REQUIRED DOCUMENTS FROM RN's

Please make copies and send to Surgi-Staff (305-266-3242 fax or surgistf@gate.net)

- **RN License**
- **MMR**
- **PHYSICAL**
- **PPD**
- **BLS**
- **DRUG SCREENING (10 PANNEL)**
- **Two forms of ID: DRIVERS LICENSE, SOCIAL SECURITY CARD, etc.**
- **ACLS, if you have one**
- **PALS, if you have one**

EMPLOYMET APPLICATION FORMS

Please complete all printed forms and send to Surgi-Staff (305-266-3242 fax or surgistf@gate.net)

Surgi-Staff

The Peri-Operative Specialists

EMPLOYMENT APPLICATION

Applicant Information

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: ( ) _____ E-mail Address: _____

Social Security No. _____ Days available: _____ Specialty: _____

Are you a citizen of the United States? YES D NO O

If no, are you authorized to work in the U.S.? YES D NO D

Have you ever worked for this company? YES D NO D

If so, when? _____

Have you ever been convicted of a felony? If yes, explain: YES D NO D

Education

School: _____ City/ State: _____

From: _____ To: _____ Did you graduate? YES D NO D Degree: _____

School: _____ City/ State _____

From: _____ To _____ Did you graduate? YES D NO D Degree: _____

School: _____ City / State _____

From: To: Did you graduate? YES ☐ NO ☐ Degree:

Previous Employment

From: _____ To: Company: _____

Address: _____ Phone :( ) _____

Supervisor: _____ Job Title: _____

Reason for leaving: _____ Starting Salary: $ Ending Salary: $

From: _____ To: _____ Company: _____

Address: _____ Phone :( ) _____

Supervisor: _____ Job Titles: _____

Reason for leaving: Starting Salary: $ Ending Salary: $

Disclaimer and Signature

I understand that employment with Surgi-Staff, Inc. is at will, and either Surgi-Staff, Inc. or I may terminate this employment relationship at any time, for any reason, with or without prior notice and with without cause. I further understand that neither this application nor any other written or oral communication I may receive from Surgi Staff, Inc. constitutes a contract of employment and that Surgi-Staff, Inc. reserves the right at any time to establish, modify, rescind or supplement any or all of its policies and benefits. I authorize Surgi-Staff, Inc. to contact any or all of my former employers listed herein and to inquire about my employment there. I release Surgi-Staff, Inc. and any employer who is contacted from any liability arising out of such inquiry or the response to such inquiry I certify that my answers are true and complete to the best of my knowledge. If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.

Signature: _____ Date: _____

DRUG-FREE WORKPLACE POLICY SUMMARY

Read carefully, ask any question and initial each item separately

____ I hereby acknowledge that I have received a summary of the Company's Drug-Free Workplace Policy. I have had the opportunity to read the Company's Drug-Free Workplaces programs and receive a satisfactory answer to any questions that I have. I have also received a copy of the list of over the counter and prescription drugs that could alter or affect the outcome of a drug test.

____ I know that if I am taking medicine that could affect my ability to perform my job (i.e., there are warning labels on the container) I must inform my supervisor immediately.

____ I know that total compliance wit the Company's Drug-Free Workplace Policy is a condition of continued employment.

____ I know that is I refuse a reasonable suspicion, post-injury, post accident, random, fitness for duty or post treatment drug or alcohol test I may lose my job, my unemployment benefits, and my workers' compensation medical and indemnity benefits.

____ I know that if am I injured or cause or contribute to the cause of an injury of an accident and test positive for drugs or alcohol I will subject to discipline up to an including discharge.

____ I know that I if I enter into a treatment program for drug or alcohol abuse and test positive for drugs or alcohol following the completion of the primary phase of my treatment I will be subject to discipline up to an including discharge.

____ I know that I have the right to challenge any positive test result and that I must notify the laboratory that I am challenging the test result.

____ I know that if I am convicted of a drug related crime, I must notify my supervisor within five working days.

____ I agree to comply with the drug and alcohol testing requirements of the Company's Drug-Free Workplace Policy.

____ I give my informed consent for the release of drug and/ or alcohol test results to Company.

____ I know that the Company's Drug-Free Workplace policy does not constitute and employment contract between the Company and me.

I have read and understood each of the preceding items that I have initialed. I have read the opportunity to question any item that I did not understand. I have voluntarily signed this form.

_____	_____	_____	_____
Employee	Date	Witness	Date

I hereby **refuse** to submit to a drug test as part of the Company's Drug-Free Workplace Program.

_____	_____	_____	_____
Employee	Date	Witness	Date

Employee Acknowledgement Form

The employee handbook describes important information about Surgi-Staff, Inc. I understand that I should consult the Executive office regarding any questions not answered in the handbook. I have entered into my employment relationship with Surgi-Staff, Inc. voluntarily and acknowledge that here is no specified length of employment. Accordingly, either Surgi-Staff, Inc. Or I can terminate the relationship at will, without cause, at anytime, so long that it is not in violation of applicable federal or state law.

Since the information, policies, and benefits described here are necessarily subject to change, I acknowledge revisions to the handbook may occur, except to Surgi-Staff, Inc.'s policy of employment-of-will. All such changes will be communicated through official notices, and I understand that revised information may supersede, modify or eliminate existing policies. Only the president of Surgi-Staff, Inc. has the ability to adopt any revisions to the policies in this handbook.

Furthermore, I acknowledge that this handbook is neither a contract of employment nor a legal document. I have received the handbook, and I understand that this is my responsibility to read and comply with the policies contained in this handbook and any revisions made to it.

_____ _____

Employee Signature Date

_____ _____

Employee Name Date

"Declination"

Hepatitis B Vaccine

I understand that due to my occupational exposure to blood or other potentially infectious material I may be at risk of acquiring Hepatitis B virus (HBV) 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 that 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 potential infectious material and I want to be vaccinated with Hepatitis B vaccine, I will receive the vaccination series at no charge to me.

_____

Employee/ Contractor name (print)

_____ _____

Employee/ Contractor Signature Date

_____ _____

Nursing Director's Signature Date

Form W-4 (2015)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2015 expires February 16, 2016. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2015. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A ____
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less. . . .	B ____
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C ____
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	D ____
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . .	E ____
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit . . . (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F ____
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $65,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $65,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child . . .	G ____
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ▶	H ____

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Separate here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Form **W-4** — Department of the Treasury, Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2015

1 Your first name and middle initial / Last name		2 **Your social security number**
Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code	4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ▶ ☐	
5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)		5
6 Additional amount, if any, you want withheld from each paycheck		6 $
7 I claim exemption from withholding for 2015, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here . . . . . ▶		7

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature *(This form is not valid unless you sign it.)* ▶ **Date** ▶

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

OMB No. 1615-0047; Expires 08/31/12

Department of Homeland Security
U.S. Citizenship and Immigration Services

Form I-9, Employment Eligibility Verification

Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification *(To be completed and signed by employee at the time employment begins.)*

Print Name: Last	First	Middle Initial	Maiden Name

Address *(Street Name and Number)*	Apt. #	Date of Birth *(month/day/year)*

City	State	Zip Code	Social Security #

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

- ☐ A citizen of the United States
- ☐ A noncitizen national of the United States (see instructions)
- ☐ A lawful permanent resident (Alien #) _____
- ☐ An alien authorized to work (Alien # or Admission #) _____ until (expiration date, if applicable - *month/day/year*) _____

Employee's Signature | Date *(month/day/year)*

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

Preparer's/Translator's Signature	Print Name

Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*

Section 2. Employer Review and Verification *(To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)*

List A	OR	List B	AND	List C
Document title:				
Issuing authority:				
Document #:				
Expiration Date *(if any)*:				
Document #:				
Expiration Date *(if any)*:				

CERTIFICATION: I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on *(month/day/year)* _____ **and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)**

Signature of Employer or Authorized Representative	Print Name	Title

Business or Organization Name and Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*

Section 3. Updating and Reverification *(To be completed and signed by employer.)*

A. New Name *(if applicable)*	B. Date of Rehire *(month/day/year) (if applicable)*

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.

Document Title: _____ Document #: _____ Expiration Date *(if any)*: _____

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Date *(month/day/year)*

SCHEDULE II TO SUPPLEMENTAL STAFFING UTILIZATION
POLICIES AND PROCEDURES

TB Questionnaire

EMPLOYEE NAME: _____
COMPANY NAME: _____ DATE: _____

STEP I
If you have had a positive PPD in the past, go to step II. If you receive PPD's on an annual basis, complete **Step I ONLY**.

DATE OF LAST PPD: _____ RESULTS OF LAST PPD IN MM: _____

STEP II
Since you have had a positive/sensitive PPD and are no longer required to have an annual chest x-ray, the following is to be completed annually and maintained in the personnel file. However, you must have the results of at least one XRAY on File.

DATE OF LAST XRAY:_____

Please read and put a checkmark in the correct Yes/No space if you are experiencing any of the following symptoms or if any of the following apply to you:

	YES	NO
1. Unplanned loss of weight(>10% of body weight).....	___	___
2. Night sweats.....	___	___
3. Fever lasting several weeks	___	___
4. Frequent coughing in the absence of a cold or flu.....	___	___
5. Coughing blood-streaked sputum.....	___	___
6. Unusual tiredness or weakness lasting weeks	___	___
7. Pain in chest when taking a breath.....	___	___
8. Have you been recently diagnosed with diabetes, silicosis, HIV disease, renal disease or liver disease?.....	___	___
9. Have you been recently been exposed to a family member or others with active TB?.....	___	___

If you checked YES to any of the above question, are you currently treating with a physician?: (Circle one) YES NO Please explain:_____
_____
_____

IF YOU DEVELOP ANY OF THE SYMPTOMS LISTED ABOVE, PLEASE CONTACT YOUR PHYSICIAN AND AGENCY **IMMEDIATELY**. A CHEST X-RAY **MUST** BE PERFORMED PRIOR TO WORKING AGAIN.

_____
SIGNATURE **DATE:**

Surgi-Staff

The
Peri-Operative
Specialists

Education Verification

I give permission to Surgi-Staff, Inc. to obtain verification of my education.

Signature: _____ Date: _____

Surgi-Staff

The
Peri-Operative
Specialists

Verification of Employment

Contact Person: _____

Contact Number: _____

_____

For Surgi-Staff Use only

Date: ___ / ___ /___

Hospital: _____

Time: _____

Signature: _____

Surgi-Staff

The
Peri-Operative
Specialists

U.S. Government Terrorist List Exemption Form

Last Name: _____

First Name: _____

Exempt By: _____

Executive Order Number: _____ Date: _____

Website: _____

Pre-Employment Refernce Check

Applicants Name: _____ Date: _____

Position Held: _____

I autherize the relese of all information on this form
Applicants Signature: _____

Name of Reference: _____ Dates of employments: _____
Phone Number: _____ Would you re-hire? : _____

		Poor	Fair	Average	Very Good	Excellent	N/A
Professional Conduct							
Quality of Work							
Suitable for Position							
Personal Apperarance							
Attendance							
Dependability							
Cooperativness Supervisor							
Cooperativeness Peers							
Creativity							
Punctuality							

Signature: _____

Name of Reference: _____ Would you re-hire? : _____
Phone Number: _____ Dates of employments: _____

		Poor	Fair	Average	Very Good	Excellent	N/A
Professional Conduct							
Quality of Work							
Suitable for Position							
Personal Apperarance							
Attendance							
Dependability							
Cooperativeness Peers							
Creativity							
Punctuality							

Signature: _____

PARALLON
WORKFORCE MANAGEMENT SOLUTIONS ™

PWMS Annual Respiratory Protection

I: Respiratory Protection Education (attached) and Questionnaire;

- Respiratory face fit testing is performed ***annually*** or as needed when if you gain or lose 10 pounds, experience facial injury/scarring, have a change in dental structure or grow/shave facial hair;
- I have been re-educated on the need for TB respiratory protection and understand that if I have a change in any of the above – at any time – I will have to be face fit tested immediately;
- I have been fit tested with N-95 mask at _____ hospital on _____

  SIZE: ☐SMALL ☐REGULAR

III: Employee Name: _____

Signature of Employee: _____ Date: _____

IV: TB Face Fit Testing

- Face fit test completed on: _____
- Fitted with no difficulty: Yes ____ No ____
- Fit test is completed:

  ☐PASS ☐FAIL SIZE: ☐SMALL ☐REGULAR

- Particulate Respirator:
  - ☒ 3M N95 1860
  - ☐ 3M N95 1870
  - ☐ Kimberly-Clark Tecnol Fluidshield PFR-95-270
  - ☐ Other (Specify) _____
- Unable to fit test:
  1. Unable to obtain seal: Yes ____ No ____
  2. Medical reasons: Yes ____ No ____
- Comments: _____

V: Signature of Fit Tester: _____ Date: _____

PARALLON WORKFORCE MANAGEMENT SOLUTIONS

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.

Part A. Section 1. (Mandatory)

Every employee who has been selected to use any type of respirator must provide the following information.

Name: _____ Title: RN - Dialysis Date: _____

Age: _____ Sex: ☐ Male ☐ Female Your height: _____ ft. _____ in. Weight_____

A phone number where the health care professional who reviews this questionnaire can reach you. Phone: _____ best time to phone you at this number: _____

Has your employer told you how to contact the health care professional who will review this questionnaire (Check one): ☐ Yes ☐ No

Check the type of respirator you will use (you can check more than one category):
a. ___X___ N, R, or P disposable respirator (filter-mask, non- cartridge type only).
b. _____ other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, Self-contained breathing apparatus).
Have you worn a respirator (Check one): ☐ Yes ☐ No
If yes what type: _____

Part A. Section 2. (Mandatory)
Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please check "yes" or "no").

1. **Do you currently smoke tobacco, or have you smoked tobacco in the last month: ☐Yes ☐No**
2. **Have you ever had any of the following conditions?**

a) Seizures: ☐Yes ☐No
b) Diabetes: ☐Yes ☐No
c) Trouble smelling odors: ☐Yes ☐No
d) Claustrophobia: ☐Yes ☐No
e) Allergic reactions that affect your breathing: ☐Yes ☐No

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

a) Asbestosis: ☐Yes ☐No
b) Asthma: ☐Yes ☐No
c) Emphysema: ☐Yes ☐No
d) Pneumonia: ☐Yes ☐No
e) Tuberculosis: ☐Yes ☐No
f) Silicosis: ☐Yes ☐No
g) Pneumothorax: ☐Yes ☐No
h) Lung cancer: ☐Yes ☐No
i) Chronic bronchitis: ☐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

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

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

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

a) Heart attack: ☐Yes ☐No
b) Stroke: ☐Yes ☐No
c) Angina: ☐Yes ☐No
d) Heart failure: ☐Yes ☐No
e) Swelling in your legs or feet (not caused by walking): ☐Yes ☐No
f) Heart arrhythmia (heart beating irregularly): ☐Yes ☐No
g) High blood pressure: ☐Yes ☐No
h) Any other heart problem that you've been told about: ☐Yes ☐No
i) Have you ever had any of the following cardiovascular or heart symptoms: ☐Yes ☐No
j) Frequent pain or tightness in your chest: ☐Yes ☐No
k) Pain or tightness in your chest during physical activity: ☐Yes ☐No
l) Pain or tightness in your chest that interferes with your job: ☐Yes ☐No
m) In the past two years, have you noticed your heart skipping or missing a beat: ☐Yes ☐No
n) Heartburn or indigestion that is not related to eating: ☐Yes ☐No

6. **Any other symptoms that you think may be related to heart or circulation problems:** ☐Yes ☐No

7. **Do you currently take medication for any of the following problems?** ☐**Yes** ☐**No**

a) Breathing or lung problems: ☐Yes ☐No
b) Heart trouble: ☐Yes ☐No
c) Blood pressure: ☐Yes ☐No
d) Seizures: ☐Yes ☐No

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

(If you've never used a respirator, check the following space and go to question 9:) ☐ Never used

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 that will review this questionnaire?**

Comments (for Healthcare professional use only)

_____

_____ _____

Employee Signature Date