

VOSH PROGRAM DIRECTIVE: 08-005A

ISSUED: 01 September 2012

SUBJECT: CSHO/Inspector Medical Examination Program

Purpose: This Directive transmits to field personnel the Department's CSHO/Inspector Medical Examination Program for DOLI personnel who conduct occupational safety and health workplace inspections or public safety boiler and pressure vessel inspections.

It also specifies that the Department will provide a single, statewide provider of the medical services necessary to implement the requirements of this Program. It updates the existing VOSH Compliance Safety and Health Officer (CSHO) Medical Examination requirements for VOSH 23(g) and 21(d) grant personnel, adds boiler safety inspectors from the DOLI Division of Boiler and Pressure Vessel Safety and memorializes the medical examination program as a VOSH Program Directive. This Directive revises the scope of employees covered by the VOSH medical examination requirements and revises program elements to better match the occupational needs of covered employees.

**Change I** at Section I.B.2 is not substantive. It provides further clarification of the distinction between the "optional" annual examinations for directors and managers and the "voluntary" third year examinations for all other employees with possible prior exposures to potentially toxic chemicals and/or biologic or physical hazards.

*This Program Directive is an internal guideline, not a statutory or regulatory rule, and is intended to provide instructions to VOSH personnel regarding internal operation of the Virginia Occupational Safety and Health Program and is solely for the benefit of the program. This document is not subject to the Virginia Register Act or the Administrative Process Act; it does not have general application and is not being enforced as having the force of law.*

Scope: This Directive applies to VOSH personnel who conduct or may conduct occupational safety and health inspections and to DOLI Boiler Program personnel who conduct public safety boiler inspections. **Participation in annual physical examination by the VOSH Medical Services Contract Provider (MSCP) is mandatory for covered VOSH staff and Boiler Inspectors.** It may also include other individuals in optional positions as detailed in Section I. A. of this Directive. This Directive shall apply to two types of individuals:

1. **Existing.** DOLI personnel who conduct either VOSH occupational safety and health inspections or DOLI Boiler safety compliance inspections. Participation in the physical examination and interim medical evaluations requirements of the program are mandatory for all Boiler Inspectors, VOSH Compliance Officers, and optional for certain other VOSH and Boiler Division staff detailed in Section I. A. 1. of this Directive.
2. **Pre-placement.** Individuals who are either: 1.) Probable new hires by the Department for a covered position; or 2.) Existing DOLI personnel seeking to transfer from a position not covered by this Directive into a covered position.

Reference: OSHA Instruction PER 04-00-005 (22 August 2009)

Cancellation: VOSH Program Directive 08-005 (01 September 2011)

Effective Date: 01 September 2012

**Expiration Date:** Not Applicable

**Action:** Directors and Managers shall ensure that affected field personnel, other affected DOLI personnel and probable new hires understand and comply with the revised medical examination requirements included in this Directive.

**Background:** Administration of the prior CSHO medical exam requirement was subject to variations in compliance from one region to another. This Directive cancels the previous VOSH requirement for annual medical evaluations for VOSH inspection personnel and issues a CSHO/Inspector Medical Examination Program to revise the description of VOSH employees covered by the Medical Examination Program.

**Summary:** This Directive replaces the existing annual medical examination requirements with a new scope of applicability and other requirements for the new CSHO/Inspector Medical Examination Program to better match the occupational needs of covered employees. It also adds DOLI Boiler Safety Program inspectors to the VOSH CSHO medical examination requirements program. Positions covered by the CSHO/Inspector Medical Examination Program are not necessarily the same as those covered under the previous annual medical examination requirements. The expanded scope now includes CSHOs, other VOSH personnel who perform field work that places them at risk for occupational exposures or other hazardous work conditions, and DOLI Boiler and Pressure Vessel Safety Program inspectors.

Therefore, the medical program title and scope now reflect the inclusion of personnel other than VOSH CSHOs. The revised schedule is based on recognition that certain medical testing or evaluations, when performed annually, are not significantly beneficial for some employees, particularly those younger than 50 years of age. Therefore, certain medical testing and other examination frequency beyond the standard medical examination will be aligned with age, individual medical conditions and occupational exposures, when applicable. The medical evaluation requirements mandated by VOSH standards will continue to be applied (*see Appendix "B"*). This directive allows the exercise of flexibility and practical judgment in determining the appropriate medical evaluation periodicity frequency for each covered employee.

The VOSH Medical Examination Program is based on a review of current medical literature, professional guidance, medical examination protocols in other agencies and non-occupational medical public health recommendations. Physical evaluation, or parts of the evaluation, may be amended by VOSH to include changes and updates issued by federal OSHA's Office of Occupational Medicine (OOM) required for federal OSHA employees in accordance with prudent medical practice.

**Annual physical examinations to be performed by the DOLI Medical Services Contract Provider (MSCP) remain mandatory for all covered employees.**

- Significant Changes:**
- The existing and long standing CSHO requirement for medical examinations is now updated and memorialized in a program directive for all personnel assigned to field duties in which there is reasonable anticipation of encountering physical, chemical and/or biological hazards including employees whose duties require on-site inspections, on-site evaluations and/or on-scene emergency response functions.
  - Chest X-rays are now voluntary after the initial pre-placement examination unless the employee has experienced an occupational exposure that triggered the medical surveillance requirements of a VOSH standard. If an exposure does trigger the requirements of a standard, the schedule for chest X-rays established by that standard will be followed.
  - Members of any special task forces or regional or specialized response teams must meet the medical qualifications of this program as long as they participate on these teams.

- Regional Directors, Compliance Managers, Boiler Safety Program Director or their designees are now required to notify the DOLI Director of the Division of Human Resources (DHR) when they become aware of an employee exposure that reaches an action level required in VOSH standards or another occupational exposure of concern. In addition, they are to notify DHR of employee hospitalizations, significant surgeries, or periods of medical restrictions exceeding one month, since these situations may signal a need for more frequent or additional medical evaluations.
- Regional Directors, Compliance Managers, Boiler Safety Program Director or their designees are also required to consult with DOLI Director of DHR and put a temporary duty restriction in place within 10 working days of notification that an employee does not meet the medical and/or physical requirements of the positions.
- Boiler and Pressure Vessel Safety Inspectors are included in the covered positions under the Program.

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Commissioner

Attachment: None.

Distribution: Commissioner of Labor and Industry  
Assistant Commissioner - Programs  
VOSH Directors and Managers  
VOSH Legal Support & IT Staff

Cooperative Programs Director & Manager  
VOSH Compliance & Cooperative Programs Staff  
OSHA Region III & OSHA Norfolk Area Offices

## TABLE OF CONTENTS

|      |                                                                   |   |
|------|-------------------------------------------------------------------|---|
| I.   | Application.....                                                  | 1 |
| A.   | Covered Positions.....                                            | 1 |
| 1.   | General Application.....                                          | 1 |
| 2.   | Response Team Members.....                                        | 1 |
| 3.   | Apprentices or Trainees.....                                      | 1 |
| B.   | Medical Evaluation.....                                           | 1 |
| 1.   | Mandatory Examinations .....                                      | 1 |
| 2    | Voluntary Examinations .....                                      | 1 |
| C.   | Purpose of Medical Evaluation.....                                | 2 |
| 1.   | Fitness for Duty.....                                             | 2 |
| 2.   | Complying with VOSH Standards.....                                | 2 |
| II.  | Background .....                                                  | 2 |
| A.   | Determination of Medical Evaluation Requirements.....             | 2 |
| B.   | Protecting Employee Health and Safety .....                       | 2 |
| III. | Medical Appointments.....                                         | 2 |
| IV.  | Definitions and Frequency of Examinations.....                    | 3 |
| A.   | Initial Examination for Anticipated Hires and Transfers.....      | 3 |
| B.   | Mandatory Annual Physical Examination.....                        | 3 |
| C.   | Options .....                                                     | 3 |
| 1.   | Hepatitis “B” Vaccinations .....                                  | 3 |
| 2.   | Post-exposure prophylaxis (PEP) for Bloodborne Pathogens .....    | 3 |
| D.   | Voluntary Physical Examination.....                               | 3 |
| 1.   | Components Included .....                                         | 3 |
| 2.   | Frequency .....                                                   | 3 |
| 3.   | Scheduling .....                                                  | 3 |
| E.   | Self-Contained Breathing Apparatus (SCBA) Medical Clearance ..... | 3 |
| 1.   | Components Included .....                                         | 4 |
| 2.   | Frequency .....                                                   | 4 |
| V.   | Additional Medical Information .....                              | 4 |
| A.   | Additional MSCP Services .....                                    | 4 |
| B.   | Medical Specialist Opinions .....                                 | 4 |
| 1.   | Selection of Consulting Physician.....                            | 4 |
| 2.   | Payment for Consulting Physician and/or Additional Tests .....    | 4 |
| 3.   | Medical Specialist Opinion.....                                   | 4 |
| C.   | Timeliness .....                                                  | 5 |
| VI.  | Incomplete Medical Examinations .....                             | 5 |
| VII. | Accommodations.....                                               | 5 |
| A.   | Overview .....                                                    | 5 |
| B.   | Interim Work Restrictions.....                                    | 5 |
| C.   | Director of DHR and Supervisor Consultation .....                 | 5 |

|       |                                                                                   |      |
|-------|-----------------------------------------------------------------------------------|------|
| D.    | Request for Accommodation.....                                                    | 5    |
| E.    | Medical Review .....                                                              | 6    |
| F.    | Coordination of Accommodation Plan.....                                           | 6    |
| G.    | Limited Duty .....                                                                | 6    |
| VIII. | Workers' Compensation and Other Employee Benefits .....                           | 6    |
| IX.   | Medical Recordkeeping.....                                                        | 6    |
| A.    | Custody of Summary Results .....                                                  | 6    |
| B.    | Medical Records from MSCP.....                                                    | 6    |
| C.    | Results of Annual Physical Examination.....                                       | 6    |
| D.    | Request for Medical Records for Current Employees by the Employee .....           | 6    |
| X.    | Appendices                                                                        |      |
|       | Appendix A. – VOSH Medical Examination Program .....                              | A-1  |
| I.    | Purpose .....                                                                     | A-1  |
| II.   | Rationale for the Necessity of Physical Requirements .....                        | A-1  |
| III.  | Medical Examinations .....                                                        | A-1  |
| IV.   | Medical Examination Parameters .....                                              | A-2  |
| A.    | Vision .....                                                                      | A-2  |
| B.    | Hearing.....                                                                      | A-2  |
| C.    | Musculoskeletal.....                                                              | A-2  |
| D.    | Cardiopulmonary.....                                                              | A-3  |
| E.    | General Medical .....                                                             | A-3  |
|       | Appendix B. – Medical Evaluation Requirements of OSHA Standards .....             | B-1  |
|       | Appendix C. – Protecting Employee Health and Safety .....                         | C-1  |
| I.    | Annual Evaluations .....                                                          | C-1  |
| II.   | Regulatory Requirements .....                                                     | C-1  |
|       | Appendix D1. – Components of Medical Examinations.....                            | D1-1 |
| I.    | General .....                                                                     | D1-1 |
| II.   | Medical History.....                                                              | D1-1 |
| III.  | Specific Examination Tests and Requirements .....                                 | D1-1 |
| IV.   | Tests and Requirements for Examinations/Evaluations .....                         | D1-2 |
|       | Table 1 – Elements of Physical Examinations and Medical Evaluations.....          | D1-3 |
|       | Table 2 – Elements of Physical Examinations and Medical Evaluations.....          | D1-4 |
|       | Table 3 – Elements of Physical Examinations and Medical Evaluations.....          | D1-5 |
|       | Appendix D2. – Audiometric Testing Program.....                                   | D2-1 |
| I.    | General .....                                                                     | D2-1 |
| II.   | Scheduling .....                                                                  | D2-1 |
| A.    | Baseline Audiogram .....                                                          | D2-1 |
| B.    | Annual Audiogram .....                                                            | D2-1 |
| C.    | Notification of Audiogram Results.....                                            | D2-1 |
| D.    | Retest Audiogram .....                                                            | D2-1 |
| E.    | Revised Baseline Audiogram.....                                                   | D2-2 |
| F.    | Standard Threshold Shift .....                                                    | D2-2 |
|       | Appendix E. – Pre-Placement Examination for Anticipated Hires and Transfers ..... | E-1  |
| I.    | Pre-placement Examination.....                                                    | E-1  |
| II.   | Failure to Meet Requirements.....                                                 | E-1  |

|                                                                              |                                           |     |
|------------------------------------------------------------------------------|-------------------------------------------|-----|
| III.                                                                         | Scheduling .....                          | E-1 |
| IV.                                                                          | Elements of the Initial Examination.....  | E-1 |
| V.                                                                           | Location of the Initial Examination ..... | E-1 |
| VI.                                                                          | Cost of Examination .....                 | E-1 |
| VII.                                                                         | Records Management.....                   | E-2 |
| Appendix F. – Comprehensive Reference List .....                             |                                           | F-1 |
| Appendix G. – Pre-placement and Annual Physical Examination Forms .....      |                                           | G-1 |
| Appendix H. – VOSH Respirator Medical Evaluation Questionnaire .....         |                                           | H-1 |
| Appendix I. – Audiogram History/Report and Sample Notification Letters ..... |                                           | I-1 |

## I. Application.

### A. **Covered Positions.**

1. General Application. This Directive applies to VOSH and the Boiler and Pressure Vessel Safety Division positions for which there is reasonable anticipation of encountering physical, chemical and/or biological hazards. This includes employees whose duties require on-site inspections, on-site evaluations and/or on-scene emergency response functions.

- a. Covered Positions . The CSHO/Inspector Medical Examination Program includes, but is not limited to, DOLI employees in the following positions for whom annual examinations are required:

|                                      |                                            |
|--------------------------------------|--------------------------------------------|
| Safety Compliance Officer Apprentice | Industrial Hygienist Compliance Apprentice |
| Safety Consultant Apprentice         | Health Consultant Apprentice               |
| Safety Consultant                    | Industrial Hygienist Compliance            |
| Safety Compliance Officer            | Health Consultant                          |
| Safety Compliance Lead               | Industrial Hygienist Lead                  |
| Safety Compliance Senior             | Industrial Hygienist Compliance Senior     |
| Safety Consultant Senior             | Health Consultant Senior                   |
| Safety Senior Compliance Engineer    | Health Senior Compliance Engineer          |
| Safety Senior Consultant Engineer    | Health Senior Consultant Engineer          |
| Boiler Inspector                     | Senior Boiler Inspector                    |
| VPP Coordinator                      |                                            |

All DOLI Employee Work Profiles (EWPs) developed or maintained by DHR for the above covered positions shall include a requirement for an annual physical examination by the MSCP under contract with the Department.

- b. Optional Positions . The Medical Examination Program annual physical examinations are optional for the following positions

|                                  |                                |
|----------------------------------|--------------------------------|
| DOLI Regional Director           | Consultation Program Manager   |
| VOSH Program Directors           | VOSH Compliance Manager        |
| Director of Cooperative Programs | Boiler Safety Program Director |

2. Response Team Members. Members of regional response teams and specialized response teams must meet the minimum medical/physical requirements of this program prior to Response Team assignment and for the duration of that assignment. They are required to complete the physical examinations and interim medical evaluations specified under this Directive.
  3. Apprentices or Trainees. VOSH Apprentices or any other form of VOSH trainee or intern are covered under this Directive if their tenure with the Department is expected to exceed a one-year period from their pre-placement examination and there is reasonable anticipation of encountering physical, chemical and/or biological hazards.

### B. **Medical Evaluation.**

1. Mandatory Examinations. All covered employees are required to complete the annual physical examinations and interim medical evaluations as specified under this Directive.
2. Voluntary Examinations. For employees **not covered under Section I.A.1.b. "optional positions" for receiving annual examinations and** whose past work assignments required them to make regular or occasional visits to establishments or other worksites where they may have been exposed to potentially toxic chemicals and/or biologic or physical hazards and whose job descriptions do not now require them to go into the field are eligible for a voluntary physical examination every three years.

### C. **Purpose of Medical Evaluation.**

1. Fitness for Duty. Medical evaluations under this Program are required in order for VOSH, the Boiler and Pressure Vessel Safety Division, and the Department to determine if covered employees are physically and medically capable of performing the essential duties of the position efficiently and without posing a hazard to themselves or others.
2. Complying with VOSH Standards. Multiple VOSH standards require routine medical tests in order to monitor the health of employees who are reasonably anticipated to experience exposures to potentially hazardous substances or physical hazards and who must be physically capable of safely utilizing personal protective equipment. Under this program, VOSH and the Boiler and Pressure Vessel Safety Division will comply with medical requirements of existing VOSH standards as they pertain to covered employees.

## II. **Background.**

### A. Determination of Medical Evaluation Requirements.

This Directive establishes medical history and physical examination requirements based on specific characteristics of the affected positions. These requirements are consistent with the practices of federal OSHA and other federal agencies and accepted public health practices. The medical evaluation requirements mandated by VOSH/OSHA standards will continue to be applied to covered employees (Appendix B).

**This directive allows for flexibility and clinical judgment in determining the appropriate medical evaluation periodicity for each covered employee.** Each employee will receive an annual examination and will receive a notification regarding the type of exam that will be performed the following year.

### B. Protecting Employee Health & Safety.

Although the VOSH and Boiler and Pressure Vessel Safety Division medical examination program does change the frequency of the extensive medical questionnaire and physical examination, it provides a timely, annual occupational medicine evaluation for all covered employees. It is also aligned with current standards of occupational medicine and preventive medicine practices that are updated from the federal CSHO Medical Program. *Appendix C summarizes the supporting logic for changes in the program.*

## III. **Medical Appointments.** A mandatory annual physical examination with the VOSH Medical Services Contract Provider (MSCP) is authorized and provided to all employees in covered positions.

- A. Examinations will be conducted during the employee's normal duty hours and will be provided free of charge to the employee.
- B. Physical examinations and medical evaluations will be scheduled by the employee after notification to the individual by the DOLI DHR.
- C. Whenever possible, appointments should be scheduled within 3 calendar days of notification by the DOLI DHR and completed within 30 calendar days.
- D. Once the appointment has been scheduled, the employee should notify DOLI DHR and their supervisor of the date, time and location.
- E. Employees shall notify their supervisors, the DOLI DHR and the MSCP clinic personnel at least 24 hours in advance if they are unable to attend the examination at the scheduled time.
- F. All employees who receive an examination must complete and submit a DOLI / MSCP feedback form providing comments on the MSCP experience. The form shall be forwarded by the employee to DHR within two (2) business days of the appointment. All forms will be reviewed by DHR. All complaints of a serious nature will receive Agency follow-up and an annual summary provided by DHR to the Assistant Commissioner-Programs and the MSCP.

- G. Annual physical examinations will follow the requirements of Appendices “D1” and “D2” of this Directive.

#### IV. **Definitions and Frequency of Examinations.**

- A. Initial Examination for Anticipated Hires and Transfers. For an external candidate or a current DOLI employee whose hiring or transfer into a covered position is anticipated by the Department, an initial medical history and initial physical examination where the candidate successfully meets all requirements of the covered position is required in order to complete the hiring process.

Such initial medical history and initial physical examination should be scheduled prior to the initiation of any work in the position. If this is not feasible, in no case shall it occur later than 60 days following the initiation of work in the position. The candidate shall be advised in advance that the formal hiring process is not complete until the results of the examination indicate that the candidate successfully meets all medical/physical requirements of the position. *Appendix E provides additional policy and procedural information related uniquely to such initial examinations.*

- B. Mandatory Annual Physical Examination. There is a mandatory medical history and physical examination for all covered employees (*see Appendix “A”*). Components: Appendix “D1”, Table 1 provides a list of the components of the Physical Examination. Appendix “D2” provides the audiometric testing procedures for pre-placement and interim medical evaluations.

- C. Options. As part of the medical examination program, employees shall be offered the following options:

1. Hepatitis “B” Vaccinations. This vaccination series shall be offered as an option to all employees as part of the annual physical examination. Employees who do not wish to receive the vaccinations must sign a waiver provided by the program indicating their voluntary decision not to receive the Hepatitis “B” Vaccination series. Upon completion, this waiver shall be placed in the employee’s medical file. If an employee initially declines the hepatitis B vaccination but at a later date while still covered under the standard decides to accept the vaccination, the hepatitis B vaccination will be made available at that time.
2. Post-exposure prophylaxis (PEP) for Bloodborne Pathogens. A post-exposure evaluation and follow-up shall immediately be made available to covered employees following a report of an exposure incident. The medical evaluation and follow-up will be conducted either through the State’s workers’ compensation process or by the MSCP. The hepatitis B vaccination series will be offered to unvaccinated employees. Employees must sign the waiver provided by the program if they decline the hepatitis B vaccination series. A copy of the waiver shall be maintained in the employee’s medical file.

- D. Voluntary Physical Examination. An optional medical examination offered to employees whose past work assignments with VOSH and Boiler and Pressure Vessel Safety Division would have required them to make visits to establishments or other worksites where they may have been exposed to chemical, physical or biological hazards and whose current job descriptions no longer require them to perform field duties. These examinations provide continued medical surveillance for conditions with a long latency period.

1. Components Included. Appendix D1, Table 1 provides a list of the components of the Voluntary Physical Examination.
2. Frequency. A Voluntary Physical Examination can be obtained every 3 years.
3. Scheduling. Voluntary Physical Examinations must be scheduled and completed during the fiscal year in which the exam was approved.

- E. Self-Contained Breathing Apparatus (SCBA) Medical Clearance. Normally, VOSH employees would not be assigned to duties that would require the use of a self-contained breathing apparatus. However, if an employee is assigned a duty that would require the use of a self-contained breathing apparatus, a mandatory medical evaluation must be performed in addition to the periodic and interim evaluations, that determines an employee’s ability to safely wear a Self-Contained Breathing Apparatus (SCBA).

1. Components Included. Appendix "D1", Table 1 provides a list of the additional medical services associated with SCBA clearance. Most significantly, SCBA clearance requires a cardiac stress test for employees age 40 or older. A cardiac stress test may be required for employees age 35 or older based on cardiac risk factors.
2. Frequency. The appropriate frequency for SCBA medical clearance renewal is individualized for each employee and is determined by a reviewing physician each time the medical evaluation is performed. The frequency is determined by the opinion of the reviewing physician, based on the individual's health risks and the Elements of Physical Examination and Medical Evaluations listed in Table 1 for SCBA Clearance (*Appendix "D1"*). Individuals over 40 years of age must have a physical examination at least every two years. The SCBA clearance can be performed as part of the Periodic Physical Examination or the Interim Medical Evaluation.

**V. Additional Medical Information.** In response to the written report by the MSCP resulting from either an annual physical examination or an interim medical evaluation, additional medical information may be required to assess an employee's medical condition(s) before determining medical fitness to perform required duties. In these situations, both the employee and the Director of DHR will be notified in writing by the MSCP that additional services are required and will so advise the DOLI Assistant Commissioner-Programs. These additional tests and evaluations are considered a continuation of the scheduled examination/evaluation.

A. Additional MSCP Services. Either while still at the clinic or subsequently, additional tests that are part of the regular services provided by the MSCP may be authorized by the DOLI Assistant Commissioner-Programs. For example, a review of a respiratory protection questionnaire may reveal an issue that requires spirometry. Costs associated with these VOSH and Boiler and Pressure Vessel Safety Division authorized services by the contract physician will be covered by the Department under the agreement with the MSCP.

B. Medical Specialist Opinions. When a covered employee does not meet the established criteria for fitness for duty, but the MSCP is unable to render a medical opinion as to detailed aspects of the employee's fitness to perform his or her job functions, the employee and the Regional Office will be informed, in writing, that a specialist's medical evaluation, limited to the area(s) of concern, is required upon authorization by the DOLI Assistant Commissioner-Programs. The employee must comply with this written notification from the MSCP in a timely manner, usually within thirty (30) calendar days of employee receipt of the notification.

1. Selection of Consulting Physician. When the need for additional medical information requires the use of a medical specialist, after consultation with the MSCP regarding the appropriate specialty of the medical specialist physician advised by the MSCP, the employee selects a qualified specialist physician. This consulting physician should be board certified in the area of the potentially disqualifying condition (e.g., selection of a cardiologist to consult on cardiovascular conditions). The employee shall notify the Director of DHR when an appointment has been scheduled.

2. Payment for Consulting Physician and/or Additional Tests. The Department is responsible for the payment of the cost of medical specialist opinions and associated medical tests specified by the MSCP. Additional testing requested by a consulting physician must be approved by the Assistant Commissioner – Programs prior to authorization for payment by the Department. The Director of DHR will approve payment certifying only that the employee had an appointment and that the Director of DHR has received the certification from MSCP. It does not act as evidence of medical procedures performed.

**If additional tests are completed which are NOT approved by the Assistant Commissioner - Programs based on the recommendation of the VOSH Medical Services Contract Provider (MSCP), the employee is responsible for payment.** If this occurs, employees should consult with the DOLI Division of Accounting and Finance for guidance on how to arrange payment.

3. Medical Specialist Opinion. The medical specialist's opinion will be used in reassessing the individual's medical qualifications for duty and in determining if specific tasks can be safely performed (e.g., using a negative pressure respirator, carrying 40 lbs. of equipment, driving,

etc.). This medical information may be shared with the VOSH contract physician, if needed, for future medical clearances. The MSCP or the Director of DHR will notify the employee and Regional Director/Compliance Manager or designee if there is any failure to meet medical requirements and will advise the Regional Director or Compliance Manager or his/her designee regarding job restrictions as appropriate.

- C. Timeliness. When additional services are required, the employee must comply with the written notification from the MSCP in a timely manner, usually within thirty (30) calendar days of employee receipt of the notification. Communication with the Director of DHR is required to obtain an extension. If the MSCP has not received pertinent additional medical information within the agreed upon time, notice will be sent to the Regional Director or Compliance Manager or his/her designee so that appropriate administrative action may be taken.

## **VI. Incomplete Medical Examinations.**

When components of a mandatory medical examination or any additional examination are not completed as requested, Director of DHR will notify the Regional Director or Compliance Manager or his/her designee that the MSCP is unable to render a medical opinion as to the fitness of the employee to perform his or her job functions. The Regional Director or Compliance Manager or his/her designee will take appropriate administrative action to ensure that VOSH medical evaluations are completed. The Boiler and Pressure Vessel Safety Division Director will take appropriate administrative action to ensure that Boiler Enforcement Division medical evaluations are completed.

## **VII. Accommodations.**

*NOTE: The use of the term Accommodation@ in this Directive does not refer to Areasonable accommodation@ under the Americans with Disabilities Act (42 U.S.C. § 12101 et seq.).*

- A. Overview. Upon notification that an employee does not meet one or more medical/physical requirements of his/her position, the Regional Director or Compliance Manager, Boiler Safety Program Director or his/her designee will confer with the MSCP and the Director of DHR to consider an appropriate accommodation plan.

The process of accommodating an employee involves job reassignment, job modification or job restriction. An employee's job accommodation is designed to avoid the aggravation of an existing medical condition and to avoid placing an employee in an occupational situation that is unsafe due to the presence of one or more medical conditions. Only DOLI management may seek accommodation of employees under this program. Accommodation plans are proposed by Regional Director or Compliance Manager, Boiler Safety Program Director, or his/her designee and are reviewed and concurred on by the Director of DHR, applicable VOSH Program Director and the Assistant Commissioner - Programs. Duty restrictions may be temporary, as in the case of a correctable condition, or they may be permanent. Accommodations for permanently restrictive conditions will be made on a case-by-case basis.

- B. Interim Work Restrictions. In order to ensure that employees are not put at risk between the time they are found not to meet one or more medical/physical requirements of their positions and final accommodation, Regional Director or Compliance Manager or his/her designee shall consult with the Director of DHR and then put in place, within 10 working days of notification by the MSCP of the employee's condition, temporary working restriction(s) limiting work assignments and/or working conditions until accommodations are finalized.
- C. Director of DHR and Supervisor Consultation. The Director of DHR and the affected employee's supervisor, i.e., Regional Director or Compliance Manager, Boiler Safety Program Director, or his/her designee shall confer with the MSCP to determine what restrictions or limitations should be placed on an individual employee. This will ensure that restrictions and limitations are pertinent to currently assigned duties and potential future duties.
- D. Request for Accommodation. The accommodation plan shall include the specific details describing how the employee will be accommodated, i.e., job restriction or job reassignment. The final terms of the accommodation plan proposals will be made by the Regional Director or Compliance Manager, Boiler Safety Program Director, or his/her designee who shall forward the proposed accommodation plan to the Director of DHR.

- E. Medical Review. The Director of DHR shall review the request and confer with the MSCP to ensure that the terms of the accommodation plan are medically appropriate.
- F. Coordination of Accommodation Plan. The Director of DHR will coordinate review and concurrence of the accommodation plan with the MSCP, the applicable VOSH Program Director or Boiler Safety Program Director and the Assistant Commissioner--Programs. The purpose of the review is to ensure Departmental consistency of application. Accommodation requests will generally be reviewed on a monthly or bimonthly basis. The Director of DHR will notify the Regional Director or Compliance Manager, Boiler Safety Program Director, or his/her designee when their accommodation plans are scheduled for review. In order to expedite resolution of issues, Regional Directors, Compliance Managers, Boiler Safety Program Director, or their designees will be invited to join the meeting.
- G. Limited Duty. This program does not change procedures that regional and field offices are presently using to provide limited duty for an employee with a temporary condition such as a broken leg or pregnancy. If an adverse medical condition is correctable, i.e., hernia or high blood pressure, VOSH may require medical attention for that condition and establish a reasonable deadline by which time the condition must be corrected or controlled, in order to meet medical requirements.

**VIII. Workers' Compensation and Other Employee Benefits.** None of the policies or procedures in this Directive affects existing employee options or benefits for VSDP, disability retirement, Workers' Compensation, and/or any other employment benefit programs.

**IX. Medical Recordkeeping.**

- A. Custody of Summary Results. The summary results of all evaluations provided under this program and its predecessor, whether mandatory or voluntary, forwarded to DHR are to be maintained by DHR and are safeguarded in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, other applicable state and federal statutes and regulations, and VOSH standard Part 1910.1020)
- B. Medical Records from MSCP. Upon completion of the physical examination or medical evaluation, the MSCP shall forward to DHR the fitness for duty records of each applicable employee's physical examination and interim medical evaluation. The employee's complete medical record, including all files and records for that employee, shall be maintained by the MSCP in accordance with the terms of the contract for services with the Department.

An employee's complete medical record shall be marked "CONFIDENTIAL" and the package shall include:

- 1. Completed medical/occupational history forms including OSHA -179 form;
  - 2. Completed physical examination forms, including the OSHA -178 form;
  - 3. All laboratory, audiometric, visual, EKG, skin test and other medical test results;
  - 4. Chest X-ray (radiograph and interpretation); and,
  - 5. Pulmonary function test.
- C. Results of Annual Physical Examination. The MSCP shall send each employee a copy of his/her medical examination report within two weeks of each examination or evaluation. If the employee does not receive a timely report, the employee shall follow up with the MSCP facility where the examination was performed. A feedback form detailing the failure shall be sent to DHR if the report is not received within one week of contacting the MSCP regarding the late report.
- D. Request for Medical Records for Current Employees by the Employee.

Requests for Medical Records for Current Employees shall be directed, in writing to the MSCP by mail or by fax to the MSCP address or fax number provided by the DOLI Division of General Services and such requests shall include the following:

- ☐ Dates of examinations for which records are being requested;

- ☐ Full name and date of birth of the VOSH or Boiler and Pressure Vessel Safety Division employee submitting the request;
- ☐ Home address and phone number to allow for express mailing;
- ☐ Work phone number; and,
- ☐ An original signature of the VOSH or Boiler and Pressure Vessel Safety Division employee whose records are being requested.

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## **Appendix A**

### **VOSH Medical Examination Program**

#### **I. Purpose.**

VOSH and Boiler and Pressure Vessel Safety Division personnel conduct on-site inspections, on-site evaluations and/or on-scene emergency response functions at commercial establishments, industrial establishments and other worksites to observe and evaluate conditions to which employees or the public are exposed. During these inspections, VOSH and Boiler and Pressure Vessel Safety Division in covered or optional positions may be exposed to potentially hazardous situations and substances. The application of a single medical requirements standard to all affected employees administered by a single medical services provider (MSCP) ensures that the health of these employees will be at a level that permits them to perform job-related assignments safely, effectively, and without health or other hazard to themselves or others.

#### **II. Rationale for the Necessity of Physical Requirements.**

The following is a general description of the physical requirements of the positions affected by the VOSH Medical Examination Program.

- A. The duties of these positions require employees to perform under conditions that vary from sedentary to maximum exertion. Normal working conditions also require the employee to perform in a reliable manner under adverse conditions. Employees examine and report on potentially hazardous worksite conditions. This may include working at heights, underground, in confined spaces, in poorly lighted facilities, in emergency situations, and work in environments with chemical, physical, and biological hazards which are regulated by Title 40.1 of the Code of Virginia and the federal OSH Act.
- B. Many of the hazards that VOSH and Boiler and Pressure Vessel Safety Division employees may face are regulated by established regulatory standards which require the use of personal protective equipment (PPE) and/or routine medical monitoring. The proper use of personal protective equipment requires an evaluation of the wearer's ability to utilize the equipment safely and without adverse effect to the wearer's health. Adverse conditions sometime occur unexpectedly, while others are anticipated and appropriate steps can be taken in an orderly and controlled manner to protect oneself and safely leave the hazard area.

#### **III. Medical Examinations.**

- A. As part of the hiring process, selected applicants must undergo a pre-placement medical examination by the MSCP and be physically and medically capable of performing the essential duties of the position efficiently and without hazard to themselves or others.
- B. Routine medical evaluations by the MSCP serve to monitor the employee's health status to ensure that he or she maintains physical capabilities to meet the qualifications of his/her position. In addition, routine medical surveillance uncovers conditions which may develop as a result of occupational exposures which have long latency periods for symptom development.
- C. Failure to meet the physical and medical requirements of pre-placement examinations will be considered to disqualify an applicant for employment for a covered position.
- D. Failure to meet the physical and medical requirements of annual physical examinations will be considered disqualifying, except when, in the determination of the applicable VOSH Program Director and the Boiler

and Pressure Vessel Safety Division Director, in consultation with the Assistant Commissioner-Programs, there is sufficient evidence that individuals can perform the essential functions of the job efficiently and without risk to themselves or others, with or without appropriate accommodation.

#### **IV. Medical Examination Parameters.**

##### **A. Vision.**

1. Physical Requirement. Distant visual acuity must be at least 20/40 in each eye separately, with or without corrective lenses. Distant binocular acuity must be at least 20/40 with or without corrective lenses. Near visual acuity must be at least 20/40 in each eye separately, with or without corrective lenses. Near binocular acuity must be at least 20/40 with or without corrective lenses. Field of vision must be 85 degrees in the horizontal meridian in each eye. The ability to distinguish the colors red, amber, and green is required for the pre-placement examination.
2. Work Activity. Routinely assigned to areas where: the reading of comprehensive literature is necessary; both near and far visual acuity are necessary for hazard recognition; potentially life-threatening environments exist (therefore, accurate reading of PPE labeling is required); color coded warning signs represent hazardous conditions; or must perform routine utilization of finely calibrated equipment.
3. Rationale. Covered employees under this program inspect workplaces or boiler and pressure vessel installations where potential safety and health hazards exist or can spontaneously occur. Once these hazards occur, inspection personnel must be capable of determining what actions are appropriate in order to safeguard the safety and health of themselves and others. These actions will always require both near and far visual acuity. For example, employees may need to quickly ascertain the condition of a respirator for use in the case of an emergency egress situation. (This requires reading finely calibrated air gauges.) While making routine inspections, a compliance officer may encounter situations where full field of vision will be necessary in order to avoid a serious accident. For example, while working on high scaffolding, it may be necessary to rapidly descend. Normal field of vision is necessary to perform this activity safely.

##### **B. Hearing.**

1. Requirement. Average hearing loss in the better ear cannot be greater than 40 decibels at 500 Hz, 1,000 Hz, and 2,000 Hz, with or without a hearing aid.
2. Work Activity. Covered employees are routinely assigned to areas where a broad spectrum of physical hazards exists, including environmental noise levels above 90 decibels.
3. Rationale. It is important that a covered employee maintain adequate auditory acuity to communicate and give instructions in a noisy environment. During the course of daily activities, it is important for employees to hear instructions and communications in order to ensure safety. A greater than 40 decibel loss of auditory acuity in the speech frequencies in the better ear may interfere with the employee's ability to communicate under noisy conditions.

##### **C. Musculoskeletal.**

1. Requirements. Employees must have: a.) The functional use of both hands, arms, legs, and feet; b.) No impairment of the use of a leg, a foot, an arm, a hand, the fingers, back or neck which would most likely interfere with the functional requirements of this position; and, c.) No established medical history

or clinical diagnosis of rheumatic, arthritic, orthopedic, muscular, neuromuscular, or vascular disease which would interfere with the ability to perform the functional requirements of this position.

2. Work Activity. A covered employee is required to perform moderate lifting, carrying, walking and standing. A covered employee will routinely be required to ascend or descend heights in order to safely egress from a potentially hazardous area. During routine activities, a covered employee must carry portable scientific equipment.
3. Rationale. It is imperative that a covered employee have no impairment of the hands, arms, legs, feet, back or neck which would prevent performing the functional requirements of moderate lifting, carrying, reaching above the shoulder, standing, walking and climbing. An established medical history of arthritis or muscular pathology that would interfere with these functional requirements could cause a potentially hazardous situation in the workplace.

D. Cardiopulmonary.

1. Requirement. No current clinical diagnosis of myocardial infarction, angina pectoris, coronary insufficiency, atherosclerosis, thrombosis, or any other cardiovascular or cardiopulmonary disease that would likely cause syncope, dyspnea, collapse, or cardiac failure. No established medical history or clinical diagnosis of cardiac or respiratory dysfunction likely to interfere with the ability to wear a respirator, if required.
2. Work Activity. A covered employee will routinely be required to: perform moderate lifting, carrying, walking and standing; ascend or descend heights in order to safely egress from a potentially hazardous area; wear a negative pressure air-purifying respirator; and operate a motor vehicle.
3. Rationale. Since covered employees may need to rapidly egress from heights or depths, it is imperative that no established medical history of significant cardiac or pulmonary disease exists. It is known that carrying heavy equipment while ascending or descending great heights places an excess burden on the cardio-pulmonary system. Therefore, it is imperative that the cardio-vascular system be without significant pathology. Since a covered employee may be required to wear a negative pressure respirator, it is imperative and required by VOSH Standard 1910.134 that a physician has medically qualified the employee to wear such a respirator. It is known that pre-existing cardiac or respiratory disease can prevent an individual from wearing such a respirator.

E. General Medical.

1. Requirement. No diagnosis of a medical condition that is likely to cause significantly impaired performance or sudden incapacitation, e.g., uncontrolled seizures, use of prescription medication that causes significant sedation, or other significant impairment. When, in the opinion of the VOSH MSCP, it is determined that for a given individual, the sedative properties of that employee's required medication poses an unacceptable risk, the employee will not receive full medical clearance. Appropriate job restrictions will be considered. This does not apply to use of over-the-counter medications.
2. Work Activity. Covered employees work in locations with known physical, chemical and biological hazards. Covered employees often work alone in isolated locations, may be required to work at heights, and often drive for long periods of time in the course of their duties.

3. Rationale. Covered employees must work in an environment where sudden incapacitation might endanger themselves or others. Therefore, covered employees must be free of known medical conditions that are anticipated to cause significantly impaired performance or sudden incapacitation.

## **Appendix B**

### **Medical Evaluation Requirements of OSHA Standards**

Certain VOSH standards have medical surveillance requirements at prescribed intervals. For example, the Occupational Hearing Conservation standard (Part 1910.95) requires an annual audiogram for employees who experience occupational noise exposure at or above the action level of an 8-hour time-weighted average of 85 decibels. For most hazard exposures for which the standard requires periodic medical surveillance, medical surveillance is required on an annual basis.

Following are brief summaries of the medical surveillance/medical monitoring requirements for each standard, as they might pertain to the duties of employees covered by this directive. These summaries do not include specific details from the standards such as on which organ systems the physician or licensed healthcare provider must focus when obtaining the medical histories or performing the physical examinations.

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**Acrylonitrile** - Part 1910.1045 (General Industry): For exposures to acrylonitrile at or above the action level of 1 ppm as an 8-hour time-weighted average, this standard mandates a medical and work history and a complete physical examination, a 14 x 17 inch postero-anterior chest radiograph and a fecal occult blood test for employees 40 years of age or older at the time of the work assignment and at least annually thereafter if the exposure continues. The standard denotes organ systems and non-specific symptoms to which particular attention is to be paid during the taking of the histories and performance of the physical examination.

**Asbestos** - Part 1926.1101(m) and Part 1915.1101(m) (Construction and Shipyards): These standards require a medical and work history, physical examination, pulmonary function test at least annually for exposures at or above the Permissible Exposure Limit (PEL) for 30 or more days a year or exposed above the Excursion Limit.

**Asbestos** - Part 1910.1001 (General Industry): When exposed at or above the PEL or above the Excursion Limit, the employee is required to complete a standardized questionnaire (from Appendix "D" of the standard) and have a physical examination annually. A postero-anterior view chest radiograph of 14 X 17 inches is to be done based on length of employment and age of the employee. This film is to be read by a B-reader.

**Benzene** - Part 1910.1028, Part 1926.1129, & Part 1915.1028 (General Industry, Construction and Shipyards, respectively): For employees exposed at or above the action level for 30 or more days per year or at or above the PEL for 10 or more days per year, these standards require initial and annual medical and work histories and physical examinations and a complete blood count with differential and quantitative platelet count. Employees who must wear respirators 30 or more days per year are required to have a pulmonary function test at least every 3 years under these standards.

**1,3-Butadiene** - Part 1910.1051 (General Industry): Employees exposed at or above the action level for 30 or more days per year or at or above the PEL on 10 or more days per year or at or above the Short-term Exposure Limit (STEL) on 10 or more days per year should have an annual health questionnaire (from Appendix C of the standard or its equivalent), an annual complete blood count with differential and platelet count, and a physical examination at least every 3 years. The physical examination should be done more often if advised by the physician or other licensed healthcare professional (PLHC) who reviews the questionnaire and the results from the blood test.

**Cadmium** - Part 1910.1027, Part 1926.1127, Part 1915.1027 and Part 1928.1027 (General Industry, Construction, Shipyards and Agriculture, respectively): Employees who experience exposure to Cadmium at or above the action level for 30 or more days during any 12 consecutive months should have medical surveillance provided at the intervals required under the standards. Surveillance includes initial and periodic medical and work histories and examinations, chest radiographs, pulmonary function tests, blood tests, urinalysis and biological monitoring

tests which include urine test for cadmium and Beta-2 microglobulin and a blood test for cadmium. The first periodic medical surveillance shall be provided within one year after the initial examination and then, at a minimum, biennially.

**Carcinogens** - Part 1910.1003, Part 1926.1103, 1915.1003 (General Industry, Construction and Shipyards, respectively): This group of standards require an annual medical and work history and physical examination for employees who must enter, as part of their assigned work, regulated areas at worksites where any of the 13 chemicals identified as carcinogens are manufactured, processed, repackaged, released, handled or stored.

**Chromium (VI)** - Part 1910.1026, Part 1926.1126, Part 1915.1026 (General Industry, Construction and Shipyards, respectively): These standards require initial and annual medical history and physical examination for employees with exposure at or above the action level for 30 or more days per year.

**Coke Oven Emissions** - Part 1910.1029 (General Industry): For employees who are in the regulated area for at least 30 days per year, the employer shall provide initial and annual medical and work histories, a postero-anterior view chest radiograph, a pulmonary function test, weight, physical examination of the skin, a urinalysis and urine cytology test.

**Compressed Air** - Part 1926.803 (Construction): Medical surveillance requirements for this standard were not included in this summation because it is unlikely that OSHA covered employees will enter a compressed air environment.

**Cotton Dust** - Part 1910.1043 (General Industry): This standard requires annual medical surveillance for employees exposed above the action levels set for cotton dust. Biennial surveillance is required for those employees exposed below the action levels. The surveillance consists of a medical history plus a questionnaire from Appendix B of the standard and pulmonary function testing. Surveillance frequency is increased to every six months for employees with specific pulmonary function test findings described in the standard.

**1,2-Dibromo-3-chloropropane (DBCP)** - Part 1910.1044, Part 1926.1144, Part 1915.1044 (General Industry, Construction and Shipyards): Initial and annual medical and work histories, physical examination, blood serum test for FSH, LH, total serum estrogen (in female employees) and a sperm count (in male employees) are required for employees who work in regulated areas with occupational exposure to DBCP.

**Ethylene Oxide** - Part 1910.1047, Part 1926.1147 (General Industry and Construction): For employees exposed at or above the action level for 30 or more days per year, the standards require initial and annual medical and work histories, physical examinations and a complete blood count with differential.

**Formaldehyde** - Part 1910.1048, Part 1926.1148, Part 1915.1048 (General Industry, Construction and Shipyards): The standards require medical and work histories initially and annually and physical examinations at the discretion of the physician based on review of the medical history of employees with exposure to formaldehyde at or above the action level or exceeding the STEL. An annual physical examination is mandated for those employees who are required to wear a respirator. This evaluation must include a yearly pulmonary function test.

**Hazardous Waste Operations and Emergency Response** - Part 1910.120, Part 1926.65 (General Industry and Construction): The standard requires an annual or biennial medical and work history and physical examination for employees exposed to hazardous substances at or above the PEL, or if there is no PEL, at or above the published exposure levels for 30 or more days a year.

**Inorganic Arsenic** - Part 1910.1018, Part 1926.1118, 1915.1018 (General Industry, Construction and Shipyards): For employees with exposure above the action level for 30 or more days per year, an initial and annual medical and work history and physical examination. The examination shall include a postero-anterior view chest radiograph of 14 X 17 inches in size.

**Lead** - Part 1910.1025, Part 1915.1025 (General Industry and Shipyards): These standards require medical surveillance for employees exposed above the action level for more than 30 days per year. The minimum requirements, if the blood lead level is less than 40 µg/100 g, include: ZPP and blood lead levels every six months, initial and annual medical and work history, physical examination, the aforementioned blood tests plus a hemoglobin and hematocrit, red blood cell indices, a peripheral blood smear with analysis of morphology, BUN, creatinine, urinalysis with microscopic examination.

**Lead** - Part 1926.62 (Construction): This standard requires an initial ZPP and blood lead level for any employee who will be exposed on any day to lead at or above the action level. It also requires medical surveillance for employees exposed at or above the action level for more than 30 days in any consecutive 12 months. The minimum medical surveillance consists of an annual medical and work history; physical examination plus tests including the blood lead level and ZPP; a hemoglobin, hematocrit, red blood cell indices; analysis of a peripheral blood smear for morphology; BUN, creatinine, and urinalysis with microscopic examination. The blood lead level and ZPP are to be repeated every 2 months for the first six months and then every 6 months if the blood lead level remains below 40 µg/dl. For employees whose blood lead levels are at or above 40 µg/dl, the frequency of required tests is stated in the standard.

**Methylene Chloride** - Part 1910.1052, Part 1926.1152 (General Industry and Construction): Periodic medical surveillance is required for employees with exposures at or above the action level on 30 or more days per year or above the PEL on 10 or more days per year or above the STEL on 10 or more days per year or through employee request after a physician finds health conditions for which methylene chloride exposure puts the employee at increased risk. The medical surveillance consists of annual updates of medical and work histories and, for employees 45 years of age or older, annual physical examinations; employees less than 45 years of age are to have physical examinations every 36 months.

**Methylenedianiline** - Part 1910.1050, Part 1926.60 (General Industry and Construction): These standards require medical surveillance for employees with exposures at or above the action level for 30 or more days per year or dermal exposure for 15 or more days per year. The surveillance includes annual medical and work histories for issues pertinent to methylenedianiline exposures, physical examination, blood tests for liver functions, and a urinalysis. Medical surveillance is required for emergency exposures.

**Occupational Noise Exposure** - Part 1910.95 (General Industry): This standard requires surveillance for noise-induced hearing loss. The surveillance consists of a baseline and annual audiogram for employees with noise exposure at or above an 8-hour TWA of 85 decibels. If the annual audiogram shows a standard threshold shift, the employer may have the audiogram repeated within 30 days.

**Respiratory Protection** - Part 1910.134, Part 1926.103 (General Industry and Construction): These standards require administration and evaluation of a mandatory medical questionnaire prior to fit testing or respirator use. If any of the answers to questions 1 to 8 in Part A, Section 2 of the questionnaire are positive, a medical examination is required. There is no mandated periodicity for use of a respiratory questionnaire or medical examination. The standards state situations that trigger the requirement for repeat medical evaluations for respirator use.

**Vinyl Chloride** - Part 1910.1017, Part 1926.1117 (General Industry and Construction): According to these standards, employees exposed in excess of the action level are required to have a medical and work history, a physical examination, blood tests for total bilirubin, alkaline phosphatase, SGOT, SGPT and GGT on an annual basis, and every six months if over 10 years of exposure. Each employee exposed in an emergency shall be afforded appropriate medical surveillance.

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## **Appendix C**

### **Protecting Employee Health and Safety**

The primary goals of the VOSH/Inspector Medical Examination Program are to determine fitness for duty and to provide medical surveillance for occupational exposures, as indicated. The intent of this Program is to assure that covered employees of the Department in these Divisions are physically able to safely perform assigned duties. In addition, the Program provides limited health promotion services that do not replace the need for personal health care. Employees are encouraged to share examination results with their personal physicians.

#### **I. Annual Evaluations.**

All covered employees will receive annual medical evaluations that include, at a minimum, medical surveillance for noise and medical clearance for respirator use. Employees' occupational exposures that may require additional medical procedures or evaluation, for example, prior silica or asbestos exposure warranting chest x-ray with B-reading, are evaluated as part of the physical examination and also whenever management reports to DHR a potential exposure that reaches an action level of a VOSH standard or another occupational exposure of concern. The periodicity or frequency of these examinations and evaluations aims to improve the timeliness of medical evaluations and of any accompanying recommendations for alterations in duty, designed to protect employees.

#### **II. Regulatory Requirements.**

The implementation of an annual interim examination that includes a hearing conservation program in accordance with the Occupational Noise Exposure standard Part 1910.95, annual medical clearance for respirator usage Section 1910.134, and interim tuberculosis screening according to need ensures that all covered employees receive appropriate occupational medical surveillance. Because VOSH and Boiler and Pressure Vessel Safety Division employees are not reasonably anticipated to encounter other occupational hazards that meet action levels for medical surveillance, they are not required or recommended to receive additional annual medical surveillance.

## **Appendix D1**

### **Components of Medical Examinations**

- I. **General.** The medical examination required herein will be conducted by a physician experienced in occupational medicine, preferably by a physician who is a member of the American College of Occupational and Environmental Medicine. The examining physician or institution will provide special instructional material (such as necessary fasting periods or special eating instructions) to DOLI management which will in turn provide this information to the examinee prior to the Periodic Physical Examination.
- II. **Medical History.** Review of the employee=s history must be conducted in regard to personal and family medical history and a work history including occupational exposures to chemical and physical hazards.
  - A. **Required Forms.** Covered employees shall complete either the VOSH Medical Program B Physician=s Report (OSHA/VOSH-179) and VOSH Medical Program B Employee History (OSHA/VOSH-178) or the OSHA Respirator Medical Evaluation Questionnaire (Mandatory) (FOH-22) and provide them to the physician prior to the examination. Both are multi-page forms for recording the affected VOSH employee=s medical and occupational history.
  - B. **Discussion with Physician.** There shall be an examining room discussion between the employee and the physician regarding medical history, with special attention given to the questionnaire on hazardous occupational exposures.
- III. **Specific Examination Tests and Requirements.** The physical examination should include, but not be limited to, a review of the following: head and neck, including visual tests, an examination of the eyes, ears, nose and throat, an examination of the respiratory, cardiovascular and central and peripheral nervous systems, an examination of the abdomen, a voluntary examination of the rectum and genitourinary system, an examination of the spine and other musculoskeletal systems, and an examination of the skin. Specific tests/measurements to be obtained include:
  - A. **Height and weight.**
  - B. **Temperature, pulse, respiration rate, blood pressure.**
  - C. **Eye examination,** including:
    1. Visual acuity, near and far.
    2. Accommodation.
    3. Field of vision.
    4. Fundoscopic exam.
  - D. **Cardiopulmonary evaluation,** which shall include the following:
    1. Resting twelve-lead electrocardiogram with interpretation.
    2. Pulmonary Function Evaluation:
      - a. FVC, FEV1, FEV1/FVC ratio.
      - b. Permanent record of flow curves must be included in the patient's report.
    3. Tuberculin skin test (TST) - a 2-step TST for all Pre-placement examinations. A TST is offered yearly to employees who have had on-the-job exposure to active TB.

4. Chest X-ray (PA) 14 x 17 inches:
  - a. Required for all Pre-placement examinations.
  - b. Unless an employee's occupational exposure (see Appendix B) reaches the action level at which medical surveillance is required, follow-up chest x-rays are voluntary. Chest X-rays and B-read examinations will be offered at the 10-year anniversary of employment, then every 6-10 years, depending on exposure history.

E. Comprehensive laboratory profile, including:

1. Urinalysis (including microscopic, if indicated).
2. Fecal occult blood test - optional unless employee has had exposure at or above the action level to Acrylonitrile (see Appendix B and VOSH Standard 1910.145).
3. CBC (complete blood count).
4. Test groups (done after 12-hour fast):

|                         |                                                                                    |
|-------------------------|------------------------------------------------------------------------------------|
| a. Chloride             | h. Bilirubin                                                                       |
| b. Sodium               | i. Total protein                                                                   |
| c. Glucose              | j. Albumin and globulin                                                            |
| d. Blood urea nitrogen  | k. Lipid Panel, incl. Triglycerides                                                |
| e. Creatinine           | l. Potassium                                                                       |
| f. LDH, AST, GGT, ALT   | m. Calcium                                                                         |
| g. Alkaline phosphatase | n. A blood lead when there is a history of lead exposure within the last 12 months |

F. Audiometric Testing will be done in accordance with the OSHA Hearing Conservation Program.

**IV. Tests and Requirements for Examinations/Evaluations.** See Table 1 for a delineation of the specific tests and requirements of the Pre-placement Examination, the Periodic Physical Examination, the Interim Examination, the Voluntary Physical Examination, and the special requirements associated with SCBA medical clearance.

**Table 1**

| Elements of Physical Examinations and Medical Evaluations |                                                                     |                             |                                         |                                         |
|-----------------------------------------------------------|---------------------------------------------------------------------|-----------------------------|-----------------------------------------|-----------------------------------------|
|                                                           | Pre-placement Examination                                           | Annual Physical Examination | Interim Medical Evaluation <sup>1</sup> | SCBA Clearance <sup>2</sup>             |
| Questionnaire                                             |                                                                     |                             |                                         |                                         |
| Medical ProgramB Physician=s Report (OSHA/VOSH-178)       | Required                                                            | Required                    |                                         |                                         |
| Medical ProgramB Employee History (OSHA/VOSH-179)         | Required                                                            | Required <sup>3</sup>       |                                         |                                         |
| OSHA Respirator Medical Evaluation Questionnaire (FOH-22) | Required when job duties require the use of respiratory protection. |                             | Required                                | Required if >6 months since Annual Exam |

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<sup>1</sup> Required only when triggered by the medical surveillance provisions of a specific VOSH standard and if deemed necessary by the MSCP when the employee gives a positive response to Questions 1 through 8 in Section 2, Part A of Appendix C of 1910.134. These tests may be performed as directed by the MSCP.

<sup>2</sup> These tests are in addition to the requirements of the Periodic Physical Examination or Interim Medical Evaluation that is being performed simultaneously with the SCBA clearance.

<sup>3</sup> Everyone must answer all questions except items 10-15 on page 3. Those seeking SCBA clearance must complete all items.

Table 2

| Elements of Physical Examinations and Medical Evaluations                |                                         |                                   |                                               |                                           |
|--------------------------------------------------------------------------|-----------------------------------------|-----------------------------------|-----------------------------------------------|-------------------------------------------|
|                                                                          | Pre-placement<br>Initial<br>Examination | Annual<br>Physical<br>Examination | Interim<br>Medical<br>Evaluation <sup>1</sup> | SCBA<br>Clearance <sup>2</sup>            |
| Test/Evaluation                                                          |                                         |                                   |                                               |                                           |
| Height                                                                   | Required                                | Required                          |                                               |                                           |
| Weight                                                                   | Required                                | Required                          |                                               |                                           |
| Temperature                                                              | Required                                | Required                          |                                               |                                           |
| Pulse                                                                    | Required                                | Required                          |                                               |                                           |
| Respiration rate                                                         | Required                                | Required                          |                                               |                                           |
| Blood pressure                                                           | Required                                | Required                          | Required                                      |                                           |
| Eye examination, including:                                              | Required                                | Required                          |                                               |                                           |
| Visual acuity, near & far                                                | Required                                | Required                          |                                               |                                           |
| Accommodation                                                            | Required                                | Required                          |                                               |                                           |
| Field of Vision                                                          | Required                                | Required                          |                                               |                                           |
| Fundoscopic exam                                                         | Required                                | Required                          |                                               |                                           |
| Color Vision                                                             | Required                                | Required                          |                                               |                                           |
| <b>Cardiopulmonary evaluation, which shall include the following:</b>    |                                         |                                   |                                               |                                           |
| Resting twelve-lead electrocardiogram with interpretation                | Required                                | Required                          |                                               |                                           |
| Pulmonary Function Evaluation (spirometry)                               | Required                                | Required                          | Req. if clinically indicated <sup>4</sup>     | Req. if clinically indicated <sup>4</sup> |
| FVC, FEV1, FEV1/FVC ratio                                                | Required                                | Required                          |                                               |                                           |
| Permanent record of flow curves must be included in the patient's report | Required                                | Required                          |                                               |                                           |
| Exercise Stress Test                                                     |                                         | May be Required <sup>5</sup>      |                                               | Required <sup>5</sup>                     |
| Tuberculin skin test (TST)                                               | Required                                |                                   |                                               |                                           |

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4

Spirometry is required for employees 60 years of age or older and for those with asthma. Other clinical indications may also warrant spirometry testing.

5

Exercise Stress Tests are required for those age 40 or older and for others as clinically indicated.

**Table 3**

| <b>Elements of Physical Examinations and Medical Evaluations</b> |                                                  |                                            |                                                        |                                        |
|------------------------------------------------------------------|--------------------------------------------------|--------------------------------------------|--------------------------------------------------------|----------------------------------------|
|                                                                  | <b>Pre-placement<br/>Initial<br/>Examination</b> | <b>Annual<br/>Physical<br/>Examination</b> | <b>Interim<br/>Medical<br/>Evaluation <sup>1</sup></b> | <b>SCBA<br/>Clearance <sup>2</sup></b> |
| <b>Test/Evaluation (con=t)</b>                                   |                                                  |                                            |                                                        |                                        |
| 2nd step TST                                                     | Required                                         |                                            |                                                        |                                        |
| Chest X-ray (PA)<br>14 x 17inches                                | Required                                         | Voluntary <sup>6</sup>                     |                                                        |                                        |
| Chest X-ray B-read                                               |                                                  | Voluntary <sup>6</sup>                     |                                                        |                                        |
| Comprehensive laboratory<br>profile                              | Required                                         | Required                                   |                                                        |                                        |
| Fecal occult blood test                                          |                                                  |                                            |                                                        |                                        |
| CBC                                                              |                                                  |                                            |                                                        |                                        |
| Test Groups including,<br>but not limited to:                    |                                                  |                                            |                                                        |                                        |
| Lead                                                             |                                                  |                                            |                                                        |                                        |
| Audiometric Testing                                              | Required                                         | Required                                   | Required                                               |                                        |

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<sup>6</sup> A periodic chest x-ray and associated B-read are voluntary unless required for surveillance of an employee's occupational exposure (see Appendix B). If required, see Appendix B for frequency.

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## Appendix D2

### **Audiometric Testing Program**

#### **I. General.**

Audiometric testing will be conducted in concert with the Agency's Medical Examination Program. All audiometric exams performed as part of the Agency's Medical Examination Program must take place in an appropriate test environment that does not interfere with the accuracy of the audiometric test thresholds. Audiometric test frequencies shall include: 500 Hz, 1,000 Hz, 2,000 Hz, 3,000 Hz, 4,000 Hz, 6,000 Hz, and 8,000 Hz. Requirements for test equipment and calibration must conform, at a minimum, to the calibration and audiometric test requirements set forth in the hearing conservation amendment 1910.95(g) to the occupational noise exposure standard.

Prior to receiving audiometric testing, VOSH and Boiler and Pressure Vessel Safety Division personnel now covered by this directive will complete an audiometric history (Forms FOH-17, FOH-16, and FOH-33 in Appendix I), in order to document pertinent medical history, noise exposure, and use of hearing protection.

#### **II. Scheduling.**

Baseline and annual audiometric exams will be scheduled concurrently with pre-placement and annual medical examinations respectively. Retest audiograms will be conducted within 30 days of the time that a Standard Threshold Shift (STS) is identified.

- A. Baseline Audiogram. The baseline audiogram must be preceded by a minimum period of 14 hours of quiet without exposure to workplace noise. The use of hearing protection is an acceptable alternative to the 14-hour quiet period before the baseline audiogram is taken. The baseline audiogram for covered personnel is defined as follows:
1. VOSH and Boiler and Pressure Vessel Safety Division personnel covered by this directive hired prior to the establishment of the Medical Examination Program will have their oldest qualifying audiogram on file identified as their baseline audiogram.
  2. VOSH and Boiler and Pressure Vessel Safety Division personnel covered by this Directive hired after its effective date will have their pre-placement audiogram identified as their baseline audiogram. Valid baseline audiograms are obtained prior to field assignment as required by the pre-employment medical requirements program.
- B. Annual Audiogram. Audiometric testing will be conducted annually. Each annual audiogram shall be compared to the baseline audiogram to validate its accuracy, and detect significant changes in hearing. The 14-hour quiet period is not necessary for annual audiograms.
- C. Notification of Audiogram Results. Immediately following audiometric testing, covered VOSH and Boiler and Pressure Vessel Safety Division personnel will receive preliminary feedback on their test results by an individual qualified to administer the audiometric exam. A preliminary determination of an STS will result in covered personnel automatically receiving an appointment for a retest audiogram. A definitive interpretation of all audiograms will take place following audiogram review by the MSCP. Formal written notification letters will be sent to each employee in the program from the MSCP regarding: findings of annual audiograms including STS, indications of possible otological pathology, and recommendations for audiological or otological follow-up. If covered personnel receive a retest audiogram, he/she will receive a single notification letter that explains the findings of both the annual and retest audiograms. (See Sample Notification Letter in Appendix "I"). The MSCP will contact covered personnel and DHR with specific information in order for them to obtain follow-up testing and treatment as needed. (see section F.5. below).

- D. Retest Audiogram. VOSH and Boiler and Pressure Vessel Safety Division personnel covered by this directive with annual audiograms that meet the STS criteria will be retested within 30 days of the annual audiogram to determine whether the threshold shift is temporary or persistent. Retest audiograms should be conducted after a 14-hour quiet period. However, hearing protection may be used as an alternative to the 14-hour quiet period. A retest audiogram conducted within 30 days of the annual audiogram may confirm a newly identified STS, or it may reveal an improvement in hearing threshold. In both of these cases, the results of the retest audiogram can be substituted for the annual audiogram.
- E. Revised Baseline Audiogram. An annual audiogram may be substituted for the baseline audiogram when: (a) the STS is persistent; or (b) the hearing threshold shown in the annual audiogram indicates significant improvement over the baseline audiogram. The audiometric findings from each ear are evaluated independently for improvement or worsening of the auditory threshold of the person on whom the audiogram was performed. If only one ear meets the criteria for STS, the baseline may be revised for that ear only. Thus, future audiometric tracking will be based on separate left and right ear baseline revisions.
- F. Standard Threshold Shift. The criterion for STS is a change in hearing threshold relative to the baseline audiogram of an average of 10 dB or more at 2,000, 3,000, and 4,000 Hz in either ear. Age corrections will be applied in deterring STS. If an STS has occurred, the employee will be informed of this fact in writing, within 21 days of the final determination. When the MSCP has determined that an STS has occurred, the following actions will take place:
1. The MSCP will send a notification letter to the affected employee. The MSCP will send a separate notification letter the Director of DHR as the employer representative. The MSCP will provide both notification letters within 21 days of determining that an STS has occurred. If the STS did not persist on the retest audiogram, or if there is an improvement in hearing thresholds, the notification letter will indicate these findings.
  2. The Director of DHR will notify the Regional Director, Boiler Safety Program Director, Program Manager or his/her designee, as appropriate, of the presence of an STS, and of the required follow-up actions, including the need for OSHA 300 log entry.
  3. The Regional Director, Boiler Safety Program Director, or his/her designee will ensure proper evaluation of the adequacy of hearing protectors. If the affected employee is not using hearing protectors, that employee will be fitted with hearing protectors, trained in their use and care, and be required to use them. If the affected employee is already wearing hearing protectors, he/she will be refitted and retrained in the use of hearing protectors and be required to use them. Alternative hearing protectors will be provided as appropriate.
  4. The MSCP will advise the Director of DHR of recommendations for additional audiological or otological evaluations. The Assistant Commissioner – Programs in consultation with the MSCP will make final determinations on appropriate referrals as necessary.
  5. The MSCP will inform the affected employee of the purpose for additional testing, the logistics for obtaining additional testing, and of the implications of test results.

## **Appendix E**

### **Pre-placement Examination for Anticipated Hires and Transfers**

#### **I. Pre-placement Examination.**

The VOSH Medical Services Contract Provider (MSCP) pre-placement examination described in this Directive is mandatory for all individuals seeking employment in covered positions listed in Section I.A.1 of this Directive. Such positions have duties that entail possible exposures to chemical, physical, or biological hazards. All new hires are required to meet, i.e., pass, the physical and medical requirements specified in this instruction. Selected applicants must successfully meet all physical and medical requirements of the covered position in order to complete the formal hiring process.

Such pre-placement examinations are also required for current DOLI employees employed in non-covered positions and who apply and are selected for one of the covered positions under this Directive.

#### **II. Failure to Meet Requirements.**

Failing to meet the physical and medical requirements of this program shall be considered disqualifying for employment in a covered position, i.e. the individual does not meet the qualification requirements of the position.

The candidates shall be advised in advance that the formal hiring process into the covered position is not complete until this examination is completed and a determination is made indicating that the candidate successfully meets all medical and physical requirements of the position.

#### **III. Scheduling.**

The pre-placement examination with the VOSH MSCP will be scheduled at the direction of the Director of DHR or his/her designee.

- A. The “anticipated hire” shall contact the MSCP to initiate an initial examination.
- B. Initial examinations for current DOLI employees moving from non-covered positions should be scheduled during the employee’s normal working hours.
- C. The pre-placement physical examination and initial medical history should normally occur prior to the initiation of work in the position. It shall in no case occur later than 30 days following the initiation of work in the position.

#### **IV. Elements of the Pre-placement Examination.**

The pre-placement examination elements will include a medical history, occupational and exposure histories, a physical examination and other medical tests as noted in Appendix “D1”, Table 1.

#### **V. Location of the Pre-placement Examination.**

The examination physicals of applicants should occur at the facilities of the MSCP location within the region where the applicant resides whether the candidate is to be hired by that Region or another Region.

#### **VI. Cost of Examination.**

Examinations will be provided free of charge to the applicant. However, if a medical specialist’s opinion is needed in order to determine fitness for duty, the costs associated with obtaining this specialist’s medical opinion will be the responsibility of the applicant.

## **VII. Records Management.**

In addition to the Records Management policies and procedures established in this Directive, the following policies and procedures apply to pre-placement physicals:

- A. The results of all examination and testing provided under this program are the property of the Department of Labor and Industry and will be safeguarded in accordance with all applicable state and federal laws and the contractual agreement between the Department and the VOSH Medical Services Contract Provider (MSCP). Additionally, the VOSH Medical Services Contract Provider is responsible for assuring that all procedures for review and handling of medical records are in accordance with VOSH Standard 1910.1020, Access to Employee Exposure and Medical Records.
  
- B. If the selected applicant is not hired into the position, the medical records of the pre-placement examination will normally be retained for one year by the MSCP for the Department. If no legal or administrative challenges are made either in regard to the Department's decision not to hire the applicant, or the handling of the file, the file will be destroyed after the one-year retention period. A log detailing the location and disposition of such records will be maintained by the MSCP.

## **Appendix F**

### **Comprehensive Reference List**

- A. American Academy of Audiology Task Force. Position Statement: Preventing Noise-Induced Occupational Hearing Loss. American Academy of Audiology, 2003.
- B. American Academy of Ophthalmology Preferred Practice Patterns Committee: Preferred Practice Pattern Guidelines. Comprehensive Adult Medical Eye Evaluation. American Academy of Ophthalmology, 2005.
- C. American Academy of Orthopedic Surgeons Research and Scientific Affairs Department: Osteoarthritis of the Knee: A Compendium of Evidence-Based Information and Resources. American Academy of Orthopedic Surgeons. 2004.
- D. American College of Rheumatism. Recommendations for the Medical Management of Osteoarthritis of the Hip and Knee. Vol. 43, No. 9, Sept. 2000. 1905-1915.
- E. American Medical Association. Medical Evaluations of Healthy Persons. Council on Scientific Affairs. JAMA 1983 Mar 25; 249 (12): 1626-1633. F. Ashley EA, Raxwal V, Froelicher V. An evidence-based review of the resting electrocardiogram as a screening technique for heart disease. Progress in Cardiovascular Diseases, Vol. 44, No. 1, July/August) 2001: 55-67.
- F. Ashley EA, Raxwal V, Froelicher V. An evidence-based review of the resting electrocardiogram as a screening technique for heart disease. *Progress in Cardiovascular Diseases*, Vol. 44, No. 1, (July/August) 2001: 55-67.
- G. Department of the Interior. Individual Occupational Requirements for Surface Mining Reclamation Specialist. Operating Manual for Qualification Standards for General Schedule Positions. IVB. 1999, 225.
- H. Environmental Protection Agency. Order number 1460.1. Occupational Medical Surveillance Program. 1996.
- I. Food and Drug Administration. Statement of Physical Ability to Perform CSO and CSI Duties: Instructions to Agency. 1998.
- J. Lesho E, Gey D, Forrester G, Michaud E, Emmons E, Huyche E. The low impact of screening electrocardiograms in healthy individuals: A prospective study and review of the literature. Military Medicine; Jan 2003; 168, 15-18.
- K. Macfarlane PW, Norrie J. The value of the electrocardiogram in risk assessment in primary prevention: Experience from the west of Scotland Coronary prevention study. Journal of Electrocardiology. 40 (2007) 101-109.
- L. Mining Safety and Health Administration. Administrative Policy and Procedures Manual, Volume IV, Chapter 1000, 2005.
- M. The National Eye Institute, National Institute of Health. National Eye institute Statements: Detection of Glaucoma. 2007.
- N. National Heart, Lung, and Blood Institute. National Institute of Health. Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure, Hypertension 2003. 42: 1206-52.
- O. National Heart, Lung, and Blood Institute, National Institute of Health, National Cholesterol Education Program. High Blood Cholesterol: What You Need to Know. 2005. (Pub. no. 05-3290).
- P. Office of Personnel Management. Single Agency Qualification Standard: Compliance Safety and Health Officer. 12/24/85.
- Q. Occupational Safety and Health Administration. Directive PER 04-00-004. Hearing Conservation Program. 6/23/08.

- R. Occupational Safety and Health Administration. Directive PER 04-00-003/PER 8-2-5. CSHO Medical Examinations. 3/31/89a.
- S. Occupational Safety and Health Administration. Directive PER 04-00-002/PER 82-4. CSHO Pre-Employment Medical Examination. 3/31/89b.
- T. Thompson JS, Gibbs JO, Reda DJ, McCarthy M Jr, Wei Y, Giobbie-Hurder A, Fitzgibbons RJ Jr. Does delaying repair of an asymptomatic hernia have penalty? Am J Surg. 2008 Jan; 195 (1): 89-93.
- U. U.S. Preventive Services Task Force. Guide to Clinical Preventive Services, 2<sup>nd</sup> and 3rd eds. International Medical Publishing, 2002.
- V. U.S. Preventive Services Task Force. Screening for Coronary Heart Disease. Agency for Healthcare Research and Quality. 2004.

## **Appendix G**

### **Pre-placement and Annual Physical Examination Forms**

- Each employee shall complete the *VOSH Medical Program – Employee History* (VOSH-179) as part of the Annual Physical Examination.
- Candidates for covered positions shall also complete the *VOSH Medical Program - Employee History* (VOSH-179).
- The completed copy of the *VOSH Medical Program – Employee History* (VOSH-179) shall be presented at the MSCP facility at the time of the appointment.
- The *VOSH Medical Program – Physician’s Report* (VOSH-178) is to be completed only by the examining Physician at the MSCP facility.



# VOSH Medical Program – Physician’s Report

Virginia Department of Labor and Industry

To be completed by examining Physician

This information is for official and medically confidential use only and will not be released to unauthorized persons.  
The release of this information is subject to the Privacy Act.

## Physical Examination

Name: ID #:

Type of Examination: Date: Time:

Weight: Temp: Resp:

Height: Pulse: BP:

| Normal                   | Abnormal                 | Clinical Evaluation                  | Normal                   | Abnormal                 | Clinical Evaluation                  |
|--------------------------|--------------------------|--------------------------------------|--------------------------|--------------------------|--------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | General Appearance                   | <input type="checkbox"/> | <input type="checkbox"/> | Vascular System (Varicosities, etc.) |
| <input type="checkbox"/> | <input type="checkbox"/> | Head, Face, Neck, Scalp              | <input type="checkbox"/> | <input type="checkbox"/> | Abdomen & Viscera (Include Hernia)   |
| <input type="checkbox"/> | <input type="checkbox"/> | Nose (Septum)                        | <input type="checkbox"/> | <input type="checkbox"/> | Anus & Rectum                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinuses                              | <input type="checkbox"/> | <input type="checkbox"/> | G-U System                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Mouth and Throat                     | <input type="checkbox"/> | <input type="checkbox"/> | Upper Extremities                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Ears ( General)                      | <input type="checkbox"/> | <input type="checkbox"/> | Lower Extremities                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Drums (Perforation)                  | <input type="checkbox"/> | <input type="checkbox"/> | Skin, Other Musculoskeletal          |
| <input type="checkbox"/> | <input type="checkbox"/> | Ophthalmoscopic                      | <input type="checkbox"/> | <input type="checkbox"/> | Spine, Lymphatics                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Pupils (Equality & Reaction)         | <input type="checkbox"/> | <input type="checkbox"/> | Neurological                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Ocular Mobility                      | <input type="checkbox"/> | <input type="checkbox"/> | Peripheral                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Lungs, Chest (Include Breasts)       | <input type="checkbox"/> | <input type="checkbox"/> | Cranial Nerves                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart (Thrust, Size, Rhythm, Sounds) | <input type="checkbox"/> | <input type="checkbox"/> | Deep Tendon Reflexes                 |

Comments:

Summary of Findings:

Base on Medical Evaluation

1. Lead exposure in last year?

-- If so, work related?

-- Blood test done?

2. TB exposure in last year?

-- Skin test done?

3. This employee has, has not (circle) been informed of the results of this medical examination

Typed or Printed Name of Physician

Signature

Date



## VOSH Medical Program – Employee History

Virginia Department of Labor and Industry

To be completed by Employee

### Present Information

Name: \_\_\_\_\_ Date of Birth (Yr., Mo., Day): \_\_\_\_\_ Date of Visit (Yr., Mo., Day): \_\_\_\_\_

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ Employer's Phone Number: \_\_\_\_\_

Type of Medical Examination: \_\_\_\_\_ Initial: ☐ Annual: ☐ Interim/Follow-up: ☐

Job Title: \_\_\_\_\_

Job Description: \_\_\_\_\_

Sex: ☐ F ☐ M

Social Security Number: \_\_\_\_\_

### Personal Physician

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Physician's Phone Number: \_\_\_\_\_

When were you last examined by him/her? \_\_\_\_\_

When was your last chest x-ray? \_\_\_\_\_ Result \_\_\_\_\_

### Past Medical History

List significant medical illnesses, and all hospitalizations.

| Illness or Condition | Hospitalization          |                          | Approximate Date(s) of Hospitalization |
|----------------------|--------------------------|--------------------------|----------------------------------------|
|                      | Yes                      | No                       |                                        |
| a. _____             | <input type="checkbox"/> | <input type="checkbox"/> |                                        |
| b. _____             | <input type="checkbox"/> | <input type="checkbox"/> |                                        |
| c. _____             | <input type="checkbox"/> | <input type="checkbox"/> |                                        |

### Privacy Act

In accordance with the Privacy Act of 1974 (Public Law No. 93-579, 5 U.S.C. 552a), you are hereby notified that:

Section 3301 of Title 5 to the U.S. Code authorizes collection of this information. The primary use of this information is to determine suitability of persons for service or assignments, report medical conditions required by law, and aid in preventive health care. The information becomes part of the Employee Medical Folder which is maintained and protected in accordance with DHRM Policy No.: 6.10, and VOSH Standard Part 1910 1020. These records are also protected by the Privacy Act of 1974 5 U.S.C. 552, §2.2-3705.5.1 of the Virginia Freedom of Information Act and are covered by DHRM Policy No.: 6.10, Employee Medical File System Records. The social security number is requested in order to more accurately identify and retrieve health care records of individuals. Providing the requested information is voluntary but failure to do so may result in the Department's inability to process application for employment or inability to determine suitability for employment. Without this information VOSH will not be able to determine if the employee can meet the physical requirements of the position.

**VOSH Medical Program – Employee History**

Virginia Department of Labor and Industry

Check Yes or No to answer each question and give specific information when asked.

| <b>Cardiovascular</b>    |                          |                                       | <b>Genitourinary</b>     |                          |                                                   |
|--------------------------|--------------------------|---------------------------------------|--------------------------|--------------------------|---------------------------------------------------|
| Yes                      | No                       |                                       | Yes                      | No                       |                                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur                          | <input type="checkbox"/> | <input type="checkbox"/> | Nephritis                                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina/Chest Pain                     | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease (Indicate Type) _____              |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack                          | <input type="checkbox"/> | <input type="checkbox"/> | Urinary Infection                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure                   | <input type="checkbox"/> | <input type="checkbox"/> | Kidney/Urinary Bladder Stones                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Vascular Disease in Arms/Legs         | <input type="checkbox"/> | <input type="checkbox"/> | Blood/Protein in Urine                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Other Heart Disorders (Specify) _____ | <input type="checkbox"/> | <input type="checkbox"/> | Venereal Disease                                  |
|                          |                          |                                       | <input type="checkbox"/> | <input type="checkbox"/> | Other Kidney or Bladder Disorders (Specify) _____ |
| <b>Gastrointestinal</b>  |                          |                                       | <b>Blood</b>             |                          |                                                   |
| Yes                      | No                       |                                       | Yes                      | No                       |                                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Peptic Ulcer                          | <input type="checkbox"/> | <input type="checkbox"/> | Anemia                                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Hiatal Hernia                         | <input type="checkbox"/> | <input type="checkbox"/> | Problems with blood clotting/bleeding             |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis                             | <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Gall Bladder Disease                  | <input type="checkbox"/> | <input type="checkbox"/> | Other Blood Disorders (Specify) _____             |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease/Jaundice                |                          |                          |                                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Cirrhosis                             |                          |                          |                                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Other Liver Disorders (specify) _____ |                          |                          |                                                   |
| <b>Skin</b>              |                          |                                       | <b>Eye</b>               |                          |                                                   |
| Yes                      | No                       |                                       | Yes                      | No                       |                                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Psoriasis                             | <input type="checkbox"/> | <input type="checkbox"/> | Require Corrective Lenses                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Eczema                                | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma                                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Contact Dermatitis                    | <input type="checkbox"/> | <input type="checkbox"/> | Cataracts                                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Other Skin Disorders (Specify) _____  | <input type="checkbox"/> | <input type="checkbox"/> | Optic Neuritis                                    |
|                          |                          |                                       | <input type="checkbox"/> | <input type="checkbox"/> | Eye Infection                                     |
|                          |                          |                                       | <input type="checkbox"/> | <input type="checkbox"/> | Other Eye Disorders (Specify) _____               |
| <b>Pulmonary</b>         |                          |                                       | <b>Nervous System</b>    |                          |                                                   |
| Yes                      | No                       |                                       | Yes                      | No                       |                                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Pneumonia                             | <input type="checkbox"/> | <input type="checkbox"/> | Seizure Disorder                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Pleurisy                              | <input type="checkbox"/> | <input type="checkbox"/> | Stroke                                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma                                | <input type="checkbox"/> | <input type="checkbox"/> | Peripheral Neuritis                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Bronchitis                            | <input type="checkbox"/> | <input type="checkbox"/> | Other Nervous Disorder (specify) _____            |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema                             |                          |                          |                                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Bronchiectasis                        |                          |                          |                                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis                          |                          |                          |                                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Silicosis                             |                          |                          |                                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Asbestosis                            |                          |                          |                                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Other Lung Disorder (Specify) _____   |                          |                          |                                                   |



## VOSH Medical Program – Employee History

Virginia Department of Labor and Industry

Check Yes or No to answer each question and give specific information when asked.

| Ear, Nose and Throat     |                          |                                                     | Musculoskeletal          |                          |                                                   |
|--------------------------|--------------------------|-----------------------------------------------------|--------------------------|--------------------------|---------------------------------------------------|
| Yes                      | No                       |                                                     | Yes                      | No                       |                                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Sinusitis                                   | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid Arthritis                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Impaired Hearing                                    | <input type="checkbox"/> | <input type="checkbox"/> | Other Injuries                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Ringling in the Ears                                | <input type="checkbox"/> | <input type="checkbox"/> | Back Injury                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Easy Nasal Bleeding                                 | <input type="checkbox"/> | <input type="checkbox"/> | Degenerative Disc Disease                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Nasal Allergies                                     | <input type="checkbox"/> | <input type="checkbox"/> | Sciatica/disc Herniation                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Tonsillectomy                                       | <input type="checkbox"/> | <input type="checkbox"/> | Bone lesions/infections                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Other Ear, Nose, Throat Disorder (Specify)<br>_____ | <input type="checkbox"/> | <input type="checkbox"/> | Other Musculoskeletal Disorder (specify)<br>_____ |

| General                  |                          |                             |                          |                          |                                                           |
|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|-----------------------------------------------------------|
| Yes                      | No                       |                             | Yes                      | No                       |                                                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Disease/Goiter      | <input type="checkbox"/> | <input type="checkbox"/> | Hernia (Specify Type) _____                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                    | <input type="checkbox"/> | <input type="checkbox"/> | Cancer (Specify Type) _____                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Gout                        | <input type="checkbox"/> | <input type="checkbox"/> | Dental/Gum Problems (Specify) _____                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Night Sweats/Fever | <input type="checkbox"/> | <input type="checkbox"/> | Other Conditions or Disease Not Listed (Specify)<br>_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemorrhoids                 |                          |                          |                                                           |

| Family History                                                                                                                           |       |                                                    |                          |                          |                                                                                                     |
|------------------------------------------------------------------------------------------------------------------------------------------|-------|----------------------------------------------------|--------------------------|--------------------------|-----------------------------------------------------------------------------------------------------|
| If any of your family noted in the following table has had any of the stated conditions, please indicate by the appropriate code number. | _____ | Allergy (Asthma, eczema, hay fever)                | Yes                      | No                       | Is your father still living? If "No" at what age did he die? What was the cause of death?<br>_____  |
|                                                                                                                                          | _____ | Blood Disease                                      | <input type="checkbox"/> | <input type="checkbox"/> |                                                                                                     |
|                                                                                                                                          | _____ | Cancer or Leukemia                                 |                          |                          |                                                                                                     |
|                                                                                                                                          | _____ | Cirrhosis                                          |                          |                          |                                                                                                     |
|                                                                                                                                          | _____ | Congenital malformation                            |                          |                          |                                                                                                     |
|                                                                                                                                          | _____ | Diabetes                                           |                          |                          |                                                                                                     |
|                                                                                                                                          | _____ | Emphysema                                          |                          |                          |                                                                                                     |
|                                                                                                                                          | _____ | Epilepsy (Seizers)                                 | Yes                      | No                       | Is your mother still living? If "No" at what age did she die? What was the cause of death?<br>_____ |
|                                                                                                                                          | _____ | Hypertension                                       | <input type="checkbox"/> | <input type="checkbox"/> |                                                                                                     |
|                                                                                                                                          | _____ | Kidney Disease                                     |                          |                          |                                                                                                     |
|                                                                                                                                          | _____ | Migraine Headaches                                 |                          |                          |                                                                                                     |
|                                                                                                                                          | _____ | Rheumatic Heart Disease                            |                          |                          |                                                                                                     |
|                                                                                                                                          | _____ | Sickle Cell Disease                                |                          |                          |                                                                                                     |
|                                                                                                                                          | _____ | Tuberculosis                                       |                          |                          |                                                                                                     |
|                                                                                                                                          | _____ | Other Disease Not Listed (Please Specify)<br>_____ |                          |                          |                                                                                                     |



## VOSH Medical Program – Employee History

Virginia Department of Labor and Industry

Check Yes or No to answer each question and give specific information when asked.

### General Health

Yes

No

☐☐

Have you been examined or treated by a doctor within the past year?

If "Yes" for what?

\_\_\_\_\_

Yes

No

☐☐

Have you had a Hepatitis B Vaccination?

Yes

No

☐☐

Have you lost more than five pounds within the last 6 months?

Yes

No

☐☐

Have you noticed any swelling or lumps in your breast, neck, armpits, groin or elsewhere during the past year?

If "Yes" specify site:

\_\_\_\_\_

Have you experienced the following signs/symptoms within the past year:

Yes

No

☐☐

Frequent headache/dizziness

☐☐

Frequent bowel problems (Constipation or diarrhea)

☐☐

Swelling of the lower extremities or eyelids

☐☐

Frequent shortness of breath, cough or morning phlegm

Indicate what you believe your health status is now:

☐☐

Excellent

☐☐

Good

☐☐

Fair

☐☐

Poor

### Hobbies

Do you have any present or past hobbies (e.g., arts/crafts, gunning, furniture refinishing) or home construction/gardening activities that may have exposed you to any hazard?

Yes

No

☐☐

If YES, specify activities and kind of material used:

### Tobacco Use

Yes

No

☐☐

Never smoked regularly

☐☐

Used to smoke regularly

How many years did you smoke? \_\_\_\_\_

How many packs did you smoke? \_\_\_\_\_

How long ago did you stop? \_\_\_\_\_

Yes

No

☐☐

Do you smoke now? \_\_\_\_\_

If "Yes", for how many years? \_\_\_\_\_

How many packs per day on average? \_\_\_\_\_

### Cigars/Pipe

Yes

No

☐☐

Ever Smoke?

### Alcohol Use

On the average, how much of the following do you drink per week?

Beer: \_\_\_\_\_ Cans

Wine: \_\_\_\_\_ Glasses

Whiskey/Liquor: \_\_\_\_\_ Jiggers

### Medication

Please indicate any medications you are taking. Include non-prescription medications, such as aspirin, laxatives, vitamins, etc.

### Reproductive History

Yes

No

☐☐

Have you or your spouse been unable to have children?

If "Yes" specify reason, if known: \_\_\_\_\_

Yes

No

☐☐

Have you ever had any children born with a handicap or congenital malformation?

If "Yes" specify: \_\_\_\_\_

### Allergies

Yes

No

☐☐

Are you allergic to anything you can think of?

If "Yes" specify: \_\_\_\_\_



## VOSH Medical Program – Employee History

Virginia Department of Labor and Industry

### Occupational History

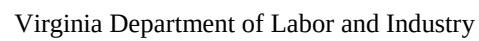
How long have you been in present job? \_\_\_\_\_ Years \_\_\_\_\_ Months

Indicate any job related illnesses or injuries you have experienced since working in present job.

Check Yes or No to answer each question and give specific information when asked.

In your work are you now, or have you been exposed to any of the following agents?

| Exposure                     | Present                  | Past                     | Exposure               | Present                  | Past                     |
|------------------------------|--------------------------|--------------------------|------------------------|--------------------------|--------------------------|
| Inorganic Fluorides          | <input type="checkbox"/> | <input type="checkbox"/> | Pesticides             | <input type="checkbox"/> | <input type="checkbox"/> |
| Lead                         | <input type="checkbox"/> | <input type="checkbox"/> | Bacteria or Viruses    | <input type="checkbox"/> | <input type="checkbox"/> |
| Benzene                      | <input type="checkbox"/> | <input type="checkbox"/> | Primate Animals        | <input type="checkbox"/> | <input type="checkbox"/> |
| Coke Oven Emissions          | <input type="checkbox"/> | <input type="checkbox"/> | Vibrating Tools        | <input type="checkbox"/> | <input type="checkbox"/> |
| Inorganic Arsenic            | <input type="checkbox"/> | <input type="checkbox"/> | Ionizing Radiation     | <input type="checkbox"/> | <input type="checkbox"/> |
| Methylene Chloride           | <input type="checkbox"/> | <input type="checkbox"/> | Non-Ionizing Radiation |                          |                          |
| Vinyl Chloride               | <input type="checkbox"/> | <input type="checkbox"/> | Glycol Ethers          | <input type="checkbox"/> | <input type="checkbox"/> |
| Toluene Diisocyanate         | <input type="checkbox"/> | <input type="checkbox"/> | Ethylene Oxide         |                          |                          |
| Excessive Noise              | <input type="checkbox"/> | <input type="checkbox"/> | Formaldehyde           | <input type="checkbox"/> | <input type="checkbox"/> |
| Nitrogen Oxides              | <input type="checkbox"/> | <input type="checkbox"/> |                        |                          |                          |
| Crystalline Silica           | <input type="checkbox"/> | <input type="checkbox"/> | Others                 |                          |                          |
| Nitric Acid                  | <input type="checkbox"/> | <input type="checkbox"/> |                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Ammonia                      | <input type="checkbox"/> | <input type="checkbox"/> |                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Beryllium                    | <input type="checkbox"/> | <input type="checkbox"/> |                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Phosgene                     | <input type="checkbox"/> | <input type="checkbox"/> |                        | <input type="checkbox"/> | <input type="checkbox"/> |
|                              |                          |                          |                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Allyl Chloride               | <input type="checkbox"/> | <input type="checkbox"/> |                        |                          |                          |
| Asbestos                     | <input type="checkbox"/> | <input type="checkbox"/> |                        |                          |                          |
| Suspect or Known Carcinogens | <input type="checkbox"/> | <input type="checkbox"/> |                        |                          |                          |

[illegible]

## **Appendix H**

### **VOSH Respirator Medical Evaluation Questionnaire**

Each employee whose job duties require the use of respiratory protection shall complete the Respirator Medical Evaluation Questionnaire as part of the Initial Medical Evaluation and when required as part of the Annual or Interim Medical Evaluation.

- All employees complete the respirator questionnaire through the first 4 lines of page 8, except questions 10-15 on page 4, and bring it to the MSCP Center on the day of the first appointment.
- Employees required to use a full-face respirator or SCBA must complete the entire respirator questionnaire including questions 10-15 on page 4.

# VIRGINIA DEPARTMENT OF LABOR AND INDUSTRY

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

**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? (select 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). Today's date \_\_\_\_\_

|               |                             |                          |
|---------------|-----------------------------|--------------------------|
| _____<br>Name | _____<br>Job Title          | _____<br>Telephone       |
| _____<br>Age  | Male/Female<br>(circle one) | _____<br>Height (ft, in) |
|               |                             | _____<br>Weight (lbs)    |

**For Clinic Staff Use Only: Please take blood pressure and check one of the choices below.**

|                          |                                                                                                                                                                                                                      |
|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| _____<br>Blood Pressure+ | <input type="checkbox"/> BP Normal. No action needed.                                                                                                                                                                |
|                          | <input type="checkbox"/> BP Elevated. Lifestyle modifications* recommended. Client advised to follow up with PCP.<br>(*Lifestyle modifications included; reduce weight, reduce sodium, reduce EtOH, DASH diet, etc.) |

Has your employer told you how to contact the health care professional who will review this questionnaire?  
(select one) Yes ☐ No ☐

**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
- |                                                       |                                                                    |
|-------------------------------------------------------|--------------------------------------------------------------------|
| <input type="checkbox"/> half-face                    | <input type="checkbox"/> Supplied-air (Air-in-Line)                |
| <input type="checkbox"/> full-face                    | <input type="checkbox"/> SCBA (Self-Contained Breathing Apparatus) |
| <input type="checkbox"/> PAPR (powered-air purifying) |                                                                    |

Have you worn a respirator (select 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 select "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?

Seizures (fits): Yes ☐ No ☐

Diabetes (sugar disease): Yes ☐ No ☐

Allergic reactions that interfere with your breathing: Yes ☐ No ☐

Claustrophobia (fear of closed-in places): Yes ☐ No ☐

Trouble smelling odors: Yes ☐ No ☐

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

|                                                     |                              |                             |
|-----------------------------------------------------|------------------------------|-----------------------------|
| Asbestosis:                                         | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Asthma:                                             | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Chronic bronchitis:                                 | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Emphysema:                                          | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Pneumonia:                                          | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Tuberculosis:                                       | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Silicosis:                                          | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Pneumothorax (collapsed lung):                      | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Lung cancer:                                        | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Broken ribs:                                        | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Any chest injuries or surgeries:                    | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Any other lung problem that you've been told about: | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

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

|                                                                                               |                              |                             |
|-----------------------------------------------------------------------------------------------|------------------------------|-----------------------------|
| Shortness of breath:                                                                          | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Shortness of breath when walking fast on level ground or walking up a slight hill or incline: | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Shortness of breath when walking with other people at an ordinary pace on level ground:       | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Have to stop for breath when walking at your own pace on level ground:                        | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Shortness of breath when washing or dressing yourself:                                        | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Shortness of breath that interferes with your job:                                            | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Coughing that produces phlegm (thick sputum):                                                 | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Coughing that wakes you early in the morning:                                                 | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Coughing that occurs mostly when you are lying down:                                          | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Coughing up blood in the last month:                                                          | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Wheezing:                                                                                     | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Wheezing that interferes with your job:                                                       | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Chest pain when you breathe deeply:                                                           | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Any other symptoms that you think may be related to lung:                                     | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

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

|                                                        |                              |                             |
|--------------------------------------------------------|------------------------------|-----------------------------|
| Heart attack:                                          | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Stroke:                                                | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Angina:                                                | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Heart failure:                                         | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Swelling in your legs or feet (not caused by walking): | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Heart arrhythmia (heart beating irregularly):          | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| High blood pressure:                                   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Any other heart problem that you've been told about:   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

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

|                                                                                    |                              |                             |
|------------------------------------------------------------------------------------|------------------------------|-----------------------------|
| Frequent pain or tightness in your chest:                                          | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Pain or tightness in your chest during physical activity:                          | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Pain or tightness in your chest that interferes with your job:                     | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| In the past two years, have you noticed your heart skipping or missing a beat:     | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Heartburn or symptoms that is not related to eating:                               | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Any other symptoms that you think may be related to heart or circulation problems: | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

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

|                             |                              |                             |
|-----------------------------|------------------------------|-----------------------------|
| Breathing or lung problems: | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Heart trouble:              | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Blood pressure:             | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Seizures (fits):            | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

**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.)**

|                 |                              |                             |
|-----------------|------------------------------|-----------------------------|
| Eye irritation: | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
|-----------------|------------------------------|-----------------------------|

Skin allergies or rashes:

Yes ☐

No ☐

Anxiety:

Yes ☐

No ☐

General weakness or fatigue:

Yes ☐

No ☐

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 10-15 below must be answered by every employee who has been selected to use either a **full-facepiece** respirator or a **self-contained breathing apparatus (SCBA)**. For employees who have been selected to use other types of respirators, answering these questions is voluntary.

**10. Have you ever lost vision in either eye (temporarily or permanently):**

Yes ☐

No ☐

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

Wear contact lenses:

Yes ☐

No ☐

Wear glasses:

Yes ☐

No ☐

Color blind:

Yes ☐

No ☐

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?**

Difficulty hearing:

Yes ☐

No ☐

Wear a hearing aid:

Yes ☐

No ☐

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?**

Weakness in any of your arms, hands, legs, or feet:

Yes ☐

No ☐

Back pain:

Yes ☐

No ☐

Difficulty fully moving your arms and legs:

Yes ☐

No ☐

Pain or stiffness when you lean forward or backward at the waist:

Yes ☐

No ☐

Difficulty fully moving your head up or down:

Yes ☐

No ☐

Difficulty fully moving your head side to side:

Yes ☐

No ☐

Difficulty bending at your knees:

Yes ☐

No ☐

Difficulty squatting to the ground:

Yes ☐

No ☐

Climbing a flight of stairs or a ladder carrying more than 25 lbs:

Yes ☐

No ☐

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 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:

| Substance/Conditions                                      | Description of exposure (only if Answer is yes) |                             |
|-----------------------------------------------------------|-------------------------------------------------|-----------------------------|
| Asbestos                                                  | Yes <input type="checkbox"/>                    | No <input type="checkbox"/> |
| Silica (e.g., in sandblasting)                            | Yes <input type="checkbox"/>                    | No <input type="checkbox"/> |
| Tungsten cobalt (e.g., grinding or welding this material) | Yes <input type="checkbox"/>                    | No <input type="checkbox"/> |
| Beryllium:                                                | Yes <input type="checkbox"/>                    | No <input type="checkbox"/> |
| Aluminum                                                  | Yes <input type="checkbox"/>                    | No <input type="checkbox"/> |
| Coal (for example, mining)                                | Yes <input type="checkbox"/>                    | No <input type="checkbox"/> |
| Iron:                                                     | Yes <input type="checkbox"/>                    | No <input type="checkbox"/> |
| Tin:                                                      | Yes <input type="checkbox"/>                    | No <input type="checkbox"/> |
| Dusty environments:                                       | Yes <input type="checkbox"/>                    | No <input type="checkbox"/> |
| Any other hazardous exposures:                            | Yes <input type="checkbox"/>                    | No <input type="checkbox"/> |

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) \*select "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 periods you are using the respirator(s), is your work effort:**

|                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| <b>Light</b> (less than 200 kcal per hour):<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                                                                                                                                                                        | If "yes", how long does this period last during the<br>average shift: _____ hrs. _____ mins. |
| <i>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</i>                                                                                                                                                                                                            |                                                                                              |
| <b>Moderate</b> (200 to 350 kcal per hour):<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                                                                                                                                                                        | If "yes", how long does this period last during the<br>average shift: _____ hrs. _____ mins. |
| <i>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 wheel barrow with a heavy load (about 100 lbs) on a level surface.</i> |                                                                                              |
| <b>Heavy</b> (above 350 kcal per hour):<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                                                                                                                                                                            | If "yes", how long does this period last during the<br>average shift: _____ hrs. _____ mins. |
| <i>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.).</i>                                                                                                           |                                                                                              |

**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 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 respirator(s) that may affect the safety and well-being of others (for example, rescue, security):

---

---

---

To the best of my knowledge, the information I have provided is true and accurate.

---

Employee Name

---

Date

---

Employee Signature

Employee Name: \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Date of birth: \_\_\_\_\_

Agency: \_\_\_\_\_ Work location: \_\_\_\_\_ Job title: \_\_\_\_\_

Supervisor's name: \_\_\_\_\_ Supervisor's phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Type of respirator use requested: \_\_\_\_\_ Disposable \_\_\_\_\_ Negative pressure (cartridge) \_\_\_\_\_ PAPR \_\_\_\_\_ Airliner \_\_\_\_\_ SCBA \_\_\_\_\_

**I. Basis for recommendations on respirator clearance:**

**Recommendations below on medical clearance for respirator use are based on a review of (check all that apply):**

- \_\_\_\_\_ Mandatory OSHA Respirator Medical Evaluation Questionnaire
- \_\_\_\_\_ Records of a medical examination on, including physical exam, done on: \_\_\_\_\_
- \_\_\_\_\_ Additional information supplied by employee's personal physician
- \_\_\_\_\_ Other information (specify): \_\_\_\_\_

**II. Recommendations on medical clearance for respirator use: (Choose A, B or C below)**

- ☐ The employee is given medical clearance to use the following respirator(s) under the conditions noted (Choose all that apply)

|                                                                                   |                                           |
|-----------------------------------------------------------------------------------|-------------------------------------------|
| N, R or P disposable respirator (filter-mask, non-cartridge type only)            | Supplied air (air line) respirator        |
| Negative pressure air-purifying (cartridge) respirator – either half or full-face | Self-contained breathing apparatus (SCBA) |
| Powered air purifying respirator (PAPR) – either half or full face                |                                           |

When using respirators, the employee is approved to perform the following (choose one)

- \_\_\_\_\_ Mild exertion low heat stress \_\_\_\_\_ Escape only
- \_\_\_\_\_ Moderate exertion \_\_\_\_\_ Normal job duties
- \_\_\_\_\_ Heavy exertion \_\_\_\_\_ Other Activity

**Mild exertion** (2-3 mets) e.g. lifting up to 10 lbs, extended walking on a flat surface, extended standing

**Moderate exertion** (4-5 mets) e.g. lifting 10 lbs., 5 lifts per min., fast walking (4 mph), gardening/digging, pushing, pulling

**Heavy exertion** (5-10 mets) e.g. jogging (10 min/mi), chopping wood, climbing hills, life-saving activities, fire fighting

**This respirator clearance expires (circle one) 1 2 3 4 5 years from the date below** (If not marked, clearance expires in 1 year)

- ☐ The employee is not given medical clearance for respirator use because **more information is needed** (Specify what is needed to make a decision)

- ☐ 1. A medical examination, including a physical exam \*is needed to make a decision\*
- \* - Please note the VOSH Medical Surveillance Health History and Physical Evaluation forms for this
- ☐ 2. The following additional information is needed for review (specify what): \_\_\_\_\_

- ☐ The employee is not given medical clearance for respirator use because **of the health problems as noted below** (Choose one below)

- ☐ 1. A temporary health problem (which should be reevaluated in \_\_\_\_\_ months)
- ☐ 2. A health problem that appears permanent (routine re-evaluation is not needed)

Examiner Reviewer Name (Print) \_\_\_\_\_

Phone number for questions \_\_\_\_\_

Examiner Review Signature \_\_\_\_\_

Date \_\_\_\_\_

Print Health Center Stamp above

## **Appendix I**

### **Audiogram History/Report and Sample Notification Letters**

- Each employee shall complete the Audiogram History/Report lines A. through D. and bring it to the MSCP Center on the day of the first appointment.
- A copy of the audiogram results will be provided to the employee and the Division of Human Resources.

## Virginia Department of Labor and Industry

Audiogram History / Report

Baseline [ ]

Annual [ ]

Retest [ ]

## A. Identification:

|                       |  |            |   |              |                   |            |
|-----------------------|--|------------|---|--------------|-------------------|------------|
| Last name             |  | First name |   | MI           | Social Security # |            |
| Date of birth         |  | /          | / | Sex          | M                 | F          |
| Mo                    |  | Date       |   | Yr.          |                   | Circle one |
| Length of time on job |  | months     |   | yrs.         |                   |            |
| Job title             |  |            |   | Job location |                   |            |

## B. Noise Exposure: (check all that apply) Steady [ ] Intermittent [ ] Impulse [ ]

Source of Noise \_\_\_\_\_ Estimated hours per day exposed \_\_\_\_\_

Time since most recent noise exposure: Hours \_\_\_\_\_ Days \_\_\_\_\_

Duration of most recent noise exposure: Hours \_\_\_\_\_ Days \_\_\_\_\_

## Other Noise Exposure: (check all that apply)

|                        |     |                 |     |
|------------------------|-----|-----------------|-----|
| Prior military service | [ ] | Loud music      | [ ] |
| Firearms               | [ ] | Motor cycles    | [ ] |
| Power tools            | [ ] | Heavy machinery | [ ] |

## C. Protective Equipment Used: Ear plugs [ ] Ear muffs [ ] Canal Caps [ ] Other [ ]

Type \_\_\_\_\_

How often do you wear this equipment: Always [ ] Sometimes [ ] Rarely [ ] Never [ ]

## D. Medical history: (check all that apply)

|                                     |     |                                       |             |
|-------------------------------------|-----|---------------------------------------|-------------|
| History of hearing loss             | [ ] | History of ringing in ears            | [ ]         |
| Family history of hearing loss      | [ ] | History of recurrent impacted ear wax | [ ]         |
| History of recurrent ear infections | [ ] | History of wearing hearing aid        | R [ ] L [ ] |
| History of head injury              | [ ] | Current cold, flu or allergy symptoms | [ ]         |

Comments: \_\_\_\_\_

TO BE COMPLETED BY PHYSICIAN OR NURSE/TECHNICIANE. Physical examination of ear: Left \_\_\_\_\_  
Right \_\_\_\_\_

## F. Education: (the following was discussed with the employee)

|                        |     |                               |     |
|------------------------|-----|-------------------------------|-----|
| Causes of hearing loss | [ ] | Types of ear protectors       | [ ] |
| How to protect hearing | [ ] | Importance of hearing program | [ ] |

## G. Assessment: (check one)

|                                                                |     |
|----------------------------------------------------------------|-----|
| Normal audiogram                                               | [ ] |
| Abnormal audiogram with no change from baseline ( R / L )      | [ ] |
| Standard threshold shift or other significant change ( R / L ) | [ ] |

## H. Recommendations: (check all that apply)

|                         |     |                         |     |                          |     |
|-------------------------|-----|-------------------------|-----|--------------------------|-----|
| Continue annual testing | [ ] | Repeat manual audiogram | [ ] | Refer to Audiologist/ENT | [ ] |
|-------------------------|-----|-------------------------|-----|--------------------------|-----|

Nurse/Technician \_\_\_\_\_  
(print name) (signature) (title) (date)Physician \_\_\_\_\_  
(print name) (signature) (date)

Remarks: \_\_\_\_\_

Health Center Stamp Here

AUDIOMETER CALIBRATION (Re:1910.95, Occupational Noise Standard)

Daily Biological/Functional Check [1910.95(h)(5)(1)]: Completed Yes [ ] No [ ]

Calibration Dates: Acoustic: [1910.95(h)(5)(ii)]

Exhaustive: [1910.95(h)(5)(iii)]

Date:

Dear \_\_\_\_\_:

Attached you will find a copy of the results of your recent audiogram, was performed by or under the direction of Federal Occupational Health Services for your employer. Based on this audiogram, your hearing appears to be:

1. \_\_\_\_\_ **Normal: No hearing threshold level over 25 db\* and no Standard Threshold Shift\*\*.** Continue to wear proper hearing protection on and off the job in noisy environments\*\*\*.
2. \_\_\_\_\_ **Abnormal, and no prior audiograms are available for comparison.** Your test results are outside the normal range, and this audiogram will be used for future comparison as your baseline unless a prior audiogram from your current employer becomes available. Continue to have audiograms annually, and wear hearing protection on and off the job in noisy environments\*\*\*.
3. \_\_\_\_\_ **Abnormal: Hearing loss is present, but there is not a new Standard Threshold Shift\*\* from your most recent baseline audiogram.** Continue to have audiograms annually, and wear hearing protection on and off the job in noisy environments\*\*\*.
4. \_\_\_\_\_ **Abnormal: Hearing loss is present, and there has been a new Standard Threshold Shift\*\*.** Your hearing results **have changed significantly** from your most recent baseline audiogram. A repeat audiogram should be performed within 30 days, if this has not already been done. It is important that you wear proper hearing protection on and off the job in noisy environments\*\*\*. It also is important that you be fitted, or refitted, with proper hearing protection, and be trained, or retrained, in its use.
5. \_\_\_\_\_ Due to the results of the hearing test, **a complete hearing evaluation is recommended by a specialist** (an ear, nose and throat physician, or an audiologist) **within 2-4 weeks.** Please bring the attached audiogram and history form to your appointment, and NOTE that this evaluation will be at your own expense (though it may be covered by your medical insurance policy) unless the hearing loss is determined to be work-related after a formal claim is presented by you to the Office of Workers' Compensation.

6. Other Comments:

\_\_\_\_\_  
Printed Name (reviewer)

\_\_\_\_\_  
Signature (reviewer)

**\*db** =decibel, a standardized unit of sound measurement.

**\*\* STS = Standard Threshold Shift** is a term used to identify a **change** in the hearing threshold level (relative to the baseline audiogram) of an **average** of 10 db or more at frequencies of 2000, 3000, and 4000 hertz, in either ear.

**\*\*\* A "noisy environment"** is one where two people standing about three feet apart must raise their voices above the normal level in order to be heard.

Date:

Dear \_\_\_\_\_:

VOSH regulations mandate that employers are to provide hearing protection and noise monitoring when workplace noise levels exceed an 8-hour time-weighted average (TWA) of 85 decibels. Part of administering an effective hearing conservation program is performing baseline and annual audiograms for those employees who may be exposed to such high levels of noise. The purpose of such audiograms is to establish baseline hearing levels and to identify employees who experience hearing loss, particularly if severe enough to represent a Standard Threshold Shift (STS). An STS is defined by VOSH as "... a change in the hearing threshold relative to the baseline audiogram of an average of 10 decibels or more at 2000, 3000 and 4000 hertz, in either ear ." If an audiogram appears to show an STS, it may be repeated within 30 days, with the results of the repeat audiogram recorded as the annual audiogram.

\_\_\_\_\_ The employee named below just received the first documented audiogram. This is considered a baseline, and will be used for comparison purposes in subsequent years.

\_\_\_\_\_ The employee named below was found to have no STS on the most recent audiogram, when compared to his/her baseline audiogram (the employee's hearing may either be normal, or there may be a prior hearing loss that has not progressed significantly since the current reference baseline). Recommendations have been or will be made to the employee regarding the use of hearing protection.

\_\_\_\_\_ The employee named below either had a confirmed (i.e., repeated) STS or, if a repeat audiogram could not be conducted, the annual audiogram appears to show an STS. The STS may be work-related or aggravated by occupational noise exposure. Per VOSH regulations, when an STS has been established, the employer is to ensure that the following steps are taken.

- 1) The employee is to be informed of the STS. The MSCP has done this for you, in writing.
- 2) The employer is to fit (or refit) and train (or retrain) the employee in the use and care of hearing protectors and provide hearing protectors with greater attenuation, if necessary. You may provide this service or the MSCP can provide it for you. Employees with an STS are to be required to use these hearing protectors in noisy environments.
- 3) The employer is to refer the employee for any necessary further clinical evaluation. Please note that we have already made, or will make, appropriate referral recommendations to the employee for you, in writing.

\_\_\_\_\_ In addition to having an STS, the employee named below has a hearing loss that must be recorded on the OSHA 300 log (the employee has an STS and an average hearing threshold at 2000, 3000, and 4000 Hz in one or both ears that is 25 dB or greater).

NAME

AUDIOGRAM DATE

If you have any questions, please feel free to contact the occupational health clinic or feel free to call me at ( \_\_\_\_\_ ) \_\_\_\_\_

\_\_\_\_\_  
Printed Name (Reviewer)

\_\_\_\_\_  
Signature (Reviewer)