart _____

Blood Pressure _____ Pulse _____ Extremities _____ Reflexes _____

Feet-toes _____ Hernia _____ Hemorrhoids _____

Urine: Sp. Gr. _____ Reaction _____ Sugar _____

Remarks: _____

_____

_____

_____

MARK ONE

☐ IS

☐ IS NOT

➡ **physically capable of sustaining the labors and exposures in the performance of his duties.**

_____ _____
(Date) (Signature of the Physician representing the Employer)

IMPORTANT: EXAMINING PHYSICIAN'S REPORT MUST BE ATTACHED TO ENROLLMENT APPLICATION.

PF-10-0061-1086

POLICE AND FIREMEN'S RETIREMENT SYSTEM

The following report must be completed by a physician representing the employing agency and attached to the employee's enrollment application.

REPORT OF EXAMING PHYSICIAN

NJ Dept. of Corrections

_____ **Social Security Number:** _____

_____ _____

Municipality *County*

State Agency: _____ _____

Department *Division*

Height: _ _ **Weight:** _____ **History:** _____

(operations, diseases, nervous disorders, disability awards, etc.)

_____

_____

Teeth: _____ **Mouth:** _____ **Nose:** _____ **Throat:** _____ **Hearing:** _____ **Vision:** _____

Color Test: _____ **Chest:** _____ **Lungs:** _____ **Heart:** _____

Blood Pressure: _____ **Pulse:** _____ **Extremities:** _____ **Reflexes:** _____

Feet-toes: _____ **Hernia:** _____ **Hemorrhoids:** _____

Urine: Specific Gravity: _____ **Reaction:** _____ **Sugar:** _____

Remarks: _____

_____

_____

_____

_____

Visual Acuity	Uncorrected NEAR	Corrected FAR	Horizontal Field	Color
Right	20/	20/	°	(NL)
Left	20/	20/	°	AB
Both	20/	20/		

MARK ONE:

☐ Is

→ physically capable of sustaining the labors and exposures in the performance of his/her duties.

☐ Is not

_____ _____

(Date) *(Signature of the Physician representing the Employer)*

IMPORTANT: EXAMINING PHYSICIAN'S REPORT MUST BE ATTACHED TO ENROLLMENT APPLICATION

RWJBarnabas HEALTH

Occupational & Corporate Health

MEDICAL HOLD

New Jersey Department of Corrections

_____ was examined at our office and needs the following condition(s) to be corrected to qualify for employment.

- ☐ Elevated Blood Pressure
- ☑ Vision Correction Required
- ☐ Abnormal EKG
- ☐ Abnormal Blood work results
- ☐ Abnormal Chest X-Ray
- ☐ Undocumented Condition or Surgery
- ☐ Other: _____

After correcting the above, the applicant may return to our office for a re-check. He/she must bring:

- ☐ Note from personal Physician stating, **Diagnosis, Treatment, and ability to work and ability to participate in HEAVY exercise program.**
- ☑ Note from ophthalmologist stating:
  - A) Best corrected vision
  - B) Color Vision
  - C) Depth perception
- ☐ Information regarding past condition or surgery
- ☐ Other: _____

Providers Sign _____ Dat

☐

☐

☐ ☐ Other

☐ I

_____

DEP's Initial Standard Threshold Shift Referral Form

Name:_____ Work Phone Number:_____

Document view

Reviewed previous audiogram & relevant material sent over from Yes:___ No: ___

Confirmed STS as a result of Contractor's audiogram review? Left:___ Right: __

If a confirmed STS, was a letter sent by Contractor Yes:___ No: ___

If a confirmed STS, indicate if occupational, non-occupational or both. Occupat: _____ Non-Occ: _____ Both: _____

If a confirmed STS, is an audiologist or ENT referral needed? Yes:___ No: ___

If a confirmed STS, is a retest\evaluation at Contractor needed? Yes:___ No: ___

NOTE- If Contractor will evaluate, keep this form & complete the bottom portion once the hearing test is done.

Comments: _____

_____

Doctors Signature: _____ Date:

Hearing Test

Visible evidence of cerumen accumulation or a foreign Yes:___ No: ___

Hearing test preformed by: _____

Hearing test results attached: Yes:___ No: ___

Was the hearing test age adjusted? Yes:___ No: ___

Reviewed previous audiogram sent over from DEP? Yes:___ No: ___

Is there a medical problem caused or aggravated by the Yes:___ No: ___

Employee was seen by **which Doctor:** _____

Confirmed STS as a result of Contractor's audiogram and Left:___ Right: __

If a confirmed STS, was a letter sent by Contractor's Yes:___ No: ___

If a confirmed STS, indicate if occupational, non-occupational or both. Occupat: _____ Non-Occ: _____ Both: _____

If a confirmed STS, is an audiologist or ENT referral Yes:___ No: ___

Comments: _____

_____

Doctors Signature: _____ Date: _____

State of New Jersey

Chris Christie
Governor

Department of Environmental Protection

Bob Martin
Commissioner

Kim Guadagno
Lt. Governor

Office of Occupational Health and Safety
428 E. State St., PO BOX 416
Trenton, NJ 08625
Phone (609) 292-1408
Fax (609) 984-2488

Immunization Sheet

NAME: _____ SS#: _____

ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

DEPARTMENT: _____ JOB TITLE: _____

WORK ADDRESS: _____CITY: _____ STATE: ____ ZIP: _____

SUPERVISOR: _____ WORK PHONE: _____

IMMUNIZATION FOR: _____ LOT #: _____

TITER ANALYSIS FOR: _____

DATE OF: 1st DOSE _____
2nd DOSE _____
3rd DOSE _____
TITER _____

ANITBODY DEVELOPMENT? YES ___ NO ___

NAME OF PHYSICIAN/MEDICAL FACILITY THAT ADMINISTERED VACCINE:

_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: _____ EXT.: _____

DOCTOR'S SIGNATURE: _____

ADM-204
1/07

New Jersey Department of Environmental Protection
Office of Occupational Health & Safety
PO Box 416, 428 E. State St., Trenton, NJ 08625-0416
(609) 292-1408

Please Press Firmly

HEALTH STATUS/RECOMMENDATIONS

Please Press Firmly

Examinee's Name Last	First	MI	ID # (last 4 digits of SS#)	Date

TYPE OF EXAMINATION:
___ Police Academy Entrance
___ Fire & Police Pension
___ Chemical Exposure
___ Medical Surveillance
___ Resp. Clearance, only
___ Medical Surveillance\including Resp. Clearance
___ Other: _____
___ CDL
___ Hepatitis B
___ Return to Work
___ Baseline Exam

Tetanus Toxoid/Diptheria Booster Date: _____

Position/Title:	Work Tele. #
Division	
Work Address	PO Box
Supervisor Name	Working Cost Center 4
Rabies Series Date: _____	Hepatitis B Series Date: _____

MEDICAL STATUS

The following recommendation is based on a review of the health history questionnaire, physical examination and/or assessment and the specific requirements of the position to be/or occupied by the examinee.

1. ___ No significant medical impairment exists, can be assigned any work consistent with skills and training.
2. ___ Medical impairment exists, has been referred to or under the care of the physician for medical follow-up. However can be assigned any work consistent with skills and training.

RESPIRATOR CLEARANCE STATUS

The following recommendation is based on a review of the health history questionnaire, the respirator questionnaire, PFT, physical examination and/or assessment and the specific requirements of the position to be/or occupied by the examinee.

The employee is medically qualified for:
___ Level A, B, C or D field activities (self-contained breathing apparatus with fully encapsulating chemically resistant protective clothing).
___ Level C or D field activities (full-face air purifying respirator with full body chemically resistant protective clothing).
___ Level D field activities, (however, is not medically qualified to wear respirator or fully encapsulating protective clothing).

RECOMMENDATIONS

1. ___ Recommend his/her return to work with no limitations on (Date) _____
2. ___ He/She may return to work on (Date) _____ with the following limitations:

___ No prolonged standing
___ No prolonged walking
___ No repeated squatting or bending
___ Not to lift over _____ pounds
___ Not to operate a motor vehicle
___ Not to work on ladders or at unprotected heights
___ No work in areas with dust, fumes or chemical irritants
___ Must wear corrective lenses
___ Must wear hearing protection, when appropriate
___ Other (specify below)

Other specific limitations: _____

3. ___ These restrictions are in effect until the examinee submits documentation from their personal physician to the contracted medical provided of clearance. At such time an updated Health Status form will be completed.
4. ___ Referred to: _____

OTHER INSTRUCTIONS

1. ___ Instructions: _____
2. ___ Follow-up Appointment *(Circle One):* Exit Baseline - 0 Annual - 1 Biannual - 2 Triannual - 3 Other: _____

The Office of Labor Relations advises DEP employees that if you fail to keep your appointment, formal disciplinary action may be taken against you.

Employee Signature	Date	Examiner Signature M.D./R.N.	Date

*Personal data, including Social Security Number, is required to facilitate identification, report generation and/or recordkeeping. Any other use of this information, and any release outside authorized State Agencies, are prohibited.

COPIES: White - Medical File Yellow - Supervisor Pink - COHS Gold - Employee

ADM-196
8/07

New Jersey Department of Environmental Protection
Office of Occupational Health and Safety

Assessment Date _____
MSP Initial Date _____
Note _____

CONFIDENTIAL HEALTH HISTORY

Your health history, including family history and habit patterns, is most important in evaluating your health and determining work assignments and risk. Please fill out this confidential questionnaire as accurately as possible. Answer all questions by placing a check mark (✓) in a "Yes" or "No" box and by printing the word(s) or number(s) answer as required. If you have any questions or need help completing this form do not hesitate to ask for assistance. Please Print.

1. IDENTIFICATION

NAME (Legal Name Please - No Nicknames) Last First MI

HOME ADDRESS - Street

City State Zip Code

SOCIAL SECURITY NO.*	EMPLOYEE ID NO.#	BIRTHDATE	AGE

SEX RACE	MARITAL STATUS		HOME TELEPHONE NO. ( )
DIVISION	PO BOX	WORKING COST CENTER	BUSINESS TELEPHONE NO. ( )
SUPERVISOR	WORK ADDRESS City		Zip Code

PERSONAL PHYSICIAN - Name

PHYSICIAN'S ADDRESS - Street

City, State, Zip Telephone No. ( )

2. FAMILY HISTORY

	Y	N	If no, AGE AT DEATH	CAUSE OF DEATH
Is your mother living?				
Is your father living?				

Has any close relative (parents, grandparents, brothers, sisters or children) ever had:

	Y	N		Y	N
Heart Trouble or Disease			Stroke		
Cancer or Leukemia			Asthma		
Diabetes			Psychiatric Illness		
High Blood Pressure			Genetic or Congenital Disease		
Kidney Trouble					

3. MEDICATIONS

Do you use any of these medicines regularly:

	Y	N		Y	N
Sedatives, Sleeping Pills			Hormones		
Insulin, Diabetic Medicine			Heart Medicines		
Thyroid Medication			Birth Control Pills		
Weight Reducing Pills			High Blood Pressure Med.		
Antacids			Stomach or Intestinal Med.		
Vitamins			Anticonvulsives		
Tranquilizers			Other, Specify		
Laxatives					

List medications and dosages:

4. ALLERGIES

Do you have any specific allergies caused by:

	Y	N		Y	N
*Drugs, (Penicillin, etc.)			Animal		
Dusts			Other, Specify		
Chemicals					
Food					

*Please list drug allergies _____

5. SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No
Did you smoke in the past? ☐ Yes ☐ No
For how many years? _____ Quit? _____ (Year)
If cigarettes, how many packs per day? _____
If pipe or cigar, specify which _____

What is you approximate alcohol consumption?

Liquor	☐ None	☐ Occas.	☐ 1-3 drinks daily	☐ 4 or more drinks daily
Beer	☐ None	☐ Occas.	☐ 1-3 drinks daily	☐ 4 or more drinks daily
Wine	☐ None	☐ Occas.	☐ 1-3 drinks daily	☐ 4 or more drinks daily

Do you (away from work):
Please list hours/week when in season.

Garden	_____	Hike/Camp	_____
Lawn Work/Mowing	_____	Other outdoor activities	_____
Hunt, Fish	_____		

How many hours/weeks do you:

Exercise	_____	Type of exercise	_____
Watch TV	_____	Other hobbies	_____

*PRIVACY ACT STATEMENT - Personal data, including Social Security Number, is required to facilitate identification, report generation and/or recordkeeping. Any other use of this information and any release outside authorized State agencies are prohibited.
*EMPLOYEE ID# can be found in eCATS on each timesheet entry page, upper left corner.

6 PERSONAL MEDICAL HISTORY -- Do you now, or have you had any of the following:

Constitutional

	Y	N
Fever, >101^0 F		
Fever, night sweats, chills		
Frequent headaches		
Generalized weakness		
Unexplained weight loss over (10 lbs.) in past year		
Unexplained weight gain over 10 lbs.) in past year		
Flu-like illness		

Eyes

	Y	N
Visual disturbance		
Cataracts		
Glaucoma		

Ears, Nose, Throat

	Y	N
Difficulty hearing		
Ringing, buzzing		
Sinus trouble		
Frequent nosebleeds		
Frequent mouth sores		
Frequent hoarseness		

Lungs

	Y	N
Frequent cough		
Coughing up blood		
Wheezing		
Asthma		
Bronchitis		
Emphysema		
Pneumonia		
Tuberculosis		
Pleurisy		

PREVIOUS HOSPITALIZATIONS

Specify approximate date and cause

Date _____
Cause _____

Date _____
Cause _____

Date _____
Cause _____

Heart

	Y	N
Heart murmur		
Rheumatic fever		
High blood pressure		
Shortness of breath		
Chest pain or pressure		
Heart attack		
Irregular heart beat		

Digestive System

	Y	N
Ulcers		
Frequent diarrhea		
Black tarry stools		
Vomiting up blood		
Hepatitis		
Pancreatitis		
Gallstones		
Hemorrhoids		

Neurologic

	Y	N
Bell's Palsy (weakness of the muscle of the face)		
Serious head injury		
Stroke		
Migraine headaches		
Seizures		
Numbness or tingling in part of your body		
Passed out		
Significant anxiety or irritability		
Depression		
Meningitis		

Musculoskeletal

	Y	N
Rheumatoid arthritis		
Other arthritis		
Neck or shoulder pain		
Back pain		
Sciatica		
Back injury		
Joint pain		
Broken bones		
Pain in hand or wrist		
Other _____		

Genitourinary & Reproductive

	Y	N
Kidney disease		
Kidney stones		
Frequent bladder or urinary infections		
Sexually transmitted disease		
Difficulty having children		
Frequent urination		
Difficult or painful urination		

(Men Only)

	Y	N
Prostate disorder		
Testicular disorder		
Vasectomy		

(Women Only)

	Y	N
Hysterectomy		
Tubal ligation (tubes tied)		
Miscarriage or stillborn pregnancy		
Irregular periods		
Menopause		
Cystic breasts		
Breast removal		
Was your mother ever given D.E.S.?		
Are you pregnant?		

Number of pregnancies _____
Number of live births _____

Skin

	Y	N
Moles that changed color or size		
Skin cancer		
Eczema		
Frequent rash		
Psoriasis		
Red, circular, expanding rash		

General

	Y	N
Swollen glands		
Thyroid disease		
Diabetes		
Gout		
Hernia		
Cancer		
Anemia		
Psychiatric illness		

Comments by examiner regarding positive items in history:

OTHER MEDICAL DISORDERS - Please specify

Are you presently under the care of a physician? ☐ Yes ☐ No

If "Yes", please explain and give name & address of physician.

PHYSICIAN _____
ADDRESS _____

7. OCCUPATIONAL HISTORY - Please answer the following questions to the best of your knowledge.

	CURRENT EMPLOYMENT	MOST RECENT PREVIOUS POSITION (whether within or outside current agency)	PREVIOUS POSITION	SECOND JOB	MILITARY
Agency or Company					
Division					
Bureau					
Job Title					
Description of Duties					
Office Machines/ other machines used					
Duration of Employment					
Percent of Time in the Field/Lab					
Exposures (i.e. Dusts, fumes, vapors, gases, chemicals, ticks, radiation, noise, vibration, repetition movements, temp. extremes, prolonged exposure to sunlight)					
Adverse Health Effects Possibly Related to Job					

Safety Equipment Use in Current Position ☐ Respirator ☐ RYVEC/Impermeable Suit ☐ Dust Mask ☐ SCUBA (Underwater) Gear ☐ Other _____

Other Exposures	YES	NO	IF YES, EXPLAIN
-- Does anyone in your family work with hazardous materials?	___	___	_____
-- Have you ever lived near a plant, waste site, mine or other facility that may have released hazardous materials?	___	___	_____
-- Do you have any hobbies involving adverse exposures?	___	___	_____
-- Any other exposures to hazardous materials?	___	___	_____

Have you ever been paid compensation for any injury or illness resulting from an insurance claim such as, homeowners, automobile, SLI, worker's compensation, etc. or is there any such claim pending? ___ Yes ___ No If "Yes", please explain the circumstances and extent of the injury (Use additional sheets if necessary).

_____

_____

EMPLOYEES -- PLEASE READ AND SIGN

The information provided on this form is true to the best of my knowledge and I acknowledge that it is part of the hiring and retention process and realize that falsification or misstatement in this document will subject me to immediate termination of employment.

_____

(Signature)

8. PHYSICAL EXAMINATION - Physician Completes

GENERAL APPEARANCE

EXACT WEIGHT BY SCALE EXACT HEIGHT

BLOOD PRESSURE PULSE

RESPIRATION RATE TEMPERATURE

	NL	AB.	COMMENT
Head and Scalp			
Eyes			
Opthalmoscopic (Fundi)			
Ears, Nose, Mouth,			
Teeth, Pharynx			
Neck			
Thyroid			
Lymph Nodes			
Thorax and Lungs			
Breasts			
Heart (size, rhythm, sounds)			
Abdomen			
Recctal Digital			
Genitalia			
Spine			
Skin			
Arterial Pulses			
Extremities			
Musculoskeletal			
Reflexes and Neurological			
Mental Status			

OTHER PHYSICAL FINDINGS

9. LABS (Results Attached)

NOTE: Below labs performed and any abnormal results.

	NL	ABNL	Not Done.	IF ABNORMAL, NOTE FINDINGS BELOW
CBC				
Urinalysis				
SMAC				
Spirometry				
Vision Testing				
Audiometrics				
Intraocular Pressure				
CXR				
EKG				
Biological Monitoring				
Other Labs				

10. ASSESSMENT AND PLAN

ASSESSMENT PLAN

Tetanus Toxoid/Diptheria Booster _____ MSP - ☐ Initial ☐ Yearly ☐ Q 2yrs. ☐ Q 3yrs. ☐ Out

Date of Last Booster

Ordered: ☐ Yes ☐ No Given _____ _____ Date

Signature of Examining Physician _____ Date _____

11. ASSESSMENT NOTES

Signature _____ Date _____

Data entered by _____

Date _____

New Jersey Department of Environmental Protection
Office of Occupational Health & Safety

Frequency of Exam ____ Annual
____ Biennial
____ Initial
If _____ changed indicate why
_____
_____
_____

Medical Service Sign-off Sheet

Name: _____ Date: _____

SS# or ID#: _____ Job Title: _____

Type of medical service: _____

Initial/or year	**Medical Action Provided**
_____	Complete Medical & Occupational History & Physical (includes ALL vital signs)
_____	Audiogram
_____	Visual Acuity Testing
_____	Pulmonary function testing
_____	Complete Metabolic Panel (Chem 14), CBC w/ Diff., Triglycerides, Cholesterol and Urinalysis
_____	PSA
_____	Chest X-ray – PA & Lat CXR at initial, exit, and every ten years thereafter or more frequently if medically necessary. _____date of last chest x-ray
_____	EKG- initial, at age 40 and every 5-6 years thereafter or more frequently if medically necessary. _____ date of last EKG. Rationale for EKG if done out of sequence _____
_____	Stool Occult
_____	Tetanus shot
_____	Hepatitis B shot
_____	Rabies shot
_____	Other Service NOS : _____
_____	Physician reviewed and discussed all results with client and answered any client questions.
_____	Immunization Record form completed (only pink)
_____	Respiratory Questionnaire reviewed (only for respiratory clearance exam)
_____	Previous hearing test reviewed and ears examined (only for hearing test outside of a regular physical)
_____	Health Status form completed.

ADM-202
11/06

State of New Jersey

DEPARTMENT OF ENVIRONMENTAL PROTECTION

Office of Occupational Health and Safety
428 E. State Street PO Box 416
Trenton, NJ 08625
Phone (609) 292-1408
Fax (609) 984-2488

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

Patient Maiden Name: _____ Phone #: _____

Home Address: _____

1. **Authorization**
I authorize the Office of Occupational Health and Safety to use or disclose the above named individual's health information as described below.
To release any and all* medical information of treatments or examinations rendered to me through the department's contracted medical vendor.

* Note: Medical Surveillance Program Participants – A copy of your most current exam on file will be sent unless otherwise specifically instructed.

2. **Release information to:** **please mark which box applies**
☐ Myself (the patient or representative) ☐ Organization/Individual below

Name of Organization/Individual: _____

Address of Organization/Individual: _____

☐ Please mail to above address ☐ Please prepare records for pick-up on this date: ____

3. I understand that I may be charged a fee for copies of my medical records and any applicable mailing/postage fees.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness (OOHS rep)

State of New Jersey

PHILIP D. MURPHY
Governor

DEPARTMENT OF ENVIRONMENTAL PROTECTION
Office of Occupational Health and Safety
PO Box 420, Mail Code 428-02
Trenton, NJ 08625
Phone: (609) 292-1408
Fax: (609) 984-2488

CATHERINE R. MCCABE
Commissioner

SHEILA Y. OLIVER
Lt. Governor

NJDEP ANTIMICROBIAL POST-EXPOSURE PROGRAM
MEDICAL REVIEW FORM

Name: _____ **Date of Birth:** _____

Contact Phone Numbers (Cell): _____ (Circle) **Work/Home:** _____

Allergies: _____ **Medication(s):** _____

Medical Problems: _____

Height: _____ **Weight:** _____

	Yes	No
1. **Do you have a known allergy to Ciprofloxacin (Cipro)?**	____	____
2. **Do you have a known allergy to Doxyclicline?**	____	____
3. **Do you have any kidney dysfunction?**	____	____
4. **Are you or could you be pregnant?**	____	____
5. **Are you currently breastfeeding?**	____	____

6. **Do you have any questions or concerns that may become an issue while taking the antibiotics? (If you wish to describe your concerns or questions, please explain below.)**

I understand that my signature, below, indicates that I have read and understand the information provided with this form regarding Ciprofloxacin (i.e., "Cipro"), including: What Cipro is used for; other important information about Cipro: side effects and incompatibilities with other drugs; how Cipro should be taken; and what to do about missed doses or inadvertent overdoses. [Source: http://www.drugs.com]

Signature: _____ **Date:** _____

Please return this form to OOHS when completed at the above address.

Form version 3:

Appendix A: Medical Screening

Contents:

Description of Medical Screening Process

Letter to Prospective Trainee

Health History Statement (PTC-7) fillable .pdf

Letter to Physician

Medical Certification Form (PTC-8) fillable .pdf

DESCRIPTION OF MEDICAL SCREENING PROCESS

Any person attending the following basic courses must undergo a medical examination by a licensed physician to determine if the individual is fit to undergo training:

- Basic Course for Police Officers
- Basic Course for Class Two Special Law Enforcement Officers
- Basic Course for Investigators
- Basic Course for State Correctional Police Officers
- Basic Course for County Corrections Officers
- Basic Course for Juvenile Detention Officers
- Basic Course for County Park Rangers
- Basic Course for Juvenile Residential and Day Program Youth Workers
- Basic Course for Parole Officers
- Basic Course for Juvenile Correctional Police Officers
- Basic Course for Juvenile Parole Officers

The medical examination shall be administered within 90 days of an officer's admittance to a basic course. The physician shall state, on a form prescribed by the commission, whether or not the individual is fit to undergo training.

The following materials pertain to the medical screening process:

- LETTER TO THE PROSPECTIVE TRAINEE - This letter informs the prospective trainee that he or she must obtain a medical clearance prior to acceptance into a commission basic course. The employing agency shall provide the prospective trainee with a copy of this letter.

- HEALTH HISTORY STATEMENT (PTC-7) - The prospective trainee shall complete this form and shall give it to the examining physician. The physician shall return the completed form to the employing agency where it shall be treated confidentially. It must be pointed out that the information on the form was obtained specifically for training purposes and access to the form shall be strictly limited. It is the responsibility of the employing agency to make known to the trainee whether or not the agency wishes to retain copies of the PTC-7 and to provide a copy of this completed form to the school that the trainee will attend.

- LETTER TO THE PHYSICIAN - This is to be given to the examining physician by the prospective trainee. The letter contains information with respect to the commission's Physicial Conditioning Training Program, Defensive Tactics training (unarmed defense), Physicial Restraint training, Firearms training, Baton training, exposure to chemical agents, and the medical screening process.

- MEDICAL CERTIFICATION FORM (PTC-8) - This form is to be completed by the examining physician and returned to the employing agency. It is the responsibility of the employing agency to indicate to the trainee whether or not the agency wishes to retain copies of the Medical Certification Form and to provide a completed copy of this form to the school the trainee will attend.

PTC
New Jersey
Police Training Commission

NOTICE TO TRAINEE

As part of the basic course you are planning to attend, you will be required to participate in certain training requiring physical activity. Depending on the basic course you are entering, these activities may include physical conditioning training, defensive tactics (unarmed defense), physical restraint training, baton training, exposure to chemical agents, and firearms training.* The purpose of this letter is to advise you that under N.J.A.C. 13:1-8.1(a)5, you are required to obtain medical clearance from a licensed physician prior to participation in the basic course.

The medical clearance is required to provide reasonable assurance that there is no medical reason why you should not participate in the training program. To obtain medical clearance, it is necessary for you to complete the Health History Statement (PTC-7) and to provide the completed statement to the examining physician. Please complete the Health History Statement prior to your physical examination.

Along with the Health History Statement and this letter to you, your agency chief (or designee) will provide you with the Medical Certification Form (PTC-8) and a letter to the examining physician. Please provide the following to the examining physician:

- Notice to Physician
- Health History Statement (PTC-7 completed)
- Medical Certification Form (PTC-8)
- An envelope which is marked Confidential and is addressed to the chief executive of the employing agency

* These activities are fully described in the Notice to Physician which your agency chief (or designee) will provide to you for submission to your examining physician. For your information, please review the description of physical activities that are applicable to the basic course you plan to attend.

The physician will be asked to return the completed Medical Certification Form to your agency. Medical clearance will depend upon the information contained in your Health History Statement and the results of your medical examination.

Thank you for your cooperation in complying with Commission requirements regarding medical clearance and best wishes for success in your career.

Revised 07/31/08

STATE OF NEW JERSEY
DEPARTMENT OF LAW AND PUBLIC SAFETY
DIVISION OF CRIMINAL JUSTICE
POLICE TRAINING COMMISSION

HEALTH HISTORY STATEMENT

Candidate's Name_____

Social Security No._____Date of Birth_____

Candidate's Address:_____

_____

Candidate's Employing Agency_____

Police Training Commission - Approved School Candidate Will Attend:

_____

Name of Course:_____

Course Dates:_____

To the Candidate: Please complete in ink the following questionaire concerning your past and present health. If you have an electronic copy of this form, it is a fillable .pdf, which can be typed and printed but cannot be saved.

Provide details for any positive answers on this statement.
(You need not explain positive answers for question 16.)
If additional pages are necessary, reproduce the last page.
The information on this form will be used strictly to determine training eligibility and the information will be treated confidentially.

1. Name and address of family doctor _____

_____

2. Date last seen and reason_____

3. Do you use Tobacco products? ☐ Yes ☐ No What type?_____

How often? _____ Quantity? _____

4. Do you use alcoholic beverages? ☐ Yes ☐ No If Yes, what is your approximate intake of these beverages?

	None	Occasional	Often	Drinks per week?
Beer	☐	☐	☐	_____
Wine	☐	☐	☐	_____
Hard liquor	☐	☐	☐	_____

5. a. Have you taken any drugs or medications prescribed by a physician in the last year? ☐ Yes ☐ No

b. Have you taken any over-the-counter or non-prescription medications in the last year? ☐ Yes ☐ No

c. Are you now on any medication? ☐ Yes ☐ No

6. a. Have you ever undergone a drug test for any employment or admission into a law enforcement training program? ☐ Yes ☐ No

b. Have you ever produced a positive result on any drug test reported in 6.a.? ☐ Yes ☐ No

7. Do you have any hearing problem or deafness? ☐ Yes ☐ No Explain:_____

_____

8. Do you wear glasses, contact lenses or have any other eye disorder? ☐ Yes ☐ No

Explain:_____

9. Do you have any dental problems? ☐ Yes ☐ No Explain:_____

_____

10. Have you ever been hospitalized? ☐ Yes ☐ No If so, when?_____

11. Have you ever had any surgery or operations? ☐ Yes ☐ No Explain:_____

_____

12. Do you have any physical or mental condition that would prevent you from participating in any form of strenuous, prolonged exercise? ☐ Yes ☐ No Explain:_____

_____

13. Do you participate in any regular exercise program or sport? ☐ Yes ☐ No

Explain:_____

14. Has your weight changed in the last year? ☐ Yes ☐ No

How much? _____ (+ or - lbs.)

15. Have you ever experienced any heat stress related emergencies, including heat fatigue, heat cramps, heat exhaustion or heat stroke? ☐ Yes ☐ No Explain:_____

_____

16. Are you pregnant? ☐ Yes ☐ No Have you ever been pregnant? ☐ Yes ☐ No

Have you given birth during the six-week period of time preceding the start of the basic course? ☐ Yes ☐ No

17. Have you ever been discharged from the armed services for medical reasons?

☐ Yes ☐ No

Family History

	Age	Health or Cause of Death		Age	Health of Cause of Death
Mother			Father		
Brothers			Sisters		

Heart and Blood Vessels

18. Have you ever had high blood pressure? ☐ Yes ☐ No When?_____

19. Have you ever had any type of heart trouble (murmer, leaky valve, rheutatic fever, heart attack, coronary?) ☐ Yes ☐ No Explain_____

_____

20. Do you have any chest pain, skipped heart beats or palpitations? ☐ Yes ☐ No

Explain_____

21. Do you have any kind of circulation problem (cold hands or feet, leg pain while walking, varicose veins, swollen legs or ankles, vein problem, phlebitis)? ☐ Yes ☐ No

Explain_____

22. Have you ever had any type of stroke? ☐ Yes ☐ No Explain_____

_____

Lung Problems:

23. Have you ever had any lung problem (shortness of breath, chronic cough, wheezing, asthma, emphysema, bronchitis, pneumonia)? ☐ Yes ☐ No Explain_____

_____

24. Are you now or have you ever used inhalers? ☐ Yes ☐ No When/how often?

_____

Muscle - Bone - Joint Problems

Have you ever had:

25. Any type of back problem (slipped disk, low back strain, back pain, neck pain)?

Explain_____

26. Recurrent dislocations of any joint, recurrent strains or sprains or any type of arthritis?

_____

27. Any athletic or other injury, broken bones, requiring medical attention?_____

_____

Nervous, Mental or Emotional Disorders

28. Have you ever had any nervous or emotional disorders (seizures, fits, epilepsy, blackouts, fainting spells, mental illness, depression, head injury or concussion)?

☐ Yes ☐ No Explain_____

_____

Allergies

29. List and explain any allergy problems (food, rash, hay fever, sinus trouble, wheezing, reaction to medicines)_____

_____

Blood Sugar, Blood Tests, Cancer

30 List and explain any high or low blood sugar, abnormal cholesterol, thyroid, anemia or other abnormal blood test, leukemia or cancer _____

_____

Please list anything else which you feel may be important in your medical history, including any conditions not specifically referred to in the preceding questions._____

_____

_____

_____

_____

_____

_____

_____

Details of “Yes” Answers. Include details as to when the condition was treated, and whether treatment was successful. Place appropriate question numbers for responses. Attach additional pages as necessary.

Question #	Details

PTC
New Jersey
Police Training Commission

Notice to Physician

Under N.J.A.C. 13:1-8.1(a)5, the individual you are examining is required to obtain medical clearance prior to acceptance into a Police Training Commission basic course involving physical activity. This training may include physical conditioning, defensive tactics (unarmed defense) training, baton training, physical restraint training, exposure to chemical agents and firearms training.

Physical conditioning consists of a series of physical fitness assessments and a program of physical exercise conducted at a school approved by the Police Training Commission. The exercise program will be conducted a minimum of three and a maximum of five times per week, each session lasting sixty minutes. For individuals who are more highly fit, an additional ten minutes of aerobic activity is permitted. The program of physical exercise will focus on flexibility, cardiorespiratory endurance (aerobics), strength, power, speed, and neuromuscular coordination (agility, balance). The intensity of training is individualized to the extent possible in a group setting and is gradually increased throughout the course of the exercise program.

Please note that some of the commission-approved schools have requested and received commission approval to include variations to the mandated physical conditioning training program. These variations include the use of Universal equipment, super-circuit weight training, boxing, obstacle courses and the horizontal ladder. The director of the school where the trainee will be enrolled has been informed to supply directly to you information concerning a school's variation from the commission-mandated physical conditioning program.

Defensive tactics (unarmed defense) training teaches the trainee to use body parts as defensive weapons. The trainee will use the open hand, elbow, forearm, knee, foot, and hand during the defensive moves. Take-down tactics, holds, punching, straight kicks and headblocks are some of the defensive tactics employed during the training. Balance and leverage (extensive use of trunk and abdominal muscles) are part of the defensive stance used by the trainee.

Chemical agent training is held at either an indoor or an outdoor training area. A trainee may be exposed to either a direct facial spray of Oleoresin Capsicum (OC) or a room in which the chemical agent has been released. The trainee experiences the physiological impairments and reactions associated with the agent as well as understanding the aftercare required.

Firearms training is held either in an indoor or an outdoor range and the trainees use

Revised 07/31/08

handguns and shotguns. A trainee walks briskly or slowly jogs from the 25-yard to the 1-yard line, with intermittent stops at designated yard lines, and fires the handgun. Standing, prone, kneeling and barricaded positions are assumed. Trainees use both the strong and support hands for handgun firing. Shotguns, weighing approximately 11 pounds, are fired from a standing position using the strong shoulder position. In the Basic Course for State Corrections Officers, rifle training is required. Rifles, weighing approximately 12 -13 pounds are fired from behind barricades from a standing and kneeling position. The strong shoulder and strong knee positions are used.

For firearms training, manual dexterity is required and there may be problems if any fingers or limbs are missing or if there are problems with vision.

To assist you in understanding the training program this individual will participate in, we have enclosed the following:

Chart 1 - Physical Conditioning Exercise Program Overview and Sequence of Exercises for Five-Day Week

Chart 2 - Physical Conditioning Exercise Program Overview and Sequence of Exercises for Three-Day Week

Chart 3 - Static and Dynamic Flexibility Exercises

Chart 4 - Calisthenics/Strength Exercises

Chart 5 - Defensive Tactics

Other - Medical Certification Form

The Commission-approved Physical Conditioning Training Program manual specifies that the following shall be included in the physical examination:

- A hearing examination.
- Physical examination of the spine and limbs for bone and joint abnormalities and of the neck, chest, abdomen, eyes, ears, nose, and throat
- Auscultation of heart and lung sounds for identification of possible cardiac murmurs, dysrhythmias, or chronic lung disease
- Measurement of resting heart rate, blood pressure and respiration
- Height and weight

The following laboratory work is required:

- Chemical analysis of blood for levels of serum cholesterol, triglycerides, glucose, and uric acid and illegal drugs.
- Urinalysis

- Electrocardiogram.

If indicated because of medical history or a finding on the examination, a chest x-ray may be required.

A maximal exercise stress test may be required. In keeping with the guidelines of the American College of Sports Medicine, it is desirable for an individual 45 years of age or older to have a maximal exercise stress test before beginning the training program. An exercise stress test prior to acceptance into the school is strongly recommended for prospective trainees whose medical screening and fitness evaluation indicate a higher risk status or the presence of disease. The physician, however, will determine whether or not the stress test is to be administered.

A Health History Statement (PTC-7) including cardiac-related information has been completed by the trainee to assist you in determining whether or not the individual is fit to undergo the commission-approved programs as specified in this letter. The trainee has been directed to provide you with the completed Health History Statement so that it may be reviewed during the medical examination. The responses contained in the Health History Statement are to be used as a starting point in the medical examination. Please feel free to inquire into any other areas which, in your medical opinion, are necessary so that you may accurately determine whether the prospective trainee is medically fit to undergo the programs described. Please retain a copy of the completed Health History Statement (PTC-7) in your files in accordance with N.J.A.C. 13:35-6.5.

Following the examination it is requested that you complete the enclosed Medical Certification Form (PTC-8). Please indicate whether the individual is:

Medically fit to participate in Defensive Tactics (unarmed defense), Chemical Agent exposure, Baton training, Physical Restraint training, Firearms Training and in the Police Training Commission's Physical Conditioning Training Program without limitations.

If the individual has a temporary illness or injury which will clear prior to the training program, please note that on the PTC-8 form.

Not medically fit to undergo training.

The nature and severity of any risks or disease should be viewed in light of the content of the training programs and the trainee's physical condition.

To ensure confidentiality of the completed Medical Certification Form and the Health History Statement, please return both in the envelope which is marked Confidential and is addressed to the chief executive of the employing agency.

Please retain a copy of the completed Medical Certification Form for your records.

Your cooperation is greatly appreciated.

CHART 1

PHYSICAL CONDITIONING EXERCISE PROGRAM

OVERVIEW AND SEQUENCE OF EXERCISES FOR FIVE-DAY WEEK

Warm-Up	5 minute walk accelerating to a slow jog.
Flexibility Exercises	7 minutes of stretching exercises to enhance range of motion of the principal joints associated with musculature. Flexibility exercises are to be selected from the exercises listed in Chart 3 and described in the Flexibility Exercises section. Exercises are to include stretching of the primary muscle groups that are going to be used during the conditioning phase.
Aerobic Activities	15-20 minutes of exercises from the following list of options: jogging/running, rope jumping, swimming, and bicycling. Trainees at the intermediate level of fitness (Level II) and at the advanced level (Level III) may add no more than an additional 10 minutes of aerobic activities to this component of the exercise session as specified in the Aerobic Activities Prescription Guidelines.
Transition Cool-down	3 minutes of rhythmic movement including stretching.
Calisthenics/Strength Exercises	20 minutes of strength exercises three times a week and 10 minutes, two times a week. Exercises are to be selected from the exercises listed in Chart 5 and described in the Calisthenics/Strength Exercises section.
Speed and Agility Exercises	5 minutes of sprinting and 5 minutes of agility running two times a week. (Trainees, however, may require additional time for the speed and agility components because of the rest periods specified in the Speed and Agility Prescription Guidelines.)
Cool-down	5 minutes

CHART 2

PHYSICAL CONDITIONING EXERCISE PROGRAM

OVERVIEW AND SEQUENCE OF EXERCISES FOR THREE-DAY WEEK

Warm-up .....5 minute walk accelerating to a slow jog.

Flexibility Exercises..... 7 minutes of stretching exercises to enhance range of motion of the principal joints associated with musculature. Flexibility exercises are to be selected from the exercises listed in Chart 3 and described in the Flexibility Exercise section. Exercises are to include stretching of the primary muscle groups that are going to be used during the conditioning phase.

Aerobic Activities.....15-20 minutes of exercise from the following list of options: jogging/running, rope jumping, swimming and bicycling. Trainees at the intermediate level of fitness (Level II) and at the advanced level (Level III) may add no more than an additional 10 minutes of aerobic activities to this component of the exercise session as specified in the Aerobic Activities Prescription Guidelines.

Transition Cool-Down.....3 minutes of rhythmic movement including stretching.

Calisthenics/Strength Exercises.....20 minutes of strength exercises every other day; 10 minutes when time is allotted for Speed/Agility exercises. See below. Exercises are to be selected from the exercises listed in Chart 5 and described in the Calisthenics Strength Exercises section.

Speed and Agility Exercises .....5 minutes of sprinting and 5 minutes of agility running every other day. See below. Trainees, however, may require additional time for the speed and agility components because of the rest periods specified in the Speed and Agility Prescription Guidelines.

Cool-Down.....5 minutes

CHART 3
STATIC AND DYNAMIC FLEXIBILITY EXERCISES

1. Neck Stretch (Dynamic)
2. Shoulder Stretches (Static)
3. Chest Stretch (Static)
4. Sitting Trunk Twist
5. Modified Indian Curl (Static)
6. Sitting Toe Touch (Static)
7. Straight Leg Abs
8. Lying Supine - Leg Over (Dynamic)
9. Prone Support Back Stretch (Static)
10. Standing Lateral Side Stretcher (Dynamic)
11. Supported Forward Stride Stretcher (Dynamic)
12. Standing Quad Stretches (Static)
13. Hamstring Stretch (Static)
14. Hamstring/Back of Knee Stretch (Static)
15. Hamstring and Calf Stretch (Static)
16. Standing Achilles and Calf Stretcher (Static)
17. Cross Body Arm Stretch
18. Standing Toe Touch
19. Lower Limb Neural Tension (Sitting)
20. Pelvic Tilt: Posterior - Legs Bent (Supine)
21. Knee-to-Chest with Neck Flexion Stretch (Supine)
22. Knee-to-Chest Stretch: Bilateral
23. Lumbar Rotation (Non-Weight Bearing)
24. Wall Slide
25. Hip Abduction (Side-Lying)
26. Hip Adduction (Side-Lying)
27. Terminal Knee Extension (Supine)
28. Hip Extension (Prone)
29. Knee Flexion (Standing)
30. Lower Limb Neural Tension (Long-Sitting)
31. Straight Leg Raise

CHART 3 , continued

32. Thoracolumbar Side-Bend: Double Arm (Standing)
33. Knee Flexion (Sitting)
34. Opposite Arm-Leg Lift (Prone)
35. Side Lunge
36. Quadras Stretch (3 Variations)
37 Thoracolumbar Side-Bend: Single Arm
38. Quadriceps Stretch
39. Lumbar Rotation Stretch
40. Gastrocnemius Stretch
41. Soleus Stretch

CHART 4

CALISTHENICS/STRENGTH EXERCISES

Back

1. Lateral Trunk Bends
2. Back Lifts
3. Sit-ups with Stabilizer Ball

Abdomen

1. Alternating Elbow to Knee Crunch
2. Bent Knee Sit-Ups (with partner)
3. Modified Curl-ups (with partner)

Chest

1. Recline Fly with Stabilizer Ball

Arms

1. Shoulder Rotations
2. Push-ups
   Incline/Decline Push-up
3. Horizontal Dips
4. Pull-ups
5. Jumping Jacks
6. Tricep Extension with Heavy Ball
7. Reverse Hammer Curl

Shoulders

1. Dumbbell Exercises (6 variations)
2. Recline Press with Stabilizer Ball

Legs

1. Platform Balancing Exercise - Side Dip
2. Heel Raises
3. Knee Bends
4. Modified Knee Bends
5. Mountain Climbing
6. Squat Thrusts
7. Windshield Wiper (Advanced Exercise)

CHART 5

DEFENSIVE TACTICS

Goal: Trainees use body parts as defensive weapons.

A. Parts of the body to be used:

1. open hand and fist
2. elbow
3. forearm
4. knee
5. foot
6. head

B. Defensive stance:

1. balance
2. leverage - extensive use of trunk and abdominal muscles
3. concentration of power
4. use of opponent's power

C. Defensive tactics employed:

1. breaking and countering choke and strangle holds
2. escaping
3. headblocks and headlocks
4. body and clothing grabs
5. blocking
6. counter actions and follow-ups
7. punching
8. straight kicks
9. come-along holds
    a. arm locks
    b. wrist locks
    c . fingerlocks
10. take-down tactics
    a. wrist throw
    b. stiff arm take-down
    c. foot sweeps
11. break falls

D. Defensive tactics from the ground

E. Weapon retention

DEPARTMENT OF LAW AND PUBLIC SAFETY
DIVISION OF CRIMINAL JUSTICE
POLICE TRAINING COMMISSION

MEDICAL CERTIFICATION FORM
(Please Print)

Candidate's Name:_____

Social Security Number:_____

Candidates's Employing Agency:_____

Agency Address:_____

_____

PTC-Approved School
Candidate Will Attend:_____

Name of Course:_____Course Dates:_____

Physician's Name:_____

Physician's Address:_____

Based upon the medical examination and review of the Health History Statement, the above-named individual is determined to be:

(Check one)

☐ Medically fit to participate in Defensive Tactics (unarmed defense), Chemical Agent exposure, Firearms Training, Baton Training, Physical Restraint Training, and in the Police Training Commission's Physical Conditioning Training Program without limitations.

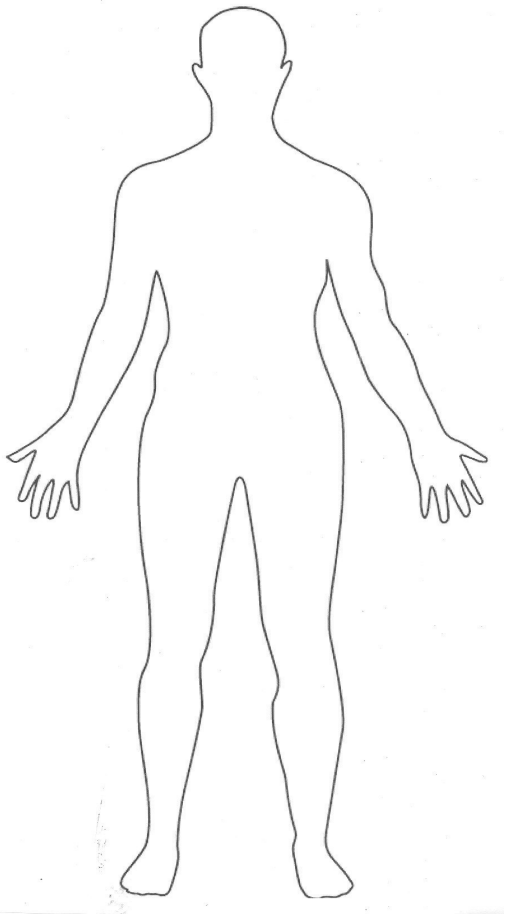
☐ Not medically fit to participate in Defensive Tactics (unarmed defense), Chemical Agent exposure, Firearms Training, Baton Training, Physical Restraint Training, and in the Police Training Commission's Physical Conditioning Training Program.

_____ _____
Physician's Signature and License No. Date

Name: _____ Social Security: _____

New Jersey Department of Corrections
Custody Recruitment Tattoo Identification

FRONT OF BODY



Draw line from figure showing location of tattoo & brandings

Number each tattoo or brand listed above and describe what it means._____
_____
_____
_____
_____
_____
_____
_____
_____

Medical will confirm all tattoos; failure to cooperate will result in removal from the hiring process.

Applicant Initials _____ Date_____

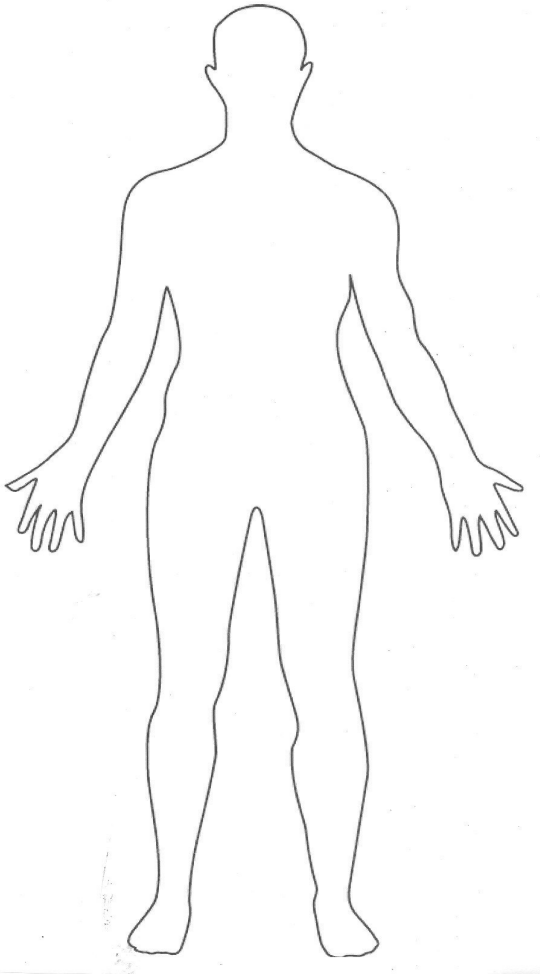
NJDOC USE ONLY

Physician's Signature_____ Date_____

Name: _____ Social Security: _____

New Jersey Department of Corrections
Custody Recruitment Tattoo Identification

BACK OF BODY



Draw line from figure showing location of tattoo & brandings

Number each tattoo or brand listed above and describe what it means._____

_____

_____

_____

_____

_____

_____

_____

Medical will confirm all tattoos; failure to cooperate will result in removal from the hiring process.

Applicant Initials _____ Date_____

NJDOC USE ONLY

Physician's Signature_____ Date_____

OOHS use only:
Last date of training _____
Worksite TWA _____ dB

New Jersey Department of Environmental Protection
Office of Occupational Health and Safety
Hearing Conservation Program Questionnaire

NAME:_____ SSN#:_____

WORK LOCATION:_____ TITLE:_____

1. Please indicate the percent of time that each device is used when protection is required:
   Plugs _____ Muffs _____ Combination _____

*****OOHS See Box Above**

2. When was your last exposure to noise? _____
3. Do you have a family member who had a hearing loss before the age of 50? Yes No
4. Do you use a hearing aid? No Left Right Both
5. Do you have ringing in your ears? No Left Right Both Both (severe)
6. Do you have frequent or severe dizziness? Yes No
7. Have you had a cold or flu in the last 2 weeks? Yes No
8. Do you have frequent allergy problems? Yes No
9. Have you ever had any of the following? (Check off those that apply)
   Measles___ Scarlet Fever___ Diabetes___ Mumps___ Meningitis___ High Blood Pressure___
10. Comments/Other Symptoms_____
11. Have you taken any antibiotics or medications in the last month? Yes N
12. Do you have current ear pain? None Left ear Right ear Both
13. Are you under a physician's care for ear problems(s)? Yes No
14. Have you had past ear infections, earaches, or drainage? None Left ear Right ear Both
15. Have you had previous ear surgery? Yes No
16. Have you been exposed to any loud explosions? Yes No
17. Have you had any previous head injury that caused unconsciousness? Yes No
18. Do you or have you shot firearms? Yes No If yes, is it sport___ or military_____ or work ____
19. Do you listen to loud music? Yes No Do you play in a band? Yes No
20. Do you have noisy hobbies (i.e. motorcycles, power tools)? Yes No
    If yes please list_____
21. Have you operated power driven equipment? Yes No
    If yes please list_____
22. Have you operated construction equipment? Yes No
    If yes please list_____
23. Did you work at a noisy job prior to current job? Yes No
    If yes please explain_____
24. Do you have a second job that is noisy? Yes No If yes, list job _____
25. Do you have a current earache, ear drainage problem? None Left ear Right ear Both ears

Employee Signature:_____ Date:_____

State of New Jersey

Department of Environmental Protection

PHILIP D. MURPHY
Governor
SHEILA Y. OLIVER
Lt Governor

CATHERINE R. McCABE
Commissioner

New Jersey Department of Environmental Protection
Office of Occupational Health & Safety
428 E. State Street
P.O. Box 416
Trenton, NJ 08625-0416
Phone # (609) 292-1408
Fax # (609) 984-2488

To: Environmental Response Training Program
1930 Radcliff Drive
Cincinnati, OH 45204

Care of: Office of Occupational Health & Safety
New Jersey Department of Environmental Protection

From: Medical Contract Provider for NJDEP

Subject: Medical Clearance for Training with Respiratory Protective Equipment

This letter is to attest _____ has been medically
(print name)
evaluated and cleared to wear respiratory protective equipment in accordance with 29

CFR 1910.134.

_____ _____
Contractor's Signature Date

NJDEP Office of Occupational Health and Safety
Quantitative Fit Test Form

Employee Last Name: _____ Test Date: _____

Employee First Name: _____ Operator: SGK JFB MM DG SH

Employee ID Number: _____ Test Device = Porta-Count-Plus: YES

Job Title: _____ HEPA Filter Used on Respirator: YES

Phone #: Smoking 30 Min. Prior to Exam: Y N

Division: Porta-Count Zeroed Before Use: YES

Respirator Program: Computer Used for Exercise: YES

Respirator Program Manager: Test Agent: Ambient Particles _____

Next Fit-Test Date: _____ (A Quantitative Fit-Test is required once per year)

Glasses Needed for Navigation: Y N _____

Manufacturer	RESPIRATOR Model	Facepiece
MSA	SCBA - ULTRA View	FULL-FACE
MSA	APR - ULTRA Twin	FULL-FACE
MSA	APR - CBRN Millennium	FULL-FACE
MSA	APR - Comfo II	HALF-FACE
MSA	APR - Comfo Classic	HALF-FACE
MSA	APR - Comfo Elite	HALF-FACE
SCOTT	APR - AV-2000	FULL-FACE
SCOTT	APR - AV-3000	FULL-FACE
3M	APR - 7500 Series	HALF-FACE
3M	APR - 7500 Series	FULL-FACE
Wilson	APR - 6100 Series	HALF-FACE

FACEPIECE MATERIAL :

RUBBER SILICONE

SIZE:

Small Medium

Large Extra Large

Pass / Fail Criteria:

Half-Face = 100 Full-Face = 500

Employee Needs To Be Issued A Respirator:

YES NO

Employee's Old Respirator Taken By OOHS:

YES NO

Test Performed Using:

OOHS Respirator Employee's Respirator

Fit Factor Score

Normal	DeepBreath	Side-Side	Up-Down	Talking	Grimace	Bending	Normal
					X		

Overall Fit Factor: _____ PASS / FAIL

Operator Signature X _____ Date: _____

Employee Signature X _____ Date: _____

NJDEP Office of Occupational Health and Safety
Quantitative Fit Test Form

1) How often do you wear your respirator? _____

2) When was the last time you wore your respirator? _____

3a) Do you think you need a respirator to perform your job? _____

3b) If Yes, why? _____

4) At what facilities have you worn your respirator? _____

_____

5) Does employee know how to wear / use the respirator? _____

Comments: _____

8/18/98

NJDEP- Office of Occupational Health Safety
Confidential Respirator Questionnaire

Stays with current MSP Evaluation

Name: _____ Job Title: _____

Bureau: _____ Work Phone: _____ Today's Date: _____

Sex (circle one): Male/Female Age: _____ Height: _____ ft. _____ ins. Weight: _____

Circle the type of respirator you have been issued or may use (you can circle more than one type):

a. Disposable dust mask respirators (type N,R, or P)
b. half or Full-facepiece
c. powered air-purifying
d. supplied air
e. self-contained breathing apparatus

Have you worn a respirator under your current job title: Yes/No
If "yes" what type and under what condition: _____

This questionnaire is required by the revised 1910.134 OSHA Respiratory Standard and will be reviewed by a medical professional at Professional Healthcare Services during your medical surveillance exam. Any questions pertaining to this questionnaire can be addressed at that time.

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 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 problems that you've been told about: Yes/No

3.) Do you currently have any of the following musculoskeletal conditions?

a. Weakness in any of your arms, hands, or feet: Yes/No
b. Back pain: Yes/No
c. Difficulty fully moving your arms and legs: Yes/No
d. Difficulty squatting to the ground: Yes/No
e. Pain or stiffness when you lean forward or backward at the waist: Yes/No
f. Difficulty fully moving your head up or down: Yes/No
g. Difficulty fully moving your head side to side: Yes/No
h. Difficulty bending at your knees: Yes/No
i. Climbing an elevation carrying more than 25 lbs.: Yes/No
j. Any other muscle or skeletal problem that interferes with using a respirator: Yes/No

4.) Have you ever had a back injury: Yes/No

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

a. Seizures (fits): Yes/No
b. Allergic reactions that interfere with breathing: Yes/No
c. Claustrophobia (fear of closed-in places): Yes/No
d. Trouble smelling odors: Yes/No
e. Diabetes (sugar disease): Yes/No

6.*) Do you currently take medication for any of the following?

a. Breathing or lung problems: Yes/No
b. Heart trouble: Yes/No
c. Blood Pressure: Yes/ No
d. Seizures (fit): Yes/No

7.*) If you've used a respirator, have you ever had any of the following problems while using?

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 problems that interfere with your use of the respirator: Yes/No

TURN OVER

8.*) Do you currently have any of the following symptoms relating to pulmonary or lung discomfort?
a. Shortness of breath: Yes/No
b. Shortness of breath while 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

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

10.) Do you currently have any of the following corrective 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

11.) Have you ever had an injury to your ears, including a broken eardrum: Yes/No

12.) Do you currently have any of the following hearing problems?
a. Difficulty hearing: Yes/No
b. Wearing a hearing aid: Yes/No
c. Any other hearing or ear problem: Yes/No

13.*) Have you ever had any of the following cardiovascular or heart symptoms?
a. Pain or tightness in chest during physical activity: Yes/No
b. Frequent pain or tightness in your chest: Yes/No
c. Heartburn or indigestion not related to eating: Yes/No
d. In the past two years, have you noticed your heart skipping or missing a beat: Yes/No
e. Pain or tightness in your chest that interferes with your job: Yes/No
f. Any other symptoms that you think may be related to heart or circulation problems: Yes/No

14.*) Have you every had any of the following cardiovascular or heart conditions?
a. High blood pressure: Yes/No
b. Heart arrhythmia (heart beating irregularly): Yes/No
c. Stroke: Yes/No
d. Heart attack: Yes/No
e. Angina: Yes/No
f. Heart failure: Yes/No
g. Swelling in your legs or feet (not caused by walking): Yes/No
h. Any other heart prob. that you've been told about: Yes/No

Comments: _____

A1.) 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

A2.) 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: Yes/No_____

A3.) 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 environment: Yes/No
j. Any other hazardous exposure: Yes/No
If 'yes," describe these exposures: _____

A4.) 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

A5.) Have you ever worked on a HAZMAT team? Yes/No

A6.) Other than medication 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: _____

A7.) Will you be using any of the following items with your respirator(s)?
a. Escape only (no rescue): Yes/No
b. Canisters (for example, gas masks): Yes/No
c. Cartridges: Yes/No

A8.) How often are you expected to use the respirator(s) (circle "yes" or "no" for all 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

A10.) During the period you are using the respirator(s), is your work effort:
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 while operating a drill press (1-3 lbs.) or controlling a machines.

b. Moderate (200-300 kcal per hour): Yes/No ___If "yes," how long does this period lst 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 (about 350 kcal per hour): Yes/No
___If "yes," how long does this period last during the average shift: _____hrs. _____ mins.
___Example 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 casting; walking up an 8-degree grade about 2 mph;
climbing stairs with a heavy load (about 50 lbs.).

A11.) 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: _____
_____

A12.) Will you be working under hot conditions (temperature exceeding 77 deg. F): Yes/No

A13.) Will you be working under humid conditions: Yes/No

A14.) Describe the work you'll be doing while you're using your respirator(s): _____
_____
_____
_____
_____
_____
_____

A15.) Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases):
_____
_____
_____

A16.) 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: _____
_____
_____

A17.) 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; 20098; April 23, 1998]

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:

Can you read (circle 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:_____

4. Sex (circle one): Male / Female

5. Your height: _____ ft. _____ in.

6. Your weight: _____ lbs.

7. Your current 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 (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-face piece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

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

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

a. Wear contact lenses: ..... Yes / No
b. Wear glasses: ..... Yes / No
c. Color blind: ..... Yes / No
d. Any other eye or vision problem: ..... Yes / No

12. Have you *ever had* an injury to your ears, including a broken ear drum: ..... Yes / No

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

a. Difficulty hearing: ..... Yes / No
b. Wear a hearing aid: ..... Yes / No
c. Any other hearing or ear problem: ..... Yes / No

14. Have you *ever had* a back injury: ..... Yes / No

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

a. Weakness in any of your arms, hands, legs, or feet: ..... Yes / No
b. Back pain: ..... Yes / No
c. Difficulty fully moving your arms and legs: ..... Yes / No
d. Pain or stiffness when you lean forward or backward at the waist: ..... Yes / No
e. Difficulty fully moving your head up or down: ..... Yes / No
f. Difficulty fully moving your head side to side: ..... Yes / No
g. Difficulty bending at your knees: ..... Yes / No
h. Difficulty squatting to the ground: ..... Yes / No
i. Climbing a flight of stairs or a ladder carrying more than 25 lbs: ..... Yes / No
j. Any other muscle or skeletal problem that interferes with using a respirator: ..... Yes / No

Part B: Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen: ..... Yes / No

If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions: ..... Yes / No

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals: ..... Yes / No

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

_____

_____

3. Have you ever worked with any of the materials, or under any of the conditions, listed below:

a. Asbestos: ..... Yes / No
b. Silica (*e.g.*, in sandblasting): ..... Yes / No
c. Tungsten/cobalt (e.g., grinding or welding this material): ..... Yes / No
d. Beryllium: ..... Yes / No
e. Aluminum: ..... Yes / No
f. Coal (for example, mining): ..... Yes / No
g. Iron: ..... Yes / No
h. Tin: ..... Yes / No
i. Dusty environments: ..... Yes / No
j. Any other hazardous exposures: ..... Yes / No
If "yes," describe these exposures: _____

_____

_____

4. List any second jobs or side businesses you have: _____

_____

5. List your previous occupations: _____

_____

6. List your current and previous hobbies: _____

_____

7. Have you been in the military services? ..... Yes / No
If "yes," were you exposed to biological or chemical agents (either in training or combat): .....Yes / No

8. Have you ever worked on a HAZMAT team? ..... Yes / No

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications): ..... Yes / No
If "yes," name the medications if you know them:_____

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

a. HEPA Filters: .....Yes / No
b. Canisters (for example, gas masks): ..... Yes / No
c. Cartridges: ..... Yes / No

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

a. Escape only (no rescue): .....Yes / No
b. Emergency rescue only: .....Yes / No
c. Less than 5 hours *per week*: ..... Yes / No
d. Less than 2 hours *per day*: .....Yes / No
e. 2 to 4 hours per day: .....Yes / No
f. Over 4 hours per day: .....Yes / No

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

a. *Light* (less than 200 kcal per hour): ..... Yes / No
If "yes," how long does this period last during the average shift:_____hrs._____mins.
Examples of a light work effort are *sitting* while writing, typing, drafting, or performing light assembly work; or *standing* while operating a drill press (1-3 lbs.) or controlling machines.

b. *Moderate* (200 to 350 kcal per hour): .....Yes / No
If "yes," how long does this period last during the average shift:_____hrs._____mins.
Examples of moderate work effort are *sitting* while nailing or filing; *driving* a truck or bus in urban traffic; *standing* while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; *walking* on a level surface about 2 mph or down a 5-degree grade about 3 mph; or *pushing* a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.

c. *Heavy* (above 350 kcal per hour): .....Yes/No
If "yes," how long does this period last during the average shift:_____hrs._____mins.
Examples of heavy work are *lifting* a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; *shoveling; standing* while bricklaying or chipping castings; *walking* up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).

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

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

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

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

16. Describe the work you'll be doing while you're using your respirator(s):

_____

_____

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases):

_____

_____

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):

Name of the first toxic substance:_____
Estimated maximum exposure level per shift:_____
Duration of exposure per shift:_____
Name of the second toxic substance:_____
Estimated maximum exposure level per shift:_____
Duration of exposure per shift:_____
Name of the third toxic substance:_____
Estimated maximum exposure level per shift:_____
Duration of exposure per shift:_____
The name of any other toxic substances that you'll be exposed to while using your respirator:

_____

_____

_____

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security): _____

_____

_____

_____

[63 FR 1152, Jan. 8, 1998; 63 FR 20098, April 23, 1998; 76 FR 33607, June 8, 2011]

State of New Jersey
DEPARTMENT OF CORRECTIONS
CUSTODY RECRUITMENT UNIT
PO BOX 863
TRENTON NJ 08625-0863

PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

MARCUS O. HICKS, ESQ.
Acting Commissioner

Institution: _____

Trainee Name: _____
(Print last name, first name, middle initial)

Social Security No.: _____

Physician's Address:

Based on my review of Appendix C to 1910.134: OSHA Respirator Medical Evaluation Questionnaire and any necessary follow-up medical evaluation, the above-named individual is medically cleared to wear or use self-contained breathing apparatus and/or an air-purifying respirator.

☐ Without Limitations

☐ With Limitations (Specify):

_____
_____
_____

☐ _____ _____
Signature and License No. Date

☐ _____ _____
Other Licensed Health Care Professional's Signature and License No. Date

I have received a copy of this evaluation.

_____ _____
Trainee Signature Date

DEP's Initial Medical Hearing Test Referral Form

Name:_____ Work Phone Number:_____

Document view

Reviewed previous audiogram & relevant material sent over from Yes:___ No: ___

Confirmed medical referral as a result of Contractor audiogram Left:___ Right: __

If a confirmed medical referral, was a letter sent by Yes:___ No: ___

Is the confirmed medical referral, caused by an occupational, non-occupational or both. Occupat: _____ Non-Occ: _____ Both: _____

If a confirmed medical referral, is an audiologist or ENT referral needed? Yes:___ No: ___

If a confirmed medical referral, is a retest\evaluation at Contractor needed? Yes:___ No: ___

NOTE- If CWH will evaluate, keep this form and complete the bottom portion once the hearing test is done.

Comments: _____

_____

Doctors Signature: _____ Date: _____

Hearing Test

Visible evidence of cerumen accumulation or a foreign Yes:___ No: ___

Hearing test preformed by: _____

Hearing test results attached: Yes:___ No: ___

Reviewed previous audiogram sent over from DEP? Yes:___ No: ___

Employee was seen by which Doctor: _____

Is there a medical problem caused or aggravated by the Yes:___ No: ___

Confirmed medical referral as a result of Contractor audiogram and evaluation? Yes: ____ No: ____ **If yes, which ear(s)?** Left:___ Right: __

If a confirmed medical referral, was a letter sent by Contractor informing employee of this hearing status and a copy sent to DEP? Yes:___ No: ___

If a confirmed medical referral, indicate if occupational, non-occupational or both. Occupat: _____ Non-Occ: _____ Both: _____

If a confirmed medical referral, is an audiologist or ENT referral needed? Yes:___ No: ___

Comments: _____

_____

Doctors Signature: _____ Date: _____

DEP's OOHS USE ONLY

Confirmed medical referral employee refitted and Yes:___ No: ___

Name of OOHS staff who retrained and refitted the medical referral employee:
_____ Date:_____

V:plihsu\hearing conservation\initial medical referral form

NJDOT MEDICAL SURVEILLANCE/TESTING CLEARANCE REPORT

Bureau of Employee Safety
1035 Parkway Avenue
Trenton, NJ 08625
(609) 963-2175 • Fax (609) 530-5719

NAME: Employee ID#: DATE:
Crew #/Unit: Supervisor/Contact:

REQUESTED MEDICAL TASK			
Asbestos Surveillance Examination (3.2.15) [27]		Anthrax Vaccination/Booster (3.3.10) [39]	
Hazardous Waste Operation & Emergency Response Surveillance Examination (3.2.11) [12]	x	Hepatitis B Vaccination (3.3.2) [28]	
Lead Surveillance Examination (3.2.13) [30]		Rabies Prophalaxis (3.3.3) [17]	
Heavy Metals Surveillance Examination (3.2.13) [30]*		Tuberculosis Vaccination/Booster (3.3.6) [32]	
Occupational Noise Surveillance Examination (3.2.3) [37]			
Silica Surveillance Examination (3.2.14) [20]			
x			
Additional Testing (3.3.14) [43]*		Basic Medical Examination, Initial Physical (3.2.1) [1]	
Blood Lead Monitoring (3.2.13.1) [25]		Basic Medical Examination, Surveillance (3.2.1.1) [2]	
Heavy Metals Monitoring (3.2.13.1) [25]*		Basic Medical Examination, Variations (3.2.1.2) [3]*	
Chest X-Ray with B-Reading (3.2.1), (3.2.10), (3.3.14) [7]		Consultation Services (3.4) [44]*	
EKG (3.3.14) [44]		Fitness for Duty Physical Examination (3.2.5) [41]	
Hepatitis B Titer (3.3.2) [22]		Hazardous Substance Post Exposure Evaluation Examination (3.2.12) [4]*	
Occupational Noise Surveillance Hearing Test (3.2.3.1) [10]		Occupational Noise Surveillance Audiogram Review (3.2.3.2) [24]	x
Pulmonary Function Test (3.3.14) [18]		Respiratory Clearance Examinations (3.2.10) [5]	
Tuberculosis Testing (Skin Test) (3.3.6) [45]		Respiratory Fit Test (3.2.10.1) [31]	
Tuberculosis Testing (Blood Test) (3.3.14) [137]		Testimony and Litigation Support (3.6) [42]	
		Visual Acuity Test (3.2.9) [34]	

NOTE: (Contract Spec Section) [Line Item #]

EXPOSURE DATA/WORK ACTIVITY: Unknown Chemicals (HAZWOPER)

*ADDITIONAL INFORMATION:
Environmental field personnel

MEDICAL DETERMINATION:

We have personally, examined/provided _____ with the above service and, have reviewed the results of the required ancillary studies and I have determined that this person

_____ Can wear a respirator and is medically qualified to do the essential functions for the job described
_____ CAN NOT wear a respirator (See COMMENTS)
_____ Is NOT medically qualified to do the essential functions or the job described (See COMMENTS)

COMMENTS: _____

_____

_____

EMPLOYEE NOTIFICATION:

_____ The employee has been informed of the examination results and any medical conditions requiring further examinations and/or treatment by their personal physician. The employee acknowledges that he/she has 30 days to obtain medical clearance from Robert Wood Johnson Medical Center.
An employee failing to obtain medical clearance will result in a review by Employee Relations to determine whether the employee should be removed for Inability to Perform Duties.

_____ _____ _____ _____
EXAMINER SIGNATURE DATE EMPLOYEE SIGNATURE DATE

NJDOT MEDICAL SURVEILLANCE/TESTING CLEARANCE REPORT

Bureau of Employee Safety
1035 Parkway Avenue
Trenton, NJ 08625
(609) 530-5472 • Fax (609) 530-5719

_____	_____	_____	_____
EXAMINER SIGNATURE	DATE	EMPLOYEE SIGNATURE	DATE