

CT OCCUPATIONAL MEDICINE PARTNERS

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> St Francis / Hartford
Tel: 860-714-4270
FAX: 860-714-8068 | <input type="checkbox"/> St. Francis / Windsor
Tel: 860-714-9444
FAX: 860-714-8900 | <input type="checkbox"/> St. Francis / Torrington
Tel: 860-482-3467
FAX: 860-482-3867 | <input type="checkbox"/> MedWorks/Bristol
Tel: 860-589-0114
FAX: 860-589-1936 |
| <input type="checkbox"/> MedWorks/Newington
Tel: 860-667-4418
FAX: 860-667-1503 | <input type="checkbox"/> CorpCare / S Windsor
Tel: 860-647-4796
FAX: 860-644-0287 | <input type="checkbox"/> Corporate Health Care / Danbury
Tel: 203-749-5720
FAX: 203-739-1881 | <input type="checkbox"/> Johnson Memorial / Enfield
Tel: 860-763-7668
FAX: 860-763-7676 |

OCCUPATIONAL HEALTH
WORK, ENVIRONMENT AND HEALTH QUESTIONNAIRE

Name: _____ Social Security # _____ / _____ / _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone Number: _____ Date of Birth: _____

Cell Phone: _____ Today's Date: _____

Email: _____

Employer Name: _____

How would you prefer to be contacted for reminders? (please **circle** preference below)

- 1.TEXT 2.EMAIL 3.PHONE (HOME or CELL)

OCCUPATIONAL HISTORY

List every place where you have been employed for more than six (6) months back to your first job, starting with your current or most recent job.

Start Mo/Yr	End Mo/Yr	Employer City, State	Type of Business	Job Title	Job Duties	Exposures

Hobbies: _____

Have you ever worn a respirator at work? Yes _____ No _____

Were you able to perform your job with a respirator on? Yes _____ No _____

Have you ever:

Filed a Worker's Compensation Claim or received benefits as a result of a work related injury or illness? Yes _____ No _____

Experienced overexposure to or ill effects from chemical exposure? Yes _____ No _____

Received a disability settlement or a permanent impairment rating? Yes _____ No _____

Do you work at another job? Yes _____ No _____

Please explain all Yes answers: _____

Patient Name: _____

IMMUNIZATION HISTORY

Please provide a written record signed by your physician with dates for the following vaccinations, illnesses, or tests. If you cannot provide these, you will be tested for immunity to these diseases.

Measles (rubeola): Date of illness _____ Date of immunization: #1 _____ #2 _____

Date of lab test: _____ Result: _____

Rubella (German measles): Date of illness _____

Date of immunization: #1 _____ #2 _____

Date of lab test: _____ Result: _____

Please provide the dates for the following where applicable:

	Immunization	Lab titer result	Illness	Comment
Chicken Pox				
Mumps				
Diphtheria/Tetanus				
Hepatitis B				
TB skin test/BCG				
Polio				
Rabies				

SMOKING AND ALCOHOL USE

Have you ever smoked cigarettes regularly? Yes _____ No _____

If yes, do you still smoke? Yes _____ No _____

When did you quit smoking? (Date) _____

How many years have you smoked, or if you no longer smoke, how many years did you smoke? _____ yrs.

On the average, how many packs per day do you smoke, or if you no longer smoke, how many did you smoke? _____ packs per day.

Have you ever smoked a pipe or cigars regularly? Yes _____ No _____

Have you ever been a regular consumer of beer or other alcohol? Yes _____ No _____

FAMILY PHYSICIAN

Name: _____

Address: _____

Telephone Number _____ Date last seen by a physician: _____

Are any other physicians currently treating you? Yes _____ No _____

If yes, please write their name, address and telephone number:

Patient Name: _____

MEDICAL HISTORY

Current Medications: _____

Allergies to medications and other substances: _____

Do you wear contact lenses? Yes _____ No _____

Have you ever been in the hospital? Yes _____ No _____

If yes, when, where, and why? _____

Do you have or have you ever had any of the following:

	No	Yes	Date of Onset	If yes, please detail
ARTHRITIS, RHUMATIC FEVER				
BLOOD DISORDER, INCLUDING ANEMIA				
LIVER DISEASE, INCLUDING HEPATITIS				
SKIN CONDITION				
MISCARRIAGE (SELF OR PARTNER)				
INFERTILITY, CHILD WITH BIRTH DEFECT				
TUBERCULOSIS				
ULCERS, OTHER STOMACH OR BOWEL DISEASE				
GALL BLADDER DISEASE				
DISORDER OF BONES OR MUSCLES				
FRACTURES				
THYROID PROBLEMS				
DIABETES				
KIDNEY DISEASE				
PROBLEMS W/PERIPHERAL NERVOUS SYSTEM (WEAKNESS, NUMBNESS)				
RUPTURE OF EARDRUM, HEARING LOSS				
CANCER OR TUMOR (TYPE)				
EPILEPSY (SEIZURES)				
BACK INJURY, PAIN OR TROUBLE				
MENTAL ILLNESS OR BREAKDOWN				
LUNG CONDITIONS (BRONCHITIS, EMPHYSEMA, PNEUMONIA, ASTHMA, BLOOD CLOT IN LUNGS)				
INJURIES TO OTHER BODY PARTS				
HEART DISEASE, INCLUDING HYPERTENSION				
OTHER CONDITIONS				
DATE OF LAST EYE EXAM				

I attest that the information contained on this three page Medical History questionnaire is truthful and complete to the best of my knowledge.

Patient Signature: _____

Date: _____

If you are under 18 years of age, guardian signature is required

Provider Signature: _____

Date: _____

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- | | | | |
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PHYSICAL EXAM FORM

NAME: _____ **DOB:** _____ **M / F** _____

JOB TITLE: _____

Vital Signs

Height	Weight	BP(repeat if needed)	Rest/Exercise Pulse	Temp	Resp Rate

Urinalysis

Color	Leukocytes	Nitrite	Protein	pH	Blood	Spec grv	Ketone	Glucose

Vision: indicate best vision with or without correction and status of color vision.

Near	<input type="checkbox"/> with / <input type="checkbox"/> without	Far	<input type="checkbox"/> with / <input type="checkbox"/> Uncorrected	Peripheral Vision	Color
Right	20/	Right	20/	Right °	Ishihara <input type="checkbox"/> Pass / <input type="checkbox"/> Fail
Left	20/	Left	20/	Left °	Color sticks <input type="checkbox"/> Pass / <input type="checkbox"/> Fail
Both	20/	Both	20/		Other

Exam Findings (normal, Abnormal, Not Examined)

	Norm	Abn	N/E	Findings
General Appearance				
Skin				
Eyes				
Ears				
Forced Whisper				Forced whisper R feet, L feet
Nose				
Throat				
Neck				
Chest				
Lungs				
Heart				
Abdomen				
Hernias				
Genitourinary				
Cervical Spine				
Thoracic Spine				
Lumbar Spine				
Shoulders				
Elbows/Forearms				
Wrists/Hands				
Hips				
Knees				
Ankle/Foot				
Neuro/Reflexes				

Pending (circle) Bloodwork PPD CXR Spirometry Med Records _____

Nurse/MA: _____

Date: _____

Physician/PA: _____

Date: _____



ECHN CorpCare

Occupational Health

2800 Tamarack Ave Ste 001 South Windsor, CT 06074

Phone 860-647-4796 Fax 860-644-0287

Hearing Conservation Program

Name: _____

Last 4 of SSN: _____

DOB: _____ / _____ / _____

Company: _____

- 1) Have you been exposed to loud noises in the last 14 hrs without hearing protection? YES or NO
- 2) Do you have a cold today? YES or NO
- 3) Have you been told or noticed that you are hard of hearing? YES or NO
- 4) Do you have ringing or buzzing in your ears? YES or NO
- 5) Do you have a history of ear infections or surgery to your ears? YES or NO
- 6) Do you normally wear hearing protection at work? YES or NO
If so, what kind? _____
- 7) Please give a history of any past exposure to noise including military, jobs and hobbies. Please indicate whether you wore hearing protection during these activities:

DO NOT WRITE BELOW FOR CORPCARE STAFF USE

Date	Right							
Time	Left	500	1000	2000	3000	4000	6000	8000

Otoscopic Inspections: _____

Booth Checked: _____ Serial # _____

Tester Printed Name: _____ Tester's Signature: _____

Comments: _____

Corpcare Occupational Health
 2800 Tamarack Avenue, STE 001
 South Windsor, CT 06074
 860-647-4796 Telephone
 860-644-0287 Fax

Hepatitis B Vaccine Offer

Patient Name: _____ Date of Birth: _____

Have you been immunized against Hepatitis B previously? If YES enter dates of Vaccination: There is no contraindication to vaccination if you have previously had the Hepatitis B series.	Yes	NO	Don't know
Have you ever had sensitive /life threatening anaphylactic reaction to east?			
Have you ever had a life-threatening allergic reaction to a previous dose of Engerix B hepatitis vaccine?			
Do you have any allergies sensitive to Latex?			

Please choose one:

Consent to Receive Hepatitis B Vaccine: YES

I do wish to receive the Hepatitis B vaccination. I understand the risks and benefits of immunization. As with all medical treatment, I am aware there is no guarantee that I will become immune or that I will not experience an adverse side effect from the vaccine. I have read the Hepatitis B vaccine information statement and I have read the Vaccine Information Statement and had the opportunity to have my questions about the Hepatitis B vaccine efficacy, side effects and administration answered.

V/S-8/15/2019

Declination for Hepatitis B Vaccine: NO

No, I do not wish to have the Hepatitis B Vaccination. I understand that due to my occupational exposure to blood or other potential infectious materials that I may be at risk of acquiring the Hepatitis B virus infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B Vaccination at this time. I understand by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Employee Signature/Date

Employee Signature/Date

CorpCare Representative Signature/Date CorpCare Representative Signature/Date

Date: _____

****MUST BE SIGNED BY EMPLOYEE AND CORPCARE REPRESENTATIVE WHETHER ACCEPTED OR DECLINED ****

1 Dose	2 Dose	3 Dose
Lot	Lot #	Lot
Exp Date	Exp Date	Exp Date
Mfg	Mfg	Mfg
Inj Site	Inj Site	Inj Site
Given By	Given By	Given By
Titer Drawn on:		Results:

CORPCARE OCCUPATIONAL HEALTH
TUBERCULOSIS SCREENING QUESTIONNAIRE

Name _____ Date _____

Employer _____ Job Title _____

Tuberculosis also known as (TB) is a bacterial infection that can cause pneumonia, fever, weight loss and may involve other body systems. Some people who acquire the disease may be very ill while others may have no symptoms. It is transmitted in the air person to person. Control of the disease is based on early detection as well as treatment of exposed people with antibiotics. Skin tests such as PPD (Purified Protein Derivative) or blood tests (IGRA) may aid in the early diagnosis of exposure to TB.

Please answer the below prior to the PPD or IGRA test.

- | | | |
|--|-----|----|
| 1. Have you ever had Tuberculosis? | YES | NO |
| 2. Do you currently, or have you ever, experienced any of the following:
Weight loss, bloody sputum, persistent fever, severe cough, loss of
appetite, night sweats? | YES | NO |
| 3. Have you ever had close contact with someone who has or had TB
such as family member, co-worker or patient? Explain. | YES | NO |
| 4. Have you ever received BCG (Bacillus Callmette-Guerin vaccine)? | YES | NO |
| 5. Are you currently, or have you recently been treated with steroids or
other medications that suppress the immune system? | YES | NO |
| 6. Were you born, traveled or lived for at least 1 month in a country with
an elevated TB rate? (NOT the US, Canada, Australia, New Zealand,
western or northern Europe.)
If yes please give details. _____ | YES | NO |
| 7. Have you ever had a positive skin test for TB?
If so, when _____
Were you treated with medication, and if so for how long: _____
Date of last Chest X-Ray: _____
Please provide details to any question answered "Yes". | YES | NO |

Upon review of the responses to the questionnaire and discussion with the person for whom the tuberculosis evaluation is required, I recommend as follows:

_____ There is no indication this person has active tuberculosis at this time.

_____ Further evaluation is recommended.

Provider signature/Date: _____

5/5/21

HIPAA

Consent and Acknowledgment Form

I consent to the use or disclosure of my protected health information by ECHN-CorpCare to any person or organization for the purpose of carrying out treatment, obtaining payment or conducting certain healthcare operations. Protected health information used or disclosed by ECHN-CorpCare may include HIV/AIDS related information, psychiatric and or other mental health information, and drug and alcohol treatment information, as long as such information is used or disclosed in accordance with Connecticut and Federal law, which may require you to provide specific authorization. I understand that information regarding how ECHN-CorpCare will use and disclose my information can be found in ECHN's Notice of Privacy Practices. I understand that this consent is effective for as long as ECHN maintains my protected health information.

By signing below, I understand and acknowledge the following:

- ❖ I have read and understand this consent
- ❖ I have received ECHN's Notice of Privacy Practices currently in effect.

Signature of Individual or Personal Representative

Date

Printed Name of Individual or Personal Representative

*****PLEASE SIGN AND DATE BOTH SIDES OF THIS FORM*****

ECHN-CorpCare

Occupational Health

Physical Examination/Test & Screen

Consent to Release Results of Examination, Test and/or Screen

I acknowledge that the examination I am about to have is directed toward determining my medical fitness to perform a specific job, or monitoring medical effects of work-related conditions and exposures. It is not meant to replace routine examinations and consultations provided by my personal physician.

Routine examinations by my personal physician are required to address general health issues and medical conditions and to provide important screening tests such as blood pressure measurement and cholesterol levels. I am aware that it is recommended that I see my physician at least once a year or more frequently if health problems arise.

I understand that in the event I do not have my own physician ECHN-CorpCare can assist me, if I so wish, in locating a physician for my basic medical needs.

I hereby authorize ECHN-CorpCare to release to my employer or prospective employer a copy of my examination records, including drugs of abuse testing for the purpose of job placement, regulatory compliance or medical surveillance monitoring.

Examinee Signature

Date

*******PLEASE SIGN AND DATE BOTH SIDES OF THIS FORM*******

2800 Tamarack Avenue Suite 001 South Windsor, CT 06074

Phone 860-647-4796 Fax 860-644-0287

OSHA INFOSHEET

Respirator Medical Evaluation Questionnaire

Respirators must be used in workplaces in which employees are exposed to hazardous airborne contaminants. When respiratory protection is required employers must have a respirator protection program as specified in OSHA's Respiratory Protection standard (29 CFR 1910.134). Before wearing a respirator, workers must first be medically evaluated using the mandatory medical questionnaire or an equivalent method. To facilitate these medical evaluations, this INFOSHEET includes the mandatory medical questionnaire to be used for these evaluations.

Medical Evaluation and Questionnaire Requirements

The requirements of the medical evaluation and for using the questionnaire are provided below:

- The employer must identify a physician or other licensed health care professional (PLHCP) to perform all medical evaluations using the medical questionnaire in Appendix C of the Respiratory Protection standard or a medical examination that obtains the same information. (See Paragraph (e)(2)(i).)
- The medical evaluation must obtain the information requested in Sections 1 and 2, Part A of Appendix C. The questions in Part B of Appendix C may be added at the discretion of the health care professional. (See Paragraph (e)(2)(ii).)
- The employer must ensure that a follow-up medical examination is provided for any employee who gives a positive response to any question among questions 1 through 8 in Part A Section 2, of Appendix C, or whose initial medical examination demonstrates the need for a follow-up medical examination. The employer must provide the employee with an opportunity to discuss the questionnaire and examination results with the PLHCP. (See Paragraph (e)(3)(i).)
- The medical questionnaire and examinations must be administered confidentially during the employee's normal working hours or at a time and place convenient to the employee and in a manner that ensures that he or she understands its content. The employer must not review the employee's responses, and the questionnaire must be provided directly to the PLHCP. (See Paragraph (e)(4)(i).)

Excerpt from Appendix C of 29 CFR 1910.134: OSHA Respirator Medical Evaluation Questionnaire

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: 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.

Once filled out, this form must be given to the PLHCP. This form should **not** be submitted to OSHA.

	YES	NO
c. Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
d. Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
e. Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
f. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
g. Silicosis	<input type="checkbox"/>	<input type="checkbox"/>
h. Pneumothorax (collapsed lung)	<input type="checkbox"/>	<input type="checkbox"/>
i. Lung cancer	<input type="checkbox"/>	<input type="checkbox"/>
j. Broken ribs	<input type="checkbox"/>	<input type="checkbox"/>
k. Any chest injuries or surgeries	<input type="checkbox"/>	<input type="checkbox"/>
l. Any other lung problem that you've been told about	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you <i>currently</i> have any of the following symptoms of pulmonary or lung illness?	<input type="checkbox"/>	<input type="checkbox"/>
a. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline	<input type="checkbox"/>	<input type="checkbox"/>
c. Shortness of breath when walking with other people at an ordinary pace on level ground	<input type="checkbox"/>	<input type="checkbox"/>
d. Have to stop for breath when walking at your own pace on level ground	<input type="checkbox"/>	<input type="checkbox"/>
e. Shortness of breath when washing or dressing yourself	<input type="checkbox"/>	<input type="checkbox"/>
f. Shortness of breath that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>
g. Coughing that produces phlegm (thick sputum)	<input type="checkbox"/>	<input type="checkbox"/>
h. Coughing that wakes you early in the morning	<input type="checkbox"/>	<input type="checkbox"/>
i. Coughing that occurs mostly when you are lying down	<input type="checkbox"/>	<input type="checkbox"/>
j. Coughing up blood in the last month	<input type="checkbox"/>	<input type="checkbox"/>
k. Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
l. Wheezing that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>
m. Chest pain when you breathe deeply	<input type="checkbox"/>	<input type="checkbox"/>
n. Any other symptoms that you think may be related to lung problems	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you <i>ever had</i> any of the following cardiovascular or heart problems?		
a. Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
b. Stroke	<input type="checkbox"/>	<input type="checkbox"/>
c. Angina	<input type="checkbox"/>	<input type="checkbox"/>
d. Heart failure	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
e. Swelling in your legs or feet (not caused by walking)	<input type="checkbox"/>	<input type="checkbox"/>
f. Heart arrhythmia (heart beating irregularly)	<input type="checkbox"/>	<input type="checkbox"/>
g. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
h. Any other heart problem that you've been told about	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you <i>ever had</i> any of the following cardiovascular or heart symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
a. Frequent pain or tightness in your chest	<input type="checkbox"/>	<input type="checkbox"/>
b. Pain or tightness in your chest during physical activity	<input type="checkbox"/>	<input type="checkbox"/>
c. Pain or tightness in your chest that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>
d. In the past two years, have you noticed your heart skipping or missing a beat	<input type="checkbox"/>	<input type="checkbox"/>
e. Heartburn or indigestion that is not related to eating	<input type="checkbox"/>	<input type="checkbox"/>
f. Any other symptoms that you think may be related to heart or circulation problems	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you <i>currently</i> take medication for any of the following problems?	<input type="checkbox"/>	<input type="checkbox"/>
a. Breathing or lung problems	<input type="checkbox"/>	<input type="checkbox"/>
b. Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>
c. Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
d. Seizures	<input type="checkbox"/>	<input type="checkbox"/>
8. If you've used a respirator, have you <i>ever had</i> any of the following problems? (If you've never used a respirator, check the following space and go to question 9.) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Eye irritation	<input type="checkbox"/>	<input type="checkbox"/>
b. Skin allergies or rashes	<input type="checkbox"/>	<input type="checkbox"/>
c. Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
d. General weakness or fatigue	<input type="checkbox"/>	<input type="checkbox"/>
e. Any other problem that interferes with your use of a respirator	<input type="checkbox"/>	<input type="checkbox"/>
9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?	<input type="checkbox"/>	<input type="checkbox"/>
<p>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.</p>		
10. Have you <i>ever</i> lost vision in either eye (temporarily or permanently)?	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you <i>currently</i> have any of the following vision problems?	<input type="checkbox"/>	<input type="checkbox"/>
a. Wear contact lenses	<input type="checkbox"/>	<input type="checkbox"/>
b. Wear glasses	<input type="checkbox"/>	<input type="checkbox"/>
c. Color blind	<input type="checkbox"/>	<input type="checkbox"/>
d. Any other eye or vision problem	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
12. Have you <i>ever had</i> an injury to your ears, including a broken eardrum?	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you <i>currently</i> have any of the following hearing problems?	<input type="checkbox"/>	<input type="checkbox"/>
a. Difficulty hearing	<input type="checkbox"/>	<input type="checkbox"/>
b. Wear a hearing aid	<input type="checkbox"/>	<input type="checkbox"/>
c. Any other hearing or ear problem	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you <i>ever had</i> a back injury?	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you <i>currently</i> have any of the following musculoskeletal problems?	<input type="checkbox"/>	<input type="checkbox"/>
a. Weakness in any of your arms, hands, legs, or feet	<input type="checkbox"/>	<input type="checkbox"/>
b. Back pain	<input type="checkbox"/>	<input type="checkbox"/>
c. Difficulty fully moving your arms and legs	<input type="checkbox"/>	<input type="checkbox"/>
d. Pain and stiffness when you lean forward or backward at the waist	<input type="checkbox"/>	<input type="checkbox"/>
e. Difficulty fully moving your head up or down	<input type="checkbox"/>	<input type="checkbox"/>
f. Difficulty fully moving your head side to side	<input type="checkbox"/>	<input type="checkbox"/>
g. Difficulty bending at your knees	<input type="checkbox"/>	<input type="checkbox"/>
h. Difficulty squatting to the ground	<input type="checkbox"/>	<input type="checkbox"/>
i. Climbing a flight of stairs or a ladder carrying more than 25 lbs.	<input type="checkbox"/>	<input type="checkbox"/>
j. Any other muscle or skeletal problem that interferes with using a respirator	<input type="checkbox"/>	<input type="checkbox"/>

This infosheet does not include the questions in Part B because they are not mandatory; rather, they may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

OSHA Educational Materials

OSHA has an extensive publications program. For a listing of free items, visit OSHA's web site at www.osha.gov/publications or contact the OSHA Publications Office, U.S. Department of

Labor, 200 Constitution Avenue, N.W., N-3101, Washington, DC 20210. Telephone (202) 693-1888 or fax to (202) 693-2498.

Contacting OSHA

To report an emergency, file a complaint or seek OSHA advice, assistance or products, call (800) 321-OSHA (6742) or contact your nearest OSHA regional, area, or State Plan office; TTY: 1-877-889-5627.

This InfoSheet is not a standard or regulation, and it creates no new legal obligations. It contains recommendations as well as descriptions of mandatory safety and health standards. The recommendations are advisory in nature, informational in content, and are intended to assist employers in providing a safe and healthful workplace. The *Occupational Safety and Health Act* requires employers to comply with safety and health standards and regulations promulgated by OSHA or by a state with an OSHA-approved state plan. In addition, the Act's General Duty Clause, Section 5(a)(1), requires employers to provide their employees with a workplace free from recognized hazards likely to cause death or serious physical harm.



U.S. Department of Labor



Occupational Safety and Health Administration