Union Center Fire Company, Inc.

PO Box 8800 Endicott, NY 13762-8800

Business: 607-748-1321 • Fax: 607-953-4273

November 22, 2016

We are using Lourdes Occupational Health Services at 3101 Shippers Road in Vestal (behind Lowes) for our physicals. Call (607) 251-2170 to make an appointment, and tell them you need a firefighter physical for the Union Center Fire Company.

Contact Wes or Bob to get an Employer Authorization letter that will list the services that will be performed during your physical. Everyone receives a hearing test and bloodwork. You should fast for 10-12 hours before the physical so that the bloodwork is accurate. If you are age 40+, you will get an EKG. In addition, you will have the option of receiving a hepatitis B vaccination. If you are an EMS member, you will be offered a TB/PPD test. If you are planning to wear SCBA at any time, you will also get a pulmonary function test.

If you are a new member, you must have a physical before you can participate in training or calls.

Fill out the following forms and bring them to your appointment, along with the Employer Authorization letter. If you save this PDF file to your computer, you will be able to type the information into the fillable forms before you print them. If you are not planning to wear SCBA at any time, you don't need to fill out the Respirator Medical Evaluation Questionnaire (3 pages), so you can discard those sheets.

Enter the building at the WALK-IN entrance facing Sam's Club. The door for Occupational Health, Suite 101 will be on your left.

Clear Form Print

LOURDES
Occupational Health Services
3101 Shippers Road, Suite 101
Vestal, NY 13850
607-251-2170 Fax 607-251-2012

Authorization for the Release of Information

Name (print):_____
Last First Middle initial

Address (print): _____
Street City and State Zip code

Phone: (_____)_____ Date of Birth:_____

Provider releasing information: Lourdes Occupational Health, 169 Riverside Drive, Binghamton, NY 13905

Requestor: Union Center Fire Company, Inc.
Employer or potential employer name

Reason for release of information: Determination of fitness for duty

_____

Your health information that is used or released under this Authorization may be subjective to re-disclosure by the recipient, and the privacy of your health information will no longer be protected by law.

This authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire one month from the date signed.

By signing this authorization, you acknowledge that you have read and understand it. Further, you authorize the release of your health information in accordance with the terms of this authority to a duly authorized representative of your employer or potential employer.

Lourdes may not condition treatment based on you signing this authorization except if:

1. Treatment is a part of a research study or
2. Health care is solely for creating health information to be shared with a third party (e.g. drug testing required by employer).

I understand that the results of these tests will be solely to determine my fitness for employment or my fitness for the job in which I am applying. I further understand that the results of any testing performed will be disclosed only to my employer or to the potential employer to whom I am submitting an application for employment.

The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____
Signature Date

Or: _____ _____
Signature of legal representative Date

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Occupational Health Services
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607-251-2170 Fax 607-251-2012

Patient Health History

Name: _____ Date of birth: _____ ID #: _____
Employer: Union Center Fire Company, Inc. Position: _____

Emergency Data:
Contact: _____Relationship: _____ Phone number: _____
Primary Care Provider: _____ Date of last visit: _____

History of past and present conditions-please check only those that apply to you

☐ 1. Allergies	☐ 13. Fractures	☐ 25. Narcotic or recreational drug use
☐ 2. Asthma	☐ 14. Heart trouble	☐ 26. Surgeries/procedures
☐ 3. Arthritis	☐ 15. Head injuries	☐ 27. Rheumatic fever
☐ 4. Back injuries	☐ 16. Hernia	☐ 28. Serious skin problems
☐ 5. Bladder problems	☐ 17. High blood pressure	☐ 29. Serious infectious disease (TB, Hepatitis, etc.)
☐ 6. Blood disease	☐ 18. Hospitalizations	☐ 30. Stomach problems
☐ 7. Chronic back pain	☐ 19. Injuries	☐ 31. Stroke
☐ 8. Diabetes	☐ 20. Jaundice	☐ 32. Thyroid disease
☐ 9.Emotional illness	☐ 21. Kidney disease	☐ 33. Chicken pox/shingles
☐ 10. Epilepsy/seizures	☐ 22. Lung disease	☐ 34. Other _____
☐ 11. Exposure to chemicals, dust, noise, fumes	☐ 23. Mental illness	
☐ 12. Fainting	☐ 24. Missing appendages (fingers, toes, arm, etc.)	

For any condition checked above, please explain: _____
_____
_____
_____
_____

Staff comments:_____
_____
_____
_____
_____
_____

Describe any other medical problems:
History of neck, back, shoulder, knee problems: ☐ Yes ☐ No
History of carpal tunnel problems (numbness, tingling of hands): ☐ Yes ☐ No

Female patients only:
Last menstrual period: _____ Is there any possibility you are pregnant? ☐ Yes ☐ No

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Name: _____ DOB: _____

Do you take any prescription medications on a regular basis? ☐ Yes ☐ No
If yes, please list_____
_____

Do you take any over-the counter medications on a regular basis? ☐ Yes ☐ No
If yes, please list _____
Are you allergic to any foods, medications, or environmental items? ☐ Yes ☐ No
If yes, please list _____

Are you addicted to, or habitually use (prescription r otherwise), depressants, stimulants, narcotics, alcohol, or other substances that could alter your behavior? ☐ No ☐ Yes _____
Do you smoke? ☐ No ☐ Yes- How much? _____ How long?_____
Are you a former smoker? ☐ No ☐ Yes- When did you quit?_____
Do you drink alcohol? ☐ No ☐ Yes- How much?_____ How often?_____
Do you use recreational drugs? ☐ Yes ☐ No
Do you participate in a regular exercise program? _____
Do you wear a seatbelt? ☐ Yes ☐ No
Do you have working smoke alarms and carbon monoxide detector? ☐ Yes ☐ No
What are your hobbies? _____

Have you ever, currently or in the past, had a work related injury or illness? ☐ Yes ☐ No
If yes, please explain: _____
Have you ever, in the past or currently, collected disability or worker's compensation? ☐ Yes ☐ No
If yes, explain: _____
When was your last tetanus shot? _____

Occupational work history:

	Employer	Date	Job description
1.			
2.			
3.			

The following statement to be signed by the applicant: I, the undersigned, hereby certify that all the information I have furnished on this form is true and correct. I willingly submit to any required tests necessary to complete the examination.

Applicant signature:_____ Date: _____

Reviewed by Occupational Health Staff: _____ Date: _____

Provider Signature: _____ Date: _____

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AUDIOMETRIC TEST
PERSONAL DATA SHEET

1) NAME: _____

2) SOC. SECURITY #: _____- _____ - _____

3) DATE OF BIRTH: _____ **SEX: MALE** ☐ **FEMALE** ☐

4) EMPLOYER OR ORGANIZATION FOR WHICH YOU ARE BEING TESTED FOR TODAY: Union Center Fire Company, Inc.
JOB TITLE: _____

5) DO YOU NORMALLY WEAR HEARING PROTECTION SUCH AS EARPLUGS/MUFFS IN HIGH LEVEL SOUND SITUATIONS? **YES** ☐ **NO** ☐

6) ARE YOU FREQUENTLY EXPOSED TO HIGH LEVEL SOUNDS SUCH AS:

a) CHAIN SAWS **YES** ☐ **NO** ☐
b) CONSTRUCTION EQUIPMENT **YES** ☐ **NO** ☐
c) ROCK MUSIC **YES** ☐ **NO** ☐
d) MANUFACTURING EQUIP/MACHINES **YES** ☐ **NO** ☐
e) OTHER NOISE SOURCES **YES** ☐ **NO** ☐
PLEASE DESCRIBE: _____
_____

7) HAVE YOU BEEN EXPOSED TO HIGH LEVEL SOUNDS, SUCH AS THOSE LISTED ABOVE WITHIN THE LAST 14 HOURS WHILE YOU WERE NOT WEARING SOUND PROTECTION DEVICES? **YES** ☐ **NO** ☐
IF YES, APPROXIMATELY HOW LONG WERE YOU EXPOSED: _____
IF YES, HOW MANY HOURS HAVE LAPSED SINCE YOUR LAST UNPROTECTED EXPOSURE TO THESE LEVELS? _____

8) HAVE YOU EVER HAD A HEARING TEST? **YES** ☐ **NO** ☐

9) WERE YOU EVER TOLD THAT YOU NEEDED A HEARING AID? **YES** ☐ **NO** ☐

10) DO YOU USUALLY EAR A HEARING AID? **YES** ☐ **NO** ☐

_____ _____
SIGNATURE **DATE**

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Respirator Medical Evaluation Questionnaire-Part A
The information provided is CONFIDENTIAL.

The following information must be provided by every employee who has been selected to use any type of respirator **(please print).**

1. Your name: _____2. Date of birth:_____
3. Sex (circle one): Male/Female 4. Height: _____ft. _____ in. 5. Your weight: _____lbs.
6. Your job title: _____7. Company/Department Union Center Fire Company, Inc. _____
8. A phone number where you can be reached by the health care professional who reviews this questionnaire:
(daytime)_____ (evening) _____

9. Check the type of respirator you will use (you can check more than one category):
   a. ☐ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
   b. ☐ Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self contained breathing apparatus) _____

10. Have you worn a respirator (circle one): Yes/No
   If "yes," what type(s):_____

Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please circle "yes" or "no").

If you answer yes to any question, please provide date of diagnosis, duration, list of medications or last episode in the comment section at the end of this questionnaire.

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

2. Have you **ever had** any of the following conditions?
   a. Seizures (fits): Yes/No
   b. Diabetes (sugar disease): Yes/No
   c. Allergic reactions that interfere with your breathing: Yes/No
   d. Claustrophobia (fear of closed-in places): Yes/No
   e. Trouble smelling odors: Yes/No

3. Have you **ever had** any of the following pulmonary or lung problems?
   a. Asbestosis: Yes/No
   b. Asthma: Yes/No
   c. Chronic bronchitis: Yes/No
   d. Emphysema: Yes/No
   e. Pneumonia: Yes/No
   f. Tuberculosis: Yes/No
   g. Silicosis: Yes/No
   h. Pneumothorax (collapsed lung): Yes/No
   i. Lung cancer: Yes/No
   j. Broken ribs: Yes/No
   k. Any chest injuries or surgeries: Yes/No
   l. Any other lung problem that you've been told about: Yes/No

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Name: _____ DOB: _____

4. Do you **currently** have any of the following symptoms of pulmonary or lung illness?
   a. Shortness of breath: Yes/No
   b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: Yes/No
   c. Shortness of breath when walking with other people at an ordinary pace on level ground: Yes/No
   d. Have to stop for breath when walking at your own pace on level ground: Yes/No
   e. Shortness of breath when washing or dressing yourself: Yes/No
   f. Shortness of breath that interferes with your job: Yes/No
   g. Coughing that produces phlegm (thick sputum): Yes/No
   h. Coughing that wakes you early in the morning: Yes/No
   i. Coughing that occurs mostly when you are lying down: Yes/No
   j. Coughing up blood in the last month: Yes/No
   k. Wheezing: Yes/No
   l. Wheezing that interferes with your job: Yes/No
   m. Chest pain when you breathe deeply: Yes/No
   n. Any other symptoms that you think may be related to lung problems: Yes/No

OHS use only

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

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

7. Do you **currently** take medication for any of the following problems?
   a. Breathing or lung problems: Yes/No
   b. Heart trouble: Yes/No
   c. Blood pressure: Yes/No
   d. Seizures (fits): Yes/No

8. If you've used a respirator, have you **ever had** any of the following problems?
   a. Eye irritation: Yes/No
   b. Skin allergies or rashes: Yes/No
   c. Anxiety: Yes/No
   d. General weakness or fatigue: Yes/No

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Name: _____ DOB: _____

e. Any other problem that interferes with your use of a respirator: Yes/No

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: Yes/No Comments: _____
_____

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

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

11. Do you currently have any of the following vision problems?
    a. Wear contact lenses: Yes/No
    b. Wear glasses: Yes/No
    c. Color blind: Yes/No
    d. Any other eye or vision problem: Yes/No

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

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

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

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

Signature: _____ Date: _____

Reviewed by: _____Date:_____
Cleared□
Follow-up required□_____

For clinician use only: Part B completed? Yes/No

LOURDES
Occupational Health Services
169 Riverside Drive
Binghamton, NY 13905
607-798-5003
Fax 607-798-5008

Name:_____
DOB: _____

Consent/Declination Form for Recombivax (Hepatitis B) Vaccination

Lourdes Hospital provides this vaccine at no charge, to protect associates considered to be at particular risk for hepatitis B. Hepatitis B can be a mild illness or one which is life threatening. After initial infection, chronic forms of this infection can develop, which may result in chronic liver inflammation, cirrhosis, liver failure, liver cancer, and death.

This vaccination has been widely tested and used. It is considered to be quite safe and effective if properly used. Three doses, appropriately timed, are required to give the protection sought. The degree of protection is high, but older people are less responsive to the vaccine. The need for booster doses in later years is still being defined. The vaccine cannot cause hepatitis B, but it may not prevent hepatitis B if you are already infected with the virus. The vaccine is made in yeast cultures; and is not contaminated by human blood. It cannot transmit other diseases such as AIDS.

The safety in pregnancy is not known; if you may be pregnant, contemplating pregnancy in the next 6 months, or you are nursing, the vaccine should not be given unless it is strongly indicated.

Side effects of the vaccine are few. You may develop local soreness or redness at the injection site. You may develop a low grade fever, aches, or fatigue. These should disappear within a few days. Guillain-Barre syndrome is a rare illness which has been associated with some types of vaccination, but which has not been shown to occur more frequently with this vaccine.

Previous severe allergic reaction to this vaccine is reason enough not to receive further doses.

[ ] Consent for vaccination

I consent to receive the 3 recommended doses of Recombivax hepatitis B vaccine. Any questions I have about this vaccine have been answered to my satisfaction. I believe that I understand the benefits and risk of vaccination, and all three doses must be received in order to have the best chance of protection. I understand however, that such protection is not guaranteed, nor is there any guarantee that I will not have an adverse effect from the vaccine. I also understand that, if I leave Lourdes Hospital service during the immunization period, I will be responsible for obtaining any remaining doses of vaccine, and that Lourdes responsibility will be limited to providing a record of any immunizations to date.

_____ _____
Associate signature Date

_____
Witness signature

LOURDES
Occupational Health Services
169 Riverside Drive
Binghamton, NY 13905
607-798-5003
Fax 607-798-5008

Name:_____
DOB: _____

[ ] Refusal of Hepatitis B Vaccine

I have read the hepatitis B vaccination information sheet and have had any questions satisfactorily answered by the Occupational Health Nurse or Practitioner/Physician. At this time, I choose not to have this immunization. I realize that the risk of not vaccinating includes susceptibility to hepatitis B infection, which can cause severe illness and death. I realize, too, that I may reconsider this choice at any time.

_____ _____
Associate signature Date

_____
Witness signature

[ ] Declining series, have had in the past

I have discussed my vaccination status with the Occupational Health Nurse or Practitioner/Physician. I have received the series of three hepatitis B vaccinations in the past. At this time I do not have record of the series and am declining to receive vaccination.

_____ _____
Associate signature Date

_____
Witness signature