MEDCARE OCCUPATIONAL HEALTH

31047 State Highway 100 · Los Fresnos, TX 78566
+1 956-233-2103 · medcareocc@gmail.com

PATIENT ID / RECORD # _____

Occupational Health Examination Packet

FORM PKT-01

PRE-PLACEMENT · ANNUAL · RETURN-TO-WORK · RESPIRATOR CLEARANCE

EMPLOYEE NAME		SSN / EMPLOYEE ID
COMPANY / EMPLOYER		JOB TITLE
DATE OF SERVICE	LOCATION / JOB #	EXAM TYPE ☐ Pre-Placement ☐ Annual ☐ Return-to-Work ☐ Other

PACKET CONTENTS

#	FORM	FORM #	COMPLETED BY	✓
01	Regulatory & Medical Surveillance Authorization (2 pages)	MC-110	Employer	☐
02	Patient Registration & Consent for Evaluation	MC-100	Employee	☐
03	Consent / Authorization for Disclosure of PHI	MC-101	Employee	☐
04	Medical History Questionnaire	MC-102	Employee	☐
05	Orthopedic History Questionnaire	MC-103	Employee	☐
06	Physical Examination	MC-104	Provider	☐
07	OSHA Respirator Medical Evaluation (4 pages)	MC-105	Employee	☐
08	Pulmonary Function Testing Report	MC-106	Provider	☐
09	Audiogram	MC-107	Provider	☐
10	Respirator Fit Test Record	MC-108	Provider	☐
11	Return to Work / School Release	MC-109	Provider	☐

BEFORE YOU BEGIN

- Complete every page. Do not detach pages — this packet is scanned and filed as a single record.
- Print clearly in blue or black ink. Answer every question; enter “N/A” where one does not apply.
- Employee forms must be signed and dated by the employee; provider forms by the examining clinician.
- The OSHA respirator questionnaire is confidential. Your employer or supervisor may not review your answers — return it directly to MedCare.
- Questions? Call MedCare Occupational Health at +1 956-233-2103 or email medcareocc@gmail.com.

FOR MEDCARE USE ONLY

RECEIVED BY	DATE RECEIVED	PACKET COMPLETE ☐ YES ☐ NO
REVIEWING PROVIDER	CLEARANCE DETERMINATION	

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PATIENT ID / RECORD # _____

Authorization for Regulatory & Medical Surveillance Exams

FORM MC-110

PHOTO ID REQUIRED The patient must present photo identification at the time of service.

EMPLOYER RESPONSIBILITY OSHA requires the employer to supply all of the information below to the licensed health care professional before the medical evaluation is performed. If a prior examination was not performed by MedCare, attach the records the employer holds — such as a written medical opinion letter from the outside clinician — and complete questions 1 through 4.

EMPLOYEE & EMPLOYER

PATIENT NAME | DATE OF BIRTH | JOB TITLE

EMPLOYER NAME

EMPLOYER ADDRESS

CONTACT NAME | CONTACT PHONE | CONTACT EMAIL

AUTHORIZATION

I authorize MedCare Occupational Health PLLC to perform the medical services checked below.

AUTHORIZER'S SIGNATURE | AUTHORIZATION DATE

RESPONSIBLE FOR PAYMENT ☐ Employer ☐ Third Party Administrator ☐ Staffing Agency ☐ Patient

TPA NAME | STAFFING AGENCY NAME

SERVICES AUTHORIZED

RESPIRATORY PROTECTION	☐ Respirator Clearance Exam
RESPIRATOR FIT TESTING	☐ Qualitative (QLFT) ☐ Quantitative (QNFT) *If fit testing is requested **without** a respirator clearance exam, complete the following:* Respirator clearance date: _____ ☐ MedCare provided the respirator clearance ☐ Another health care provider performed the clearance exam — results attached Any change in the employee's job, mask used, or work environment since the prior clearance? ☐ YES ☐ NO

MEDICAL SURVEILLANCE

EXAM REASON ☐ Baseline ☐ Baseline Follow-Up ☐ Periodic ☐ Biologic Monitoring ☐ Exit

EXPOSURE TYPE(S)

☐ Arsenic	☐ Ethylene Oxide	☐ Pesticides
☐ Asbestos	☐ Formaldehyde	☐ Silica
☐ Benzene	☐ Hexavalent Chromium	☐ Hearing / Noise
☐ Beryllium	☐ Lead	☐ Firefighter
☐ Cadmium	☐ Mercury	☐ Hazardous Waste Operator
☐ Diacetyl	☐ Methylene Chloride	☐ Multiple Exposures

Other exposure: _____

☐ Information from previous medical examinations that is not otherwise available to the examining clinician is attached — for example biologic monitoring results such as lead, cadmium or mercury levels.

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Authorization for Regulatory & Medical Surveillance Exams

FORM MC-110

FIRST NAME	LAST NAME	DATE OF BIRTH	TODAY'S DATE

1. RESPIRATOR TYPE, WEIGHT, FREQUENCY & DURATION OF USE

☐ Air purifying (non-powered)	☐ N95 mask	☐ Closed circuit SCBA	☐ Supplied air
☐ Combination air-line / SCBA	☐ Air purifying (powered)	☐ Dust mask	☐ Half face with canisters
☐ Open circuit SCBA	☐ Continuous flow	☐ Atmosphere supplying	☐ Full face with canisters

☐ Respirator is not used Other: _____

WEIGHT OF RESPIRATOR(S) IN USE	FREQUENCY OF USE	DURATION OF EACH USE
	_____ per ☐ Day ☐ Week ☐ Month ☐ Emergency ☐ Escape only	_____ ☐ Minutes ☐ Hours

2. OTHER PERSONAL PROTECTIVE EQUIPMENT TO BE USED

☐ Safety glasses / goggles	☐ Hearing protection	☐ Gown	☐ Fire resistant clothing
☐ Steel toed shoes / boots	☐ Gloves	☐ Chemical resistant suit	

Other PPE: _____

3. WORK ENVIRONMENT & EXPECTED PHYSICAL EFFORT

WORK ENVIRONMENT (CHECK ALL THAT APPLY)

☐ Indoor	☐ Outdoor	☐ Hot	☐ Heights / scaffolding
☐ Dusty	☐ Cold	☐ Humid	☐ Enclosed places / pits

MOST COMMON EXPECTED PHYSICAL EFFORT

☐ Light (0–10 lbs)	☐ Moderate (10–25 lbs)	☐ Heavy (25–50 lbs)	☐ Very heavy (over 50 lbs)

4. EXPOSURES, APPLICABLE OSHA STANDARDS, DURATION & LEVEL

EXPOSURE(S)	APPLICABLE OSHA STANDARD	DURATION & FREQUENCY	ANTICIPATED EXPOSURE LEVEL
e.g. lead, silica, asbestos	*e.g. 29 CFR 1926.1101*	*hours per day / week / month*	*greater than which of the below?*
			☐ Action Level ☐ PEL ☐ Company guideline ☐ Unknown
			☐ Action Level ☐ PEL ☐ Company guideline ☐ Unknown
			☐ Action Level ☐ PEL ☐ Company guideline ☐ Unknown
			☐ Action Level ☐ PEL ☐ Company guideline ☐ Unknown

PEL = permissible exposure limit.

EMPLOYER CERTIFICATION

By signing below I authorize MedCare Occupational Health PLLC to perform the medical services requested on this form. Regulated examinations will be conducted to at least the minimum federal and state requirements, which may include additional testing specified in the applicable OSHA standard.

Under OSHA, the employer is responsible for determining which medical surveillance is required based on the industry, exposure types and exposure levels, for selecting appropriate protective equipment, and for maintaining exam records for each employee. MedCare will conduct the examinations, establish baseline and periodic testing values, and issue written medical opinions to the employee and employer at the completion of the evaluation.

COMPANY SAFETY REPRESENTATIVE NAME	TELEPHONE NUMBER

SIGNATURE OF COMPANY SAFETY REPRESENTATIVE	DATE

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PATIENT ID / RECORD # _____

Patient Registration & Consent for Evaluation

FORM MC-100

PATIENT INFORMATION

PATIENT NAME	DRIVER LICENSE #
DATE OF BIRTH	GENDER ☐ Male ☐ Female
HOME ADDRESS	CITY, STATE, ZIP
PHONE #	EMAIL
EMERGENCY PHONE #	BARCODE / CHAIN OF CUSTODY #

REASON FOR VISIT

SERVICES REQUESTED

☐ Urine Drug Test **(UDT)**	☐ Pre-Employment Physical Examination **(PEP)**
☐ Hair Follicle Drug Test **(HFDT)**	☐ DOT Physical Examination **(DOT PE)**
☐ Oral Fluid Drug Test **(OFDT)**	☐ Non-DOT Physical Examination **(NDP)**
☐ Breath Alcohol Test **(BAT)**	☐ HAZWOPER Medical Examination **(HME)**
☐ Random Drug Test **(RDT)**	☐ Firefighter Medical Examination **(FME)**
☐ Blood Collection **(BC)**	☐ Return to Work Evaluation **(RTW)**
☐ Medical Weight Management **(MWM)**	☐ Audiogram / Hearing Test **(AUD)**
	☐ Respirator Fit Test **(RFT)**

CONSENT FOR EVALUATION AND TREATMENT

I hereby consent to receive medical evaluation, treatment, and related occupational health services as deemed necessary by the licensed healthcare provider at MedCare Occupational Health PLLC. I understand that these services are provided for employment and occupational purposes, and that relevant results may be shared with my employer or their designated representative as permitted by law. I acknowledge that care provided by MedCare Occupational Health PLLC does not replace the medical care of my personal physician.

PATIENT SIGNATURE _____ DATE _____

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PATIENT ID / RECORD # _____

Consent / Authorization for Disclosure of PHI

FORM MC-101

PURSUANT TO 45 CFR 164.508

PATIENT IDENTIFICATION

FIRST NAME | LAST NAME | SSN / EMPLOYEE ID

DATE OF BIRTH | AGE | SEX ☐ Male ☐ Female | TODAY'S DATE

ADDRESS | CITY | STATE | ZIP

CELL / HOME PHONE | WORK PHONE | EMAIL

AUTHORIZATION

I HEREBY AUTHORIZE (CLINIC NAME)

CLINIC ADDRESS

to disclose medical information and/or protected health information (PHI) of the patient listed above to:

MedCare Occupational Health PLLC
31047 State Highway 100, Los Fresnos, TX 78566 · Phone +1 956-233-2103 · medcareocc@gmail.com

PURPOSE Evaluation requested by employer or prospective employer.

TREATMENT DATE(S) FROM | THROUGH

THIS AUTHORIZATION EXPIRES UPON THE FOLLOWING DATE OR EVENT

ACKNOWLEDGEMENTS

- If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Custodian of Records of the above facility. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- The information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected.
- Fees/charges will comply with all laws and regulations applicable to release of information.
- I understand authorizing the use of disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.
- I specifically authorize written, oral and telefax communications with MedCare Occupational Health.
- I understand and agree that the results will be disclosed to my Company's representative and/or Medical Review Officer and hereby release MedCare Occupational Health, any employees and/or agents thereof from any and all claims or causes of actions resulting from the disclosure of these results. Additionally, in accordance with Federal Regulations, the Medical Review Officer is authorized to verify medical information supplied by me under the Department of Health and Human Services Mandatory Guidelines for Federal Workplace Drug Testing Programs (this information may include medical records from a hospital, my personal physician, dentist, or pharmacy records).

_____ INITIAL I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results and/or AIDS information.

I have read the above and authorize the disclosure of the protected health information as stated.

SIGNATURE _____ DATE _____

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PATIENT ID / RECORD # _____

Medical History Questionnaire

FORM MC-102

FIRST NAME | LAST NAME | SSN / EMPLOYEE ID

DATE OF BIRTH | AGE | SEX ☐ Male ☐ Female | TODAY'S DATE

PRESENT OCCUPATION | COMPANY

MEDICAL HISTORY

Mark every line. If you answer YES to any item, explain it in the space below.

CONDITION	Y	N	CONDITION	Y	N	CONDITION	Y	N
Asthma / wheezing	☐	☐	Heart trouble	☐	☐	Neck pain	☐	☐
Pneumonia	☐	☐	Palpitation / pounding heart	☐	☐	Back pain / injury	☐	☐
Tuberculosis / lung disease	☐	☐	Pain / pressure in chest	☐	☐	Fractured / broken bones	☐	☐
Frequent bronchitis	☐	☐	High blood pressure	☐	☐	Swollen / stiff / painful joints	☐	☐
Shortness of breath	☐	☐	Diabetes	☐	☐	Amputations	☐	☐
Chronic cough	☐	☐	Stroke	☐	☐	Deformities of legs, feet, arms, hands, back or joints	☐	☐
Coughing up blood	☐	☐	Rheumatic fever	☐	☐	Loss of appetite	☐	☐
Sleep apnea / loud snoring	☐	☐	Bleeding disorder or issue	☐	☐	Unexplained weight change	☐	☐
Glasses / contacts	☐	☐	Inflammation of veins / clots	☐	☐	Tumors / abnormal growths	☐	☐
Glaucoma	☐	☐	Enlarged / varicose veins	☐	☐	Thyroid problems	☐	☐
Eye injury / operation / defects	☐	☐	Nausea / vomiting (frequent)	☐	☐	Hernia	☐	☐
Loss of hearing / ringing in ears	☐	☐	Vomiting up blood	☐	☐	Hemorrhoids	☐	☐
Headaches (frequent / severe)	☐	☐	Ulcer(s)	☐	☐	Venereal disease(s)	☐	☐
Head injury	☐	☐	Diarrhea (frequent / severe)	☐	☐	Allergies (drug, hay fever, food)	☐	☐
Blackouts / dizziness / fainting	☐	☐	Constipation (frequent / severe)	☐	☐	Currently taking medications	☐	☐
Epilepsy / seizures	☐	☐	Blood in bowel movement	☐	☐	Previous surgery(s)	☐	☐
Nervous disorders	☐	☐	Gallbladder trouble	☐	☐	Other illness or injury	☐	☐
Fear of heights	☐	☐	Kidney / bladder problems	☐	☐	Other: _____	☐	☐
Claustrophobia	☐	☐	Liver disease	☐	☐	Other: _____	☐	☐
Skin conditions	☐	☐	Cancer	☐	☐			

EXPLANATION OF ALL "YES" ANSWERS

_____

_____

LIFESTYLE & WORK HISTORY

	Y	N	IF YES
Current or former smoker	☐	☐	*Packs a day?* _____ *For how many years?* _____ *If former, how long ago did you quit?* _____
Do you drink alcoholic beverages?	☐	☐	*Drinks per week?* _____ *What type(s)?* _____
Have you ever had a drug or alcohol problem?	☐	☐	*Please explain:* _____

	Y	N	IF YES
Have you **ever** been injured at work?	☐	☐	*Please explain:* _____ *Company name & address:* _____
Have you **ever** received worker's comp benefits?	☐	☐	*Please list:* _____
Have you **ever** been placed on light duty from an injury?	☐	☐	*Please explain:* _____
Has any injury or illness left you with a physical limitation?	☐	☐	*Please explain:* _____

I understand that failure to answer truthfully may result in the denial of compensation benefits, including medical treatment and expenses. I hereby certify that the information provided above and the information which I will provide to the medical provider in connection with this examination is true and correct to the best of my knowledge. I understand that any omission of fact or false statement is sufficient grounds for denial of employment or, if employed, termination of my employment.

EMPLOYEE SIGNATURE _____

DATE _____

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PATIENT ID / RECORD # _____

Orthopedic History Questionnaire

FORM MC-103

FIRST NAME | LAST NAME | SSN / EMPLOYEE ID

DATE OF BIRTH | AGE | SEX ☐ Male ☐ Female | TODAY'S DATE

PRESENT OCCUPATION | COMPANY

MUSCULOSKELETAL HISTORY

Have you ever had pain in, or injured, any of the following?

BODY AREA	INJURED?	WHERE DID IT HAPPEN?	DATES, TREATMENT GIVEN, HOW LONG IT PERSISTED
Neck	☐ YES ☐ NO	☐ Home ☐ Work	
Shoulder	☐ YES ☐ NO	☐ Home ☐ Work	
Back	☐ YES ☐ NO	☐ Home ☐ Work	
Hand	☐ YES ☐ NO	☐ Home ☐ Work	
Knee	☐ YES ☐ NO	☐ Home ☐ Work	
Foot	☐ YES ☐ NO	☐ Home ☐ Work	

ORTHOPEDIC CARE & RESTRICTIONS

Have you ever had surgery on your back, neck, or other orthopedic surgery? ☐ YES ☐ NO

Date(s): _____ *Type of surgery:* _____

Are you currently taking any medication for a back, neck or other orthopedic injury? ☐ YES ☐ NO

Medication(s): _____

Are you currently under the care of a physician, physical therapist, chiropractor, or pain management specialist? ☐ YES ☐ NO

Provider name: _____ *Provider phone:* _____

Have you had any restrictions placed on you, current or past, due to a back, neck or other orthopedic injury? ☐ YES ☐ NO

Please list: _____

Have you experienced numbness or tingling, current or past, in your upper or lower extremities due to an injury? ☐ YES ☐ NO

Please explain: _____

I understand that failure to answer truthfully may result in the denial of compensation benefits, including medical treatment and expenses. I hereby certify that the information provided above and the information which I will provide to the medical provider in connection with this examination is true and correct to the best of my knowledge. I understand that any omission of fact or false statement is sufficient grounds for denial of employment or, if employed, termination of my employment.

EMPLOYEE SIGNATURE _____

DATE _____

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PATIENT ID / RECORD # _____

Physical Examination

FORM MC-104

FIRST NAME | LAST NAME | SSN / EMPLOYEE ID

DATE OF BIRTH | AGE | SEX ☐ Male ☐ Female | TODAY'S DATE

VITAL SIGNS

HEIGHT (IN)	WEIGHT (LB)	BLOOD PRESSURE	PULSE	RESP. RATE	TEMP

REPEAT BP	ARM	REPEAT PULSE	TIME	CLINICIAN
_____ / _____	☐ L ☐ R			
_____ / _____	☐ L ☐ R			

SYSTEMS REVIEW

SYSTEM	NORMAL	ABNORMAL	COMMENTS
General Appearance	☐	☐	
Skin	☐	☐	
Lymphatics	☐	☐	
Muscular Development	☐	☐	
Eyes	☐	☐	
Ears	☐	☐	
Nose	☐	☐	
Throat	☐	☐	
Teeth / Oral Hygiene	☐	☐	
Chest	☐	☐	
Heart	☐	☐	
Lungs	☐	☐	
Abdomen	☐	☐	
Hernia	☐	☐	
Genitalia (optional)	☐	☐	
Rectum (optional)	☐	☐	
Spine	☐	☐	
Extremities	☐	☐	
Peripheral Vessels	☐	☐	
Reflexes	☐	☐	
Neurologic	☐	☐	

SCREENING

URINALYSIS Sp. Gravity _____ Glucose _____ Protein _____ pH _____ Ketones _____ Blood _____

VISION	LEFT	RIGHT	BOTH	
Far	20/ _____	20/ _____	20/ _____	Corrected: ☐ YES ☐ NO
Near	20/ _____	20/ _____	20/ _____	
Color	Colors of caution: _____ / 3			Color blind: ☐ YES ☐ NO

ROS	☐ Asthma ☐ HTN ☐ Diabetes
PMH	
PSH	
MEDS	

PROVIDER SIGNATURE _____ DATE _____

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PATIENT ID / RECORD # _____

OSHA Respirator Medical Evaluation · Part A

FORM MC-105

TO THE EMPLOYER Answers to questions in Section 1, and question 9 in Section 2 of Part A, do not require a medical examination.

TO THE EMPLOYEE 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 FOR EVERY EMPLOYEE SELECTED TO USE A RESPIRATOR

FIRST NAME	LAST NAME	SSN / EMPLOYEE ID

DATE OF BIRTH	AGE	SEX	TODAY'S DATE
		☐ Male ☐ Female	

HEIGHT (FT / IN)	WEIGHT (LB)	CELL / HOME PHONE	BEST TIME TO REACH YOU

COMPANY	LOCATION / JOB #	YOUR JOB TITLE

Has your employer told you how to contact the health care professional who will review this questionnaire? ☐ 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 (ex...half or full-facepiece type, powered-air purifying, supplied-air, (SCBA) self-contained breathing apparatus).

Have you ever worn a respirator? ☐ YES ☐ NO

If "YES", What type(s): _____

Have you ever <u>failed</u> a respirator examination or pulmonary function test? ☐ YES ☐ NO

If "YES", Why? _____

Have you ever been <u>denied</u> or <u>turned down</u> for the use of a respirator? ☐ YES ☐ NO

If "YES", Why? _____

PART A · SECTION 2 — MANDATORY

Questions 1 through 9 must be answered by every employee who has been selected to use any type of respirator.

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? ☐ YES ☐ NO

If "YES", How long have you been smoking? _____ *Amount per day?* _____

What type of tobacco? (Check all that apply) ☐ Cigarettes ☐ Cigars ☐ Pipe tobacco

If "NO", Are you a former smoker? ☐ YES ☐ NO

How long ago did you quit? _____ *How long did you smoke?* _____ *Amount per day?* _____

2. Have you ever had any of the following conditions?

Explain all "yes" answers in the space provided (Include dates and treatment)

A.	Seizures	☐ YES ☐ NO	
B.	Diabetes (sugar disease)	☐ YES ☐ NO	
C.	Allergic reactions that interfere with your breathing	☐ YES ☐ NO	
D.	Claustrophobia (fear of closed-in places)	☐ YES ☐ NO	
E.	Trouble smelling odors	☐ YES ☐ NO	

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

Explain all "yes" answers in the space provided (Include dates and treatment)

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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PATIENT ID / RECORD # _____

OSHA Respirator Medical Evaluation · Part A

FORM MC-105

FIRST NAME	LAST NAME	DATE OF BIRTH	TODAY'S DATE

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

Explain all "yes" answers in the space provided (Include dates and treatment)

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 you think may be related to lung problems	☐ YES ☐ NO	

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

Explain all "yes" answers in the space provided (Include dates and treatment)

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?

Explain all "yes" answers in the space provided (Include dates and treatment)

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 2 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 you think may be related to heart or circulation problems	☐ YES ☐ NO	

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

Explain all "yes" answers in the space provided (List medications and dosages)

A.	Breathing or lung problems	☐ YES ☐ NO	
B.	Heart trouble	☐ YES ☐ NO	
C.	Blood pressure	☐ YES ☐ NO	
D.	Seizures	☐ YES ☐ NO	

8. If you have used a respirator, have you ever had any of the following problems?

Explain all "yes" answers in the space provided

☐ Check if you have never used a respirator, then skip to question 9

A.	Eye irritation	☐ YES ☐ NO	
B.	Skin allergies or rashes	☐ YES ☐ NO	
C.	Anxiety	☐ YES ☐ NO	
D.	General weakness or fatigue	☐ YES ☐ NO	
E.	Any other problem that interferes with your use of a respirator	☐ YES ☐ NO	

9. Would you like to talk to the health care professional who will review your answers on this questionnaire? ☐ YES ☐ NO

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PATIENT ID / RECORD # _____

OSHA Respirator Medical Evaluation · Questions 10–15

FORM MC-105

FIRST NAME	LAST NAME	DATE OF BIRTH	TODAY'S DATE

MANDATORY for every employee selected to use a full-facepiece respirator or a self-contained breathing apparatus (SCBA).

VOLUNTARY for employees selected to use other types of respirators — answering questions 10–15 is optional.

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?**		
	Explain all "yes" answers in the space provided (Include dates and treatment)		
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 eardrum?**	☐ YES ☐ NO	
13.	**Do you currently have any of the following hearing problems?**		
	Explain all "yes" answers in the space provided (Include dates and treatment)		
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?**		
	Explain all "yes" answers in the space provided (Include dates and treatment)		
A.	Weakness in any part of your arms, hands, legs, or feet	☐ YES ☐ NO	
B.	Back pain	☐ YES ☐ NO	
C.	Difficulty fully moving your arms and legs	☐ YES ☐ NO	
D.	Pain or stiffness when you lean forward or backward at the waist	☐ YES ☐ NO	
E.	Difficulty fully moving your head up or down	☐ YES ☐ NO	
F.	Difficulty fully moving your head side to side	☐ YES ☐ NO	
G.	Difficulty bending at your knees	☐ YES ☐ NO	
H.	Difficulty squatting to the ground	☐ YES ☐ NO	
I.	Climbing a flight of stairs or a ladder carrying more than 25 lbs	☐ YES ☐ NO	
J.	Any other muscle or skeletal problem that interferes with using a respirator	☐ YES ☐ NO	

PART B · DISCRETIONARY QUESTIONS

Any of these questions, and others not listed, may be added at the discretion of the reviewing health care professional.

1.	**In your present job, are you working at high altitudes (over 5,000 ft) or in a place that has lower than normal amounts of oxygen?**	☐ YES ☐ NO
	If "YES", do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions?	☐ YES ☐ NO
2.	**At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust) or have you come into skin contact with hazardous chemicals?**	☐ YES ☐ NO
	If "YES", Name the chemicals if you know them: _____	
3.	**Have you ever worked with any of the materials, or under any of the conditions listed below?**	
	If "YES", Describe these exposures (Include dates and treatment)	
A.	Asbestos	☐ YES ☐ NO
B.	Silica (e.g., in sandblasting)	☐ YES ☐ NO
C.	Tungsten/Cobalt (e.g., grinding or welding this material)	☐ YES ☐ NO
D.	Beryllium	☐ YES ☐ NO
E.	Aluminum	☐ YES ☐ NO
F.	Coal (e.g., mining)	☐ YES ☐ NO
G.	Iron	☐ YES ☐ NO
H.	Tin	☐ YES ☐ NO
I.	Dusty environments	☐ YES ☐ NO
J.	Any other hazardous exposures	☐ YES ☐ NO
4.	**List any previous occupations:** _____	
5.	**List your current and previous hobbies:** _____	
6.	**List any second jobs or side businesses you have:** _____	

MEDCARE OCCUPATIONAL HEALTH

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PATIENT ID / RECORD # _____

OSHA Respirator Medical Evaluation · Part B

FORM MC-105

FIRST NAME | LAST NAME | DATE OF BIRTH | TODAY'S DATE

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
List the chemicals (if known): _____

8. **Have you ever worked on a HAZMAT team?** ☐ YES ☐ NO
If "YES", please list: _____

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 known): _____

10. **Will you be using any of the following items with your respirator(s)?**
- **A.** HEPA Filters ☐ YES ☐ NO
- **B.** Canisters (e.g., gas masks) ☐ YES ☐ NO
- **C.** Cartridges ☐ YES ☐ NO

11. **How often are you expected to use the respirator(s)?**
- **A.** Escape only (No Rescue) ☐ YES ☐ NO
- **B.** Emergency Rescue only ☐ YES ☐ NO
- **C.** Less than 5 hours per week ☐ YES ☐ NO
- **D.** Less than 2 hours per day ☐ YES ☐ NO
- **E.** 2 to 4 hours per day ☐ YES ☐ NO
- **F.** Over 4 hours per day ☐ YES ☐ NO

12. **During the period you are using the respirator(s), is your work effort:**
- **A.** Light (less than 200 kcal per hour) ☐ YES ☐ NO
  If "YES", how long does this period last during the average shift: _____ hours _____ minutes
  ** Examples of light work effort: sitting while writing, typing, drafting, or performing light assembly work; standing while operating a drill press (1–3 lbs.) or controlling machines.*
- **B.** Moderate (200 to 350 kcal per hour) ☐ YES ☐ NO
  If "YES", how long does this period last during the average shift: _____ hours _____ minutes
  ** Examples of moderate work effort: sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; walking on a level surface about 2 mph or down a 5-degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.*
- **C.** Heavy (above 350 kcal per hour) ☐ YES ☐ NO
  If "YES", how long does this period last during the average shift: _____ hours _____ minutes
  ** Examples of heavy work effort: lifting a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).*

13. **Will you be wearing protective clothing/equipment (other than the respirator) when you are using your respirator?** ☐ YES ☐ NO
If "YES", please describe this protective clothing and/or equipment: _____

14. **Will you be working under hot conditions?** *(Temperatures exceeding 77° Fahrenheit)* ☐ YES ☐ NO

15. **Will you be working under humid conditions?** ☐ YES ☐ NO

16. **Describe the work you will be doing while you are using your respirator(s):**

_____

_____

17. **Describe any special or hazardous conditions you might encounter when you are using your respirator(s)?**
(e.g., confined spaces, life-threatening gases):

_____

18. **Provide the following information** *(if known)* **for each toxic substance that you will be exposed to when you are using your respirator(s):**

A. 1st toxic substance *(name):* _____
Estimated max exposure level per shift: _____ Duration of exposure per shift: _____

B. 2nd toxic substance *(name):* _____
Estimated max exposure level per shift: _____ Duration of exposure per shift: _____

C. 3rd toxic substance *(name):* _____
Estimated max exposure level per shift: _____ Duration of exposure per shift: _____

D. List any other toxic substances that you will be exposed to while using your respirator: _____

19. **Describe any special responsibilities you will have while using your respirator that may affect the safety and well-being of others.**
(e.g., rescue, security):

_____

EMPLOYEE SIGNATURE _____ DATE _____

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Pulmonary Function Testing Report

FORM MC-106

FIRST NAME | LAST NAME | DATE OF BIRTH | TODAY'S DATE

COMPANY

TEST STATUS

☐ PFT has been performed — *attach the results printout to this page*

RESULTS

MEASURE	RESULT	PERCENT PREDICTED	NOTES
FVC			
FEV1			

IF TESTING WAS NOT PERFORMED

Please advise whether the employee is able to use respiratory protective equipment in accordance with 29 CFR 1910.134.

☐ **YES** ☐ **NO**

PROVIDER INTERPRETATION & NOTES

PROVIDER SIGNATURE

DATE

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PATIENT ID / RECORD # _____

Audiogram

FORM MC-107

ALL FIELDS ARE REQUIRED

EMPLOYEE INFORMATION

EMPLOYEE NAME

SSN / EMPLOYEE ID

DATE OF BIRTH

POSITION / JOB

COMPANY

LOCATION

TEST TYPE & NOISE EXPOSURE

☐ Baseline (Applicant / New Hire) ☐ Annual

NOISE EXPOSURE LEVEL _____ ☐ N/A — applicant / new hire

When working in a high noise area, do you wear hearing protection?

☐ YES ☐ NO ☐ N/A — applicant, or not currently exposed to high noise

AUDIOMETRIC THRESHOLDS (DB HL)

DATE OF EXAM · LEFT EAR	500 HZ	1000 HZ	2000 HZ	3000 HZ	4000 HZ	6000 HZ

DATE OF EXAM · RIGHT EAR	500 HZ	1000 HZ	2000 HZ	3000 HZ	4000 HZ	6000 HZ

AUDIOMETER & EXAMINER

MAKE	MODEL	SERIAL #

AUDIOMETER CALIBRATION DATE

TESTER / EXAMINER NAME

*** Calibration date must be within the last year.*

TESTER / EXAMINER SIGNATURE

DATE

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PATIENT ID / RECORD # _____

Respirator Fit Test Record

FORM MC-108

EMPLOYEE & TEST DATE

NAME OF EMPLOYEE / APPLICANT

TEST DATE

SIGNATURE OF EMPLOYEE BEING TESTED

RESPIRATOR TESTED

Specific make, style and model # of the respirator used for this test.

MAKE

STYLE

MODEL #

MASK SIZE *(check one)*

☐ Small ☐ Medium ☐ Large ☐ One Size Fits All ☐ Regular

TEST METHOD & RESULT

TYPE OF FIT TEST PERFORMED *(check one)*

☐ Qualitative (QLFT) ☐ Quantitative (QNFT) Fit factor (QNFT only): _____

RESULT OF FIT TEST — POSITIVE SEAL?

☐ **YES — PASS** ☐ **NO — FAIL**

TEST ADMINISTRATOR

PRINTED NAME OF TEST ADMINISTRATOR

SIGNATURE OF TEST ADMINISTRATOR

DATE

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PATIENT ID / RECORD # _____

Return to Work / School Release

FORM MC-109

DATE _____

To Whom It May Concern,

This letter certifies that _____

was treated in our office on _____.

Due to his/her medical condition, he/she is advised to refrain from:

- ☐ Work
- ☐ School
- ☐ Other _____

He/She is expected to resume his/her activities on _____.

Please contact our office if you have any questions.

Sincerely,

PROVIDER SIGNATURE _____ DATE _____