

Blue

CLINICAL OCCUPATIONAL HEALTH EXAMINATION REQUIREMENTS	WORKPLACE IDENTIFIER	[REDACTED]	[REDACTED]	[REDACTED]
Data As Of: [REDACTED]	BASE	[REDACTED]	ORGANIZATION	
Edited By: [REDACTED]	WORKPLACE			
PEG: STRUCTURAL	[REDACTED]			
Risk Category: 1 (High)	BLDG NO/LOCATION	ROOM/AREA		
	[REDACTED]			

EXAMINATION REQUIREMENTS: **Required for everyone**

EXAMINATIONS	AGE START	AGE STOP	ONE TIME	FREQ	PRE TERM	RATIONALE & NOTES
Occ and Environmental Health Exposure Data	0	100	<input type="checkbox"/>	12	<input checked="" type="checkbox"/>	BE complete OEHD IAW AFI 48-145_ANGSUP 2.11.9 and DoD 6055.05M C 1.2.1. AFI 48-145_ANGSUP 2.12.5.4 OEHD is filed in medical record.
Respirator Fit Test	0	100	<input type="checkbox"/>	12	<input checked="" type="checkbox"/>	AFI 48-137 2.15.2. Conducts medical evaluations of individuals identified to wear a respirator, as required, and determines fitness to use the respiratory protection specified in the individuals workplace-specific plan and/or medical evaluation questionnaire, 29 CFR 1910.134(f), 29 CFR 1910.134 App A, DoD 6055.05-M C4.13 TC2. T17
Respirator Questionnaire	0	100	<input checked="" type="checkbox"/>	0	<input checked="" type="checkbox"/>	AFI 48-137 5.2.1 The medical evaluation consists, at a minimum, of completing the respirator medical evaluation questionnaire for PLHCP review, and is only an initial requirement. There is no requirement to re-accomplish respirator medical evaluation questionnaires annually, however, medical evaluation will need to be redone under certain circumstances (i.e., job duty change, respiratory protection changes, relocation to a new duty location, etc.) as determined by BE. At a minimum, the mandatory questions stated in the 29 CFR 1910.134, Appendix C, will be used.

IMMUNIZATIONS REQUIRED:

None

Noise ECL (in dbA) = 84.12

[1] Personnel receive initial training for HAZCOM, and annual training for Fetal Health Protection Training

[2] Initial OSHA respirator questionnaire is required for all personnel who wear respirators

TYPED OR PRINTED NAME, AERO MED COUNCIL CHAIRMAN	SIGNATURE	DATE
[REDACTED]	[REDACTED]	[REDACTED]