**(Model SOP)**

**United States Army**

**Name of the Clinic**

 **Occupational Health**

**(OFFICE SYMBOL) SOP No.\_\_\_\_\_\_**

 **Effective Date\_\_\_\_\_**

**Date Removed from Service\_\_\_\_\_**

**WORKPLACE EPIDEMIOLOGIC Investigations**

1. **PURPOSE**

To provide guidance for (name of clinic) in performing Workplace Epidemiologic Investigations at (name of installation).

1. **AUTHORITY AND REGULATORY COMPLIANCE**

Federal, DoD, and Army regulations governing medical surveillance examinations are included below in the References section of this SOP.

1. **REFERENCES**
2. AR 40-5, Preventive Medicine, 25 May 2007
3. DA PAM 40-11, Preventive Medicine, 22 July 2005
4. DoDI 6055.05, Occupational and Environmental Health, 11 Nov, 2008
5. **ABBREVIATIONS / TERMS**

DoDI – Department of Defense Instruction

MEDDAC – Medical Activity

MEDCEN – Medical Center

USAPHC – US Army Public Health Command

Worksite – DoD military and civilian places of work and operations

1. **PROCEDURE**
2. Take a Thorough Medical History from Affected Individual(s)
3. Providers should focus their medical history taking by asking questions regarding date, time of onset, and duration of signs and symptoms, location and activity at time of onset (if acute), and recent medical history including medications, treatments, smoking history, etc.
4. Take a Thorough Occupational History and Current Work Activity
5. Providers should focus a worker’s current occupational history by asking questions regarding the patient’s specific work area (building number, room, and worksite), a list of all possible exposures known to employee, the exact nature of work performed, amount of time spent performing task/working with suspected hazard, personal work habits, PPE used, and areas where breaks are taken.
6. Past occupational and non-occupational exposure history should also be reviewed. Questions about hobbies and home work projects should also be included.
7. Establish or Confirm the Diagnosis
8. A thorough and appropriate medical examination should confirm the diagnosis in most cases
9. Document physical examination findings with appropriate laboratory and clinical studies
10. Keep accurate and well organized records of the results
11. Verify Worksite Hazards
12. Review Industrial Hygiene monitoring data and site visit records and any available Safety Data Sheets.
13. Coordinate with Industrial Hygiene and Safety, talk to supervisors, and make a coordinated worksite visit to try to determine what the causative agent may be.
14. Note any new operations or changes in old operations and try to determine associations between patient contact and onset of signs or symptoms.
15. Request that additional samples be taken or an updated survey be conducted, if indicated.
16. Coordination with IH and/or the installation Safety Officer to conduct an in-person worksite visit may also be required in some cases.
17. Identify Other Cases
18. When investigating a worksite in an attempt to find other workers possibly affected by a occupational health hazard, certain questions must be entertained:

1. What is the total population at risk to the same illness or injury?
2. How many employees work in the same building, same room or work area, and/or on the same type of job as the ill or injured person?
3. How many employees work with the same chemical or other potential hazard?
4. Determine if any other people are experiencing the same signs or symptoms or if other workers have had abnormal medical examination findings or have been diagnosed to have the same illness or injury. This may be accomplished through a medical records review and/or interviews with workers.
5. Organize All Collected Data
6. Use tables, charts, graphs, and drawings of the physical plant as indicated to make the information as clear as possible. Look for common items which are associated with the symptomatic workers.
7. Final Disposition
8. When the cause is determined, take appropriate action to correct the problem and protect workers.
9. If the cause is not readily apparent, or if more detailed investigation is indicated, request assistance from the MEDDAC/MEDCEN and/or USAPHC. The information gathered thus far will be a very good starting point for conducting a more complete epidemiologic investigation.
10. **APPENDICIES**

**Appendix A: Example Investigation Form**

**Appendix B: [Sample] Occupational Health Worksite Visit Checklist**

**Appendix A**

**Example Investigation Form**

**Medical Evaluation for Indoor Air Complaints**

**History Date:**

Patient Name: Patient ID:

Job title:

Department/ Work Location:

Contact Phone (number and type — duty, cell, home):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gender** ❑Male ❑Female Age:

**Chief Complaint:**

**History of Current Illness:**

**Current Medications (include regularly used over the counter medications):**

**History of Work Area Problems (visible mold, moisture incursions, recent renovations, recent move, ventilation issues noted, etc.):**

**Area or room where you spend the most time in the building:**

**Do any of your work activities produce dust or odor?** ❑Yes ❑No
Describe:

**Office / workplace characteristics:**

 Number of persons sharing same room/work area

 Number of windows in room/work area

 Do windows open? ❑Yes ❑No ❑ N/A

Please rate adequacy of workspace per person

 Poor Average Excellent

I 2 3 4 5
Please rate room temperature

 Poor Average Excellent

I 2 3 4 5

 Do others smoke in / near your work area? ❑Yes ❑No

How many years or months have you worked in this area?

In this room/area? \_\_\_\_\_ years \_\_\_\_\_ months In this building? Years months
**Have coworkers complained about the work environment or been evaluated for related symptoms?** ❑Yes ❑No

**Name and ID:**

**Do you:**

Smoke ❑Yes ❑No

Have hay fever/pollen allergies? ❑Yes ❑No

Have skin allergies/dermatitis? ❑Yes ❑No

Have asthma? ❑Yes ❑No

Have a cold/flu? ❑Yes ❑No

Have sinus problems? ❑Yes ❑No

Have other allergies? ❑Yes ❑No

Have history of allergy testing? (If yes, when? ) ❑Yes ❑No

Wear contact lenses? ❑Yes ❑No

Operate video display terminals? ❑Yes ❑No

Use other special office machines? ❑Yes ❑ No

Specify:

**Symptoms:** Select any symptoms you have experienced in this building. More than one may apply

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Symptom | Occasionally | Frequently | Daily | Worse at Work | Better Away from Work | *New* problem since starting this job |
| Difficulty in concentrating |  |  |  |  |  |  |
| Memory Loss loss |  |  |  |  |  |  |
| Aching joints |  |  |  |  |  |  |
| Muscle twitching |  |  |  |  |  |  |
| Back pain |  |  |  |  |  |  |
| Hearing problems |  |  |  |  |  |  |
| Dizziness |  |  |  |  |  |  |
| Dry, flaking skin |  |  |  |  |  |  |
| Discolored skin |  |  |  |  |  |  |
| Skin irritation |  |  |  |  |  |  |
| Itching |  |  |  |  |  |  |
| Heartburn |  |  |  |  |  |  |
| Nausea |  |  |  |  |  |  |
| Sore throat |  |  |  |  |  |  |
| Sinus congestion |  |  |  |  |  |  |
| Sneezing |  |  |  |  |  |  |
| High stress levels |  |  |  |  |  |  |
| Chest tightness |  |  |  |  |  |  |
| Eye irritation |  |  |  |  |  |  |
| Nose burning or irritation |  |  |  |  |  |  |
| Cough |  |  |  |  |  |  |
| Shortness of breath |  |  |  |  |  |  |
| Wheezing |  |  |  |  |  |  |
| Fainting |  |  |  |  |  |  |
| Headache |  |  |  |  |  |  |
| Fatigue/drowsiness |  |  |  |  |  |  |
| Temperature too hot |  |  |  |  |  |  |
| Temperature too cold |  |  |  |  |  |  |
| Other specify |  |  |  |  |  |  |

**Have you seen a health care practitioner for any or all of these symptoms?** ❑Yes ❑No

If yes, did s/he relate this to your work, and if so, what were the diagnosis and recommended treatment?

**When do you experience relief from these symptoms?**

**When do these problems usually occur?**

**TIME OF DAY** Morning Afternoon Evening

**DAY OF WEEK** S M T W TH F S

**MONTH** JFMAMJJASOND

**SEASON** Spring Summer Fall Winter**Name and ID:**

Physical Examination:

|  |  |  |
| --- | --- | --- |
| VS: Heart Rate: | BP: RR: Temp: |  |
| HEENT: Eyes | Redness Discharge | Lid swelling | Appear normal |
| Ears  | TM redness Fluid behind TM |  | Appear normal |
| Nose | Rhinorrhea Congestion | Swollen turbinates |  |
|  | Sinus tenderness (where?) |  | Appears normal |
| Mouth | Pharynx injected Postnasal drip | Appears normal |

 Pharyngeal or lingual lesions (describe):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Skin Urticaria Eczema — location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Appears normal

 Rash or lesions (describe):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LungsCough Wheezing Tachypnea Rales Normal sounds

 Other finding: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardiac (if relevant symptoms) Irregular beats Murmur Tachycardia Normal

Abdomen (if relevant symptoms)Tenderness (describe):

Swelling / Mass / Enlargement (describe):

Other finding: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Normal

Neurologic Tremor Focal deficit (describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Appears normal (oriented, alert and appropriate)

Other:

Diagnosis/es: Asthma Bronchitis Viral syndrome Sinusitis Seasonal Allergies (hayfever) Allergic rhinitis Dermatitis Other:

Conclusions:

Recommendations:

Testing: Spirometry Peak Flow meter for\_\_\_\_\_\_days Chest X-ray

 Specialist evaluation

(Allergist/ Dermatologist/ Pulmonologist/ Other

 Follow up with Primary MD

RTW without restrictions

 may work in an area pending remediation in usual work area

 may not RTW at this time

Return appt date (if indicated): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**APPENDIX B**

**[Sample] Occupational Health Worksite Visit Checklist**

**Date/ Time**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Organization/Department/Division/Shop**:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**POC**: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Identify the major mission/product of the organization**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Identify any sub-section(s) of the organization and its products/mission (if any):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Potential Hazards (indicate by a √):**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Noise |  | Eye Hazards |
|  | Heavy Lifting |  | Communicable disease |
|  | Solvents/ Chemicals |  | Bloodborne pathogen |
|  | Heat |  | Bio/Chemical Agents |
|  | Sun |  | Radiation |
|  | Humidity |  | Confined Space |
|  | Cold |  | Height |

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

**Work Environment (indicate by a √):**

|  |  |  |
| --- | --- | --- |
|  | Satisfactory | Unsatisfactory |
| Lighting |  |  |
| Temperature |  |  |
| Ventilation |  |  |
| Noise Level |  |  |
| Eating Area |  |  |
| Hygiene Facility |  |  |
| Bathroom Facility |  |  |
| Safety Signs |  |  |

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

**Personal Protective Equipment (indicate by a √):**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| PPE | Compliant | Non-compliant | PPE | Compliant | Non-compliant |
| Ear plugs/ muffs |  |  | Gloves |  |  |
| Safety glasses/goggles |  |  | Face Shields |  |  |
| Respirator |  |  | SCBA |  |  |
| Safety Shoes |  |  | Clothing |  |  |
| Hard Hat |  |  |  |  |  |

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

**Safety Data Sheet**:

|  |  |
| --- | --- |
| Last Update (date): |  |
| Location: |  |
| Accessibility |  | Satisfactory |  | Unsatisfactory |

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

**Safety/ Health Issues (indicate by a √):**

|  |  |  |
| --- | --- | --- |
|  | Vision Conservation | Medical Surveillance Compliance |
|  | Hearing Conservation |  | Satisfactory |  | Unsatisfactory |
|  | Respiratory Protection | Safety/ Health Training: |
|  | Radiation Protection |  | Satisfactory |  | Unsatisfactory |
|  | Ergonomics Program | Frequency: |

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

**Overall Issues/ Concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Overall Recommendation(s):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Follow-up date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OH Staff (Name & Title):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other Reviewing Attendees: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**