|  |  |
| --- | --- |
| **Office Use Only** | |
| Please indicate which of the following best describes the reason for this medical assessment. | |
| Pre-placement | HUET / TBOSIET Training |
| Periodic | Other: (specify: |
| Proof of Identity Confirmed?  Yes  No | Identification Type and Number: |

|  |  |  |
| --- | --- | --- |
| Personal Information – Completed by Employee |  | |
| First Name: | Address: | |
| Last Name: |  | |
| Date of Birth: | City: | State: |
| Sex:  Male  Female | Postal / Zip Code: | Country: |
| Job Title: | Phone No.: | |
| **Safety-Sensitive Position? (Refer to the PET HSE Medical Assessment & Surveillance Procedure for definition)** | Email: | |

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| ***This section to be filled out by Health Care Professional*** | | | |
| **Health Care Professional's Assessment** | | | |
| I understand the essential duties and work environment for this individual. This individual has been examined in accordance with the Pet DW (WEL) Medical Assessment & Surveillance Procedure, and in my professional opinion is: | | | |
|  | **Fit to Work** - individual meets the Pet DW (WEL) medical and functional requirements of the position. | | |
|  | **Unfit to Work (Medical Hold)** - individual does NOT meet Pet DW (WEL) medical requirements for the safe performance of essential job functions and needs further review; Medical Hold. | | |
|  | **Fit to Work Subject to Restrictions (Medical Hold)** - list the required restrictions on page 2.  Expected duration of restrictions? | | |
| Date of Examination (mm/dd/yyyy): | | | |
| Certificate valid for:  Two years (default)  One year  Six months Other (specify): | | | |
| **Health Care Professional Information** | | | |
| Health Care Professional Name (print): | | | |
| Clinic Name: | | | |
| Address: | | | City: |
| State/Province: | | Postal / Zip Code: | Country: |
| Health Care Professional Signature: | | | Date (mm/dd/yyyy): |

**Please send all physical results by email or fax to:**[**Health@woodside.com**](mailto:Health@woodside.com) **OR 1-713-456-2841**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Fit to Work Subject to Restrictions** | | | | | | | |
| Last Name: | First Name: | | | Date (mm/dd/yyyy): | | | |
| If the individual is certified **Fit to Work Subject to Restrictions,** document the specific restrictions required below. | | | | | | | |
| Activity Restrictions | | Maximum Hours / Day | | | | | |
| 0 | 2 | | 4 | 6 | 8+ |
| Standing | |  |  | |  |  |  |
| Sitting | |  |  | |  |  |  |
| Walking | |  |  | |  |  |  |
| Bending / Stooping / Squatting | |  |  | |  |  |  |
| Push / Pull | |  |  | |  |  |  |
| Lifting (up to max weight): | |  |  | |  |  |  |
| Carrying (up to max weight): | |  |  | |  |  |  |
| Keyboarding / Mousing | |  |  | |  |  |  |
| Reaching | |  |  | |  |  |  |
| Climbing | |  |  | |  |  |  |
| Driving Company Motor Vehicle | |  |  | |  |  |  |
| Operating Equipment (fork lift, etc.) | |  |  | |  |  |  |
| Use of Upper Extremities:  Left  Right | |  |  | |  |  |  |
| Use of Lower Extremities:  Left  Right | |  |  | |  |  |  |
| Safety Sensitive Duties | |  |  | |  |  |  |
| PPE Restrictions (use of gloves, respirator, etc.) | |  |  | |  |  |  |
| Repetitive Tasks: | |  |  | |  |  |  |
| Work at Height: | |  |  | |  |  |  |
| Shift Work: | |  |  | |  |  |  |
| Vibration: | |  |  | |  |  |  |
| Work Off-shore / High Risk / Remote / Alone (circle restricted environment) | |  |  | |  |  |  |
| Other (vision, cognition, critical thinking, etc.): | |  |  | |  |  |  |

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| **This section to be filled out by the Employee  and reviewed by the Examining Health Care Professional.** | | | | |
| The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. ‘Genetic information’ as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. | | | | |
| **Personal Information** | | | |  |
| Last Name: | First Name: | | | Date of Birth (mm/dd/yyyy): |
| **General Health Information** | | | | |
| **Present major  complaints/health problems** | YES | NO | If YES, explain | |
| **Personal Physician** (or other medical contact) |  |  | If YES, provide name and phone number | |
| **Past hospitalizations, surgeries,  major illnesses/injuries, treatment for mental health condition, etc.** |  |  | If YES, provide description and date(s) | |
| **Medication**  If YES, list any prescription, over-the-counter medication, dietary supplements that could affect your ability to safely perform the essential functions of your job. |  |  | *If YES, provide name, dosage* | |
| **Exposure, Lifestyle and Allergies** | | | | |
| **Exposure History** | YES | NO | If YES, describe your exposure in detail | |
| *Loud noise* |  |  |  | |
| *Radiation* |  |  |  | |
| *Dusts or Fibers* |  |  |  | |
| *Chemicals or Fumes* |  |  |  | |
| *Vibration* |  |  |  | |
| **Lifestyle** | YES | NO | If YES, how often? | |
| *Do you smoke?* |  |  |  | |
| *Do you drink alcohol?* |  |  |  | |
| *Do you use drugs?* |  |  |  | |
| *Do you exercise?* |  |  |  | |
| **Allergies** | YES | NO | If YES, provide details and describe severity | |
| *Medicine allergies* |  |  |  | |
| *Food allergies* |  |  |  | |
| *Environmental allergies* |  |  |  | |
| *Other:* | | | | |

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| --- | --- | --- | --- | --- |
| Previous and Current Conditions (please check the box if you have ever had any of the following) | | | | |
| Allergies: Seasonal (hay fever) | | Fatigue: Sleep disorders | | Previous Heat Illness |
| Allergies: Sinus trouble | | GI: Blood in stool | | Pregnancy: Current (or Suspected) |
| Amputation or prosthesis | | GI: Change in bowel movements | | Respiratory: Coughed blood |
| Back pain / injury | | GI: Gall bladder disease | | Respiratory: Emphysema |
| Blood disorders | | GI: Recurrent indigestion | | Respiratory: Asthma / bronchitis |
| Breast pain / lump / discharge | | GI: Stomach pain / ulcer | | Respiratory: Shortness of breath |
| Broken bones | | GI: Vomiting / nausea | | Respiratory: Silicosis |
| Cancer | | Head injury or unconsciousness | | Respiratory: Tuberculosis |
| Cardiac: Blood Pressure: High or Low | | Headaches / migraine | | Rheumatic fever |
| Cardiac: Chest pain or angina | | Hernia | | Skin trouble |
| Cardiac: Heart disease / Heart attack | | Immunodeficiency disorder | | Sleep Apnea |
| Cardiac: Stroke | | Jaundice or hepatitis | | Surgical operation |
| Cardiac: Thrombosis / Blood clots | | Joint problems / arthritis / gout | | Tropical disease (malaria, etc.) |
| Dental problems or dentures | | Kidney disease | | Unexplained weight loss / gain |
| Diabetes | | Kidney stones | | Unsteady gait / frequent falls |
| Dizziness / fainting | | Knee problems | | Urine: Bloody |
| Ears: aches / ringing / drainage | | Mental Health Issues (depression, etc.) | | Urine: Painful passage |
| Ears: Difficulty hearing | | Mental Health: Anxiety Disorders | | Varicose veins |
| Epilepsy / seizures / convulsions | | Mental Health: Drug/alcohol abuse | | Vision: Any difficulties |
| Evacuated from offshore/onshore site | | Muscle weakness or paralysis | | Vision: Color blindness |
| Fatigue: Chronic | | Neck pain / whiplash | | Vision: Wear glasses / contacts |
| Fatigue: Fall asleep during the day | | Numbness / tingling | |  |
| Other (please explain): | | | | |
| **Additional Information** | If you check any of the above boxes, please provide additional information including:   * Approximate date(s) of diagnosis * Any limitations * If the condition is controlled * Other pertinent details | |  | |
| **Consent to Release Information** | | | | |
| Yes  No | I certify that all information that I have reported is true and correct to the best of my knowledge, and I have not knowingly omitted to report any material information relevant to this form. I hereby authorize the examining medical personnel and/or Physician to disclose any information provided by me in this questionnaire and the results of the medical assessment to the designated medical practitioner of Petroleum Deepwater (WEL) as applicable in a confidential manner to determine my ability to perform the essential requirements of my job. I understand that the information collected based on the foregoing statements will be kept in a confidential file separate from my personnel file. | | | |
| Printed Name: | | | | Date: |
| Signature: | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Personal Information | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
| Last Name: | | | | | First Name: | | | | | | | | | | Date of Birth (mm/dd/yyyy): | | | | | | | | | | | | |
| **Vital Signs** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Height | Weight | BMI | | | | Blood Pressure | | | | | | Pulse | | | | Temperature | | | Respiration Rate | | | | | | | | |
|  |  |  | | | |  | | | | | |  | | | |  | | |  | | | | | | | | |
| **Vision** | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
| *The visual acuity of each eye should be tested with Snellen's charts and the results recorded below.* | | | **Uncorrected** | | | | | | | | | | | | **Corrected** | | | | | | | | | | | | |
| Left Eye | | | | | Right Eye | | | | | Both | | Left Eye | | | Right Eye | | | | Both | | | | | |
| **Distant** | | |  | | | | |  | | | | |  | |  | | |  | | | |  | | | | | |
| **Near** | | |  | | | | |  | | | | |  | |  | | |  | | | |  | | | | | |
| Color vision (Ishihara): | | | Normal | | | | Abnormal | | | | | | Explain / Detail all abnormal vision findings | | | | | | | | | | | | | | |
| Field of Vision: | | | Normal | | | | Abnormal | | | | | |
| Depth perception: | | | Normal | | | | Abnormal | | | | | |
| **Physical Examination** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Description | | | | | | | | | | Normal | Abnormal | | | Description | | | | | | | | | | Normal | | | Abnormal |
| **Appearance:** Appearance, behavior, mobility | | | | | | | | | |  |  | | | **Respiratory:** Chest expansion, breath sounds | | | | | | | | | |  | | |  |
| **Eyes:** Pupils, fundi | | | | | | | | | |  |  | | | **Musculoskeletal:** Balance, coordination, joints, flexibility, range of motion, spine, etc. | | | | | | | | | |  | | |  |
| **Ears / Hearing:** Gross hearing, canals, ear drums | | | | | | | | | |  |  | | | **Skin:** Scars, dermatitis, ulcer, BCC, etc. | | | | | | | | | |  | | |  |
| **Neurological:** Speech, coordination, reflexes | | | | | | | | | |  |  | | | **Gastrointestinal:** Abdomen, hernia, ulcers, organs | | | | | | | | | |  | | |  |
| **Nose:** Sinuses | | | | | | | | | |  |  | | | **Leg Veins:** Varicose, edema (note severity below) | | | | | | | | | |  | | |  |
| **Teeth and Mouth:** Teeth, gum, fillings, throat | | | | | | | | | |  |  | | | **Endocrine:** Lymph glands, thyroid | | | | | | | | | |  | | |  |
| **Cardiovascular:** Heart sounds, rhythm, murmur | | | | | | | | | |  |  | | | **Other:** Provide details below | | | | | | | | | |  | | |  |
| Please detail any abnormal findings: | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Tests** | | | |  | | | | |  | | | | |  | | | |  | |  | | | | |  | | |
| ECG/EKG indicated or over 40 | | | | Yes | | | | | No | | | | | Vaccines offered?  (Optional: Hep A, Hep B & TDap) | | | | Yes | | | | | No | | | | |
| Audiogram if baseline  or in HCP | | | | Yes | | | | | No | | | | | Urine Drug Test Conducted? (pre-placement safety-sensitive only) | | | | Yes | | | | | No | | | | |
| Spirometry indicated if in the RPP? | | | | Yes | | | | | No | | | | | Urinalysis (dipstick) | | | | Negative | | | Positive | | | | | Trace | |
| Respiratory medical clearance? | | | | Yes | | | | | No | | | | | Protein | | | |  | | |  | | | | |  | |
| Chest X-ray indicated? | | | | Yes | | | | | No | | | | | Blood | | | |  | | |  | | | | |  | |
| Requires referral to Primary Care Physician or Specialist? | | | | Yes | | | | | No | | | | | Glucose | | | |  | | |  | | | | |  | |
| Blood Chemistry  (including CBC with differential and platelet count, CMP with LFT and lipid profile) | | | | Normal | | | | | Abnormal | | | | | Breath Alcohol Test (pre-placement safety sensitive only) | | | |  | | |  | | | | | N/A | |
| Framingham Cardiac Risk Assessment indicated? | | | | Yes | | | | | No | | | | | Physical Agility/Functional Capacity Assessment indicated? | | | | Yes | | | No | | | | | | |
| Health Care Professional Signature: | | | | | | | | | | | | | | | | | Date (mm/dd/yyyy): | | | | | | | | | | |

**Please send all physical results by email or fax to:**[**Health@woodside.com**](mailto:Health@woodside.com) **OR 1-713-456-2841**