TO THE PRE-EMPLOYMENT CANDIDATE
POLICE OFFICER

Please complete the enclosed forms prior to your appointment in Medical Services. Instructions are listed here. Please review the instructions before completion.

Medical Examination (with NJ Transit logo top/left)- Complete only the line with the your name, date of birth, and social security number on the first side of the form. On the other side, complete the **ENTIRE** page. These questions refer to your health history **throughout your lifetime (not just the past 5 years).** Sign and date at the bottom after completing.

Obstructive Sleep Apnea Evaluation- Answer the yes/no questions **TO BE COMPLETED BY PATIENT** section only.

Noise Level and Hearing Loss Survey- Answer the questions. Sign & date the bottom after completing.

Audiological Examination- Complete all of side #1 and answer the question regarding "other activities" on side #2. You may write "no" or N/A for other activities if they do not apply to you. Sign & date

Respiratory Testing Form- Complete all of side #1 and answer the questions on side #2, stopping @ "doctor's examination"

Respirator Medical Evaluation Questionnaire- Complete this 7-page questionnaire. If you are unsure of any answer, leave blank.

Drug & Alcohol General Briefing Form- read both sides and sign your name at the bottom of page #2.

If you are unsure of any question, leave it blank and we will discuss it when you are here for your appointment.

Please bring this completed packet with you for you appointment at Medical Services.
Thank you.

NJTRANSIT The Way To Go.

MEDICAL EXAMINATION

- ☐ - Pre-Placement Exam
- ☐ - Periodic Exam
- ☐ - Return From Furlough
- ☐ - Other ____________
- ☐ - Return From Occupational Disability
- ☐ - Return From Non-Occ. Disability

Date and time of exam: / / at :

JOB TITLE & LOCATION:

Name: Last	First	Middle	Employee No. or Social Security No.	Date of Birth

Blood Pressure		Pulse	Ht.	Wt.	Age	Sex	Eyes	Hair

Urinalysis	Albumin	Glucose	Sp. Gr.

NORMAL	EXAMINATION	ABN/NA
	1. General Appearance	
	2. Head, Face and Neck	
	3. Nose and Sinuses	
	4. Mouth, Dental and Throat	
	5. Eyes and Pupils	
	6. Ears and Eardrums	
	7. Lungs and Chest	
	8. Heart	
	9. Vascular and Lymphatics	
	10. Abdomen and Viscera	
	11. Hernia	
	12. Endocrine and G-U System	
	13. Spine – (Range of Motion)	
	14. Upper Extremities – (ROM)	
	15. Lower Extremities – (ROM)	
	16. Skin, Body marks and Scars	
	17. Neurologic System	
	18. Emotional Status	
	19. Habits – Substance Abuse	
	20. Tobacco – ETOH Dependency	
	21. GYN History	

Nurse's Comments on Abnormalities

Denies any injuries to neck, back, shoulders or knees. ____________
initials

Physician's Comments on Abnormalities

Job Classification: A = Sedentary Work B = Light Work C = Moderate Work D = Hard Work E = Very Hard Work

- ☐ Accepted For Job Classification (Circle One): A B C D E ☐ Without Lenses ☐ With Lenses
- ☐ Conditional Acceptance With Reasonable Accommodation:
- ☐ Conditional Acceptance Pending: ☐ Medical Treatment ☐ Attending Doctor's Clearance ☐ Additional Testing
- ☐ Not Qualified
- ☐ Remarks: ____

____

Date:	Staff:	Physician:

DO NOT WRITE BELOW THIS LINE

REVIEW OF DIAGNOSTIC PROCEDURES & ASSESSMENTS

FCE	☐ Normal	☐ Abnormal	☐ See Report
Stress Test	☐ Normal	☐ Abnormal	☐ See Report
Psyche Evaluation	☐ Normal	☐ Abnormal	☐ See Report
EKG	☐ Normal	☐ Abnormal	☐ See Report
Spirometer	☐ Normal	☐ Abnormal	☐ See Report
X-Ray	☐ Normal	☐ Abnormal	☐ See Report
Blood Work	☐ Normal	☐ Abnormal	☐ See Report

Hearing: ____________

Other: ____________

Vision Acuity: ____________

Color: ____________

Other: ____________

Drug/Alcohol Test: ____________

Reviewed By: ____________

PLEASE COMPLETE ENTIRE PAGE

Position		Date
Name: Last, First, Middle	Social Security or Employee No.	Birthdate
Home Address: No. Street, City, State, Zip Code		Telephone No.
Name And Address Of Your Personal Physician		Date Last Seen

	YES	NO	EXPLANATION
Have you been examined by any other physicians other than your personal physician as above?			
Have you taken any medications in the past two weeks, and are you on any medication now?			
Have you ever been a patient in a hospital, clinic, institution or a rehabilitation/detoxification center?			
Have you ever received counseling or treatment regarding the use of alcohol or drugs?			
Have you ever used Marijuana, Cocaine, Amphetamines, PCP, Heroin, Opiates, Barbiturates or other narcotics?			
Do you know of any physical or mental condition which might restrict your ability to work?			
Do you have any deformity, amputation or physical defect?			
Have you lost any time from work?			
Have you ever received or are now receiving disability payments because of injury, illness or military service disability?			
Have you ever been diagnosed or treated for sleep apnea?			

Have you ever been treated for, do you have or have you ever had any of the following?:

	YES	NO		YES	NO		YES	NO
Alcoholism			Headaches			Lung Problems or Asthma		
Drug Addiction			Dizziness or Vertigo			Tuberculosis		
Allergies			Epilepsy or Convulsions			Thyroid Problems		
Back Trouble, Disc or Injury			Fainting Spells			Stomach Problems or Ulcer		
Bone or Joint Deformity			Mental Disorder			Liver Problems or Hepatitis		
Broken Bones or Diseases			Nervous Disorder/Breakdown			Malaria		
Shoulder, Arm, Hand Trouble			Eye Trouble			Hernia or Rupture		
Shoulder, Arm, Hand Pains			Double Vision or Blindness			Diabetes		
Hip, Knee, Leg Trouble			Ear Trouble or Tinnitus			Recent Weight Gain or Loss		
Hip, Knee, Leg Pains			Hearing Loss			Hives or Poison Ivy		
Neck, Trouble, Disc or Injury			High or Low Blood Pressure			Dermatitis or Skin Rash		
Varicose Veins			Heart Trouble or Murmur			Bladder/Urination Problems		
Foot Trouble or Pains			Chest Pains or Palpitations			Kidney Trouble or Stone		
Painful Joints or Muscles			Diagnostic Tests (i.e.:CT scan/MRI)			Cancer, Tumor or Cyst		
Arthritis or Rheumatism			Shortness of Breath or Cough			Other – Not Listed Above		
Anxiety/Depression			Weakness or Fatigue					
Head Injury or Concussion			Anemia or Blood Problems					

If any of the above have been answered **YES**, please explain in the space provided below:

____

____

____

____

____

I certify that I have read and truthfully answered all questions regarding my health history. I understand that statements on this form may be investigated and that any misrepresentation or omission of material fact will be sufficient cause for my dismissal from the Company's service if I am employed. In submitting this form, I understand that I am giving permission for a medical examination.

Date:	**Employee Signature:**	**Witness:**

Philip D. Murphy, Governor
Sheila Y. Oliver, Lieutenant Governor
Diane Gutierrez-Scaccetti, Commissioner
Kevin S. Corbett, President & CEO

NJ TRANSIT
MEDICAL SERVICES
(973) 378-6072
(973) 609-1828

New Jersey Transit
MEDICAL SERVICES
Obstructive Sleep Apnea Evaluation

Last Name: ______________________ First Name: ____________________ Age: _____ Gender: _____

Have you ever been diagnosed or treated for sleep apnea? **YES** ☐ **NO** ☐

TO BE COMPLETED BY EMPLOYEE

Is it possible that you have Obstructive Sleep Apnea (OSA)?

Please answer the following questions below ▼ and to your right ▶

STOP-Bang Questionnaire

		Circle Y= yes N= no	
S	Do you **Snore Loudly** (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)?	Y	N
T	Do you often feel **Tired, Fatigued, or Sleepy** during the daytime (such as falling asleep during driving or talking to someone)?	Y	N
O	Has anyone **Observed** you **Stop Breathing** or **Choking/Gasping** during your sleep?	Y	N
P	Do you have or are being treated for **High Blood Pressure**?	Y	N
B	**Body Mass Index more than 35 kg/m2?**	Y	N
A	**Age older than 50?**	Y	N
N	**Neck size large? (Measured around Adams apple)** For male, is your shirt collar 17 inches / 43cm or larger? For female, is your shirt collar 16 inches / 41cm or larger?	Y	N
G	**Gender = Male?**	Y	N

STOP-Bang Scoring Criteria:

- Low risk of OSA: Yes to 0-2 questions
- Intermediate risk of OSA: Yes to 3-4 questions
- High risk of OSA: Yes to 5-8 questions
  - *or Yes to 2 or more of 4 STOP questions + male gender*
  - *or Yes to 2 or more of 4 STOP questions + BMI > 35 kg/m2*
  - *or Yes to 2 or more of 4 STOP questions + neck circumference*
  (17"/43cm in male, 16"/41cm in female)

Score ______

Proprietary to University Health Network. www.stopbang.ca

Total your questions answered "Yes", fill in number here ▲

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life recently. Even if you haven't done some of these things recently, try to figure out how they would have affected you.

0 = no chance
1 = slight chance
2 = moderate chance
3 = high chance

Situation				
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (i.e. in a theater or a meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

ESS Scoring Criteria:

- 0-5 Lower Normal Daytime Sleepiness
- 6-10 Higher Normal Daytime Sleepiness
- 11-12 Mild Excessive Daytime Sleepiness
- 13-15 Moderate Excessive Daytime Sleepiness
- 16-24 Severe Excessive Daytime Sleepiness

Score ______

ESS © MW Johns 1990-1997. Used under License

Total your above values and fill in number here ▲

Employee Number: ______________________

Employee Signature: ______________________ Date: ___/___/___

Total Scores and Sign – *Your Portion is Complete*
DO NOT WRITE ON SECOND PAGE

TO BE COMPLETED BY PHYSICIAN

OBSTRUCTIVE SLEEP APNEA RISK ASSESSMENT

Weight: ________ Height: ______ BMI: ______ Neck Circumference: ______

☐ BMI = ≥ 40 kg/m² - ***Automatically meets criteria for diagnostic sleep evaluation*** ☐ BMI ≥ 33 kg/m² and < 40 kg/m²

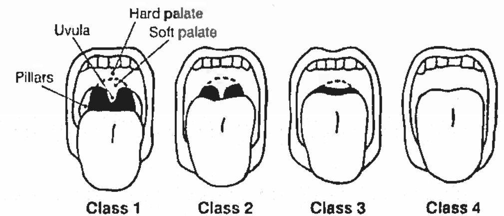
☐ Neck Circumference greater than 17 inches in males, or 15.5 in females ☐ Age ≥ 42 years

History of: ☐ Hypertension ☐ Type II Diabetes ☐ Stroke / CAD / Arrhythmia ☐ Retrognathia or Micrognathia

☐ Loud Snoring ☐ Witnessed Apneas ☐ Untreated Hypothyroidism ☐ Male or Post-Menopausal Female

Mallampati Classification: ☐ III or ☐ IV (small airway)

Class I - Visualization of labeled anatomy and lauces
Class II - Unable to visualize pillars
Class III - Visualization of soft palate and base of uvula
Class IV - Unable to visualize soft palate



PHYSICIAN COMMENTS:

FINAL OBSTRUCTIVE SLEEP APNEA RISK DETERMINATION	CERTIFICATION STATUS
☐ BMI = ≥ 40 kg/m²	*Pending determination* Referred for evaluation of OSA
☐ BMI ≥ 33 kg/m² and < 40 kg/m² with ≥ 3 risk elements identified above	*Pending determination* Referred for evaluation of OSA
☐ • Admits to fatigue or sleepiness during the wake period • Has been involved in a sleep-related motor vehicle crash or accident or near crash • Non-compliant with treatment plan for existing diagnosis of OSA • CME determines individual at extremely high risk	**IMMEDIATE DISQUALIFICATION**

☐Maplewood ☐Hoboken ☐Camden ☐Egg Harbor ☐Outside Facility

Physician Name: ____________________ Physician Signature: ____________________ Date: ___/___/___

Outside Facility Information

Facility Name: ______________________________

Address: ______________________________

____

Phone Number: (   ) _____-________ ext. _______

NJ TRANSIT
MEDICAL SERVICES

NOISE LEVEL and HEARING LOSS SURVEY/QUESTIONNAIRE

Employee Name/Number: ______________________________

Assigned Location: ______________________________

1. What recreation activities do you participate in outside of work? (Hunting, Boating, Target practice with a firearm, Night Clubs/Disco, Play in a musical band, Use of iPod, Headphones, Loud music, Swimming, Contact sports, etc.)
   (List all): ______________________________
   ____

2. Do you have another job outside of NJT? (Y) (N) (Landscaping, Airport, Disc Jockey, Bartender, Club Security, Manufacturing Plant (Describe): ______________________________
   ____

3. Do you experience ringing in the ears, if so when and how long? (Y) (N) ______________
   ____

4. Have you ever had mumps, ear infection, high fevers, sinus infections or any other illnesses related to the head? (Y) (N) ______________________________

5. Have you ever had any direct impact to the ear area or ear canal? (Y) (N) ______________
   ____

6. Do you use Q-tips or any other objects or solutions to clean your ears? (Y) (N) __________
   ____

7. What activities do you perform regularly as a ______________________ (Job Title) for NJT and for how long each day? (List)

Job Description	Time Period (Hr./Min.)
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

8. Do you wear hearing protection either a work or for outside activities? If yes, what activities? What activities?
   ____

Completed by (Name/Title): ______________________ / ______________________

Date Completed: ______________________

AUDIOLOGICAL EXAMINATION

Print Employee Name ______________________________ Employee # __________

Date _____/_____/_____ Social Security # ________-______-________

Birth Date _____/_____/_____ Age ____ Sex M __ F __ Hire Date _____/_____/_____

What is your job title? ______________________________

How long have you worked in this job? ______________________________

Have you been exposed to loud noises over the last 14 hours? Yes ____ No ____

Please complete the following history by answering "yes" or "no":

		YES	NO
1.	Have you ever had noise in your ears?	______	______
2.	Have you ever had dizzy spells?	______	______
3.	Have you ever had clogged feeling in your ears?	______	______
4.	Have you ever had pain in your ears?	______	______
5.	Have you ever had fluctuating hearing loss?	______	______
6.	Have you ever had sudden or rapid hearing loss?	______	______
7.	Have you ever had an ear infection? If "yes" when ______________________	______	______
8.	Have you ever been to an ear specialist? If "yes" when ______________________	______	______
9.	Have you ever had ear surgery? If "yes" when ______________________	______	______
10.	Have you ever had a head injury or been unconscious? If "yes" when ______________________	______	______
11.	Do you hunt or shoot a gun? If rifle or shotgun, which shoulder is used? Right ____ Left ____	______	______
12.	Do you have any noisy hobbies? If "yes" describe ______________________	______	______
13.	Have you ever taken mycins, quinine, excessive aspirin?	______	______
14.	Have you ever had a hearing test before? If "yes" when ______________ where ______________	______	______
15.	Is there a family history of hearing loss?	______	______
16.	Any current hearing problems? If "yes" describe the problem ______________________ ______________________________	______	______
17.	Have you ever had the following: Measles: Yes ____ No ____ Chicken Pox: Yes ____ No ____ Scarlet Fever: Yes ____ No ____ Diphtheria: Yes ____ No ____		
18.	Were you ever in the Military? If "yes" when ______________ How many years? ________ Branch ______________ Job ______________	______	______
19.	Have you ever worked in a job that was noisy?	______	______

Employee's Signature ______________________________ Date ______________

OVER

Since the last examination, have you performed any of the following activities?

Activity	No. of Years	Is Hearing Protection Used		Type
		Yes	No	
Powered Wood Working Tools				
Metal Working				
Go-Carts				
Motorcycles				
Farm Machinery				
Stereo Headphones				
Airplane Pilot				
Chain Saws				
Grinders				
Riveter				
Air-Driven Tools				
Gas Lawn Mowers				
Rock Concerts/Music				
Leaf Blower				

TRAINING RECORD

The following topics of the NJ TRANSIT Rail Hearing Conservation Program have been reviewed with me:

The effects of noise on hearing (on and off the job)

The purpose of hearing protectors, the advantages, disadvantages and attenuation of various types and instructions on selection, fitting, use and care and

The purpose of audiometric testing and an explanation of test procedures.

____________________ Employee Signature　　________________ Employee #　　______________ Date

Reason for screen:　　　　Initial Examination Yes ____ No ____

Post Offer _____ Routine PHE _____ Special Req _____ HCP _____ Re-Test _____ Other _____

OTOSCOPIC EXAMINATION:	Right	Left
Is eardrum visible?	Yes ____ No ____	Yes ____ No ____
Perforation present?	Yes ____ No ____	Yes ____ No ____
Is eardrum normal?	Yes ____ No ____	Yes ____ No ____
Are there any abnormal findings?	Yes ____ No ____	Yes ____ No ____

If yes, please explain:

____

____

____

Doctor's Signature ____________________________ Date ______________

ATTACH RESULTS OF SCREENING

RESPIRATORY TESTING FORM

Name: Last/First ______ Employee No. ______ Date of Birth

Work Location ______ Job Title ______ Date of Hire

Home Address

City ______ State ______ Zip Code

Home Phone Number ______ Cell Phone Number

Employee's Signature ______ Today's date

Medical History: <u>To be completed by EMPLOYEE</u>
DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Y/N
- □□ 1. Heart Problems
- □□ 2. Lung Problems
- □□ 3. Shortness of Breath
- □□ 4. Chest Pain
- □□ 5. Persistent Cough
- □□ 6. High Blood Pressure
- □□ 7. Blood Disorder
- □□ 8. Diabetes

Y/N
- □□ 9.Thyroid Problems
- □□ 10. Stroke
- □□ 11. Ruptured Ear Drum
- □□ 12. Fear of Enclosed Spaces
- □□ 13. Physical Limitations
- □□ 14. Hearing Problems
- □□ 15. Are there other conditions that you feel may affect your ability to wear a respirator?

SMOKING HISTORY:
Have you ever smoked cigarettes regularly? Y____ N ____
Approximately how many years have you smoked cigarettes regularly? ____ Yrs.
During these years how many packs per day did you smoke? ____ Pack(s)/Day
Do you currently smoke cigarettes? Y ____ N ____ ____ Pack(s)/Day
If not currently smoking when did you stop? ____________
Do you currently smoke cigars or a pipe? Y ____ N ____
Do you use snuff or chewing tobacco?

MEDICATIONS: Do you currently take any medications (prescription, over-the-counter)?
If yes, list medications:

____

____

HAVE YOU WORKED IN THE FOLLOWING AREAS:

	Y/N	FROM/TO
Foundry	☐☐	______________
Mine	☐☐	______________
Quarry	☐☐	______________
Asbestos	☐☐	______________
Sand-blasting	☐☐	______________
Textile Mills	☐☐	______________
Dust, Fumes	☐☐	______________

New onset of constipation? ( ) YES ( ) NO If yes, explain ______________________________

Blood in the stool? ( ) YES ( ) NO If yes, explain ______________________________

Black or tarry stool? ( ) YES ( ) NO If yes, explain ______________________________

Abdominal pain? ( ) YES ( ) NO If yes, explain ______________________________

Frequent nausea? ( ) YES ( ) NO If yes, explain ______________________________

Vomiting blood? ( ) YES ( ) NO If yes, explain ______________________________

Chest pain upon exertion? ( ) YES ( ) NO If yes, explain ______________________________

DOCTOR'S EXAMINATION: Age ____ Height ___ Blood Pressure ____/____

Eyes ______________________________

Ears ______________________________

Throat ______________________________

Neck ______________________________

Chest ______________________________

Heart ______________________________

Lungs ______________________________

Abdomen ______________________________

______________________________ M.D.

PASS ____ TRIAL ____ PFTs ______________

Significant History: ______________________________

Appendix C to 1910.134:OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

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:

Can you read (circle one): Yes No

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) The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Today's date:____

2. Your name:____

3. Your age (to nearest year):_______________________________________

4. Sex (circle one): Male Female

5. Your height: __________ ft. __________ in.

6. Your weight: ____________ lbs.

7. Your job title:____

8. A phone number where you can be reached by the health care professional who reviews this questionnaire

(include the Area Code): ______________________________

9. The best time to phone you at this number: _______________

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

11. Check the type of respirator you will use (you can check more than one category):
a. ______ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
b. ______ Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

12. Have you worn a respirator (circle one): .... Yes No

If "yes," what type(s):____

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 circle "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 (fits): ....Yes No
   - b. Diabetes (sugar disease): ....Yes No
   - c. Allergic reactions that interfere with your breathing: ....Yes No
   - d. Claustrophobia (fear of closed-in places): ....Yes No
   - e. Trouble smelling odors (except when you had a cold): ....Yes No

3. Have you ever had any of the following pulmonary or lung problems?
   - a. Asbestosis: ....Yes No
   - b. Asthma: ....Yes No
   - c. Chronic bronchitis: ....Yes No
   - d. Emphysema: ....Yes No
   - e. Pneumonia: ....Yes No
   - f. Tuberculosis: ....Yes No
   - g. Silicosis: ....Yes No
   - h. Pneumothorax (collapsed lung): ....Yes No
   - i. Lung cancer: ....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

6. Have you ever had any of the following cardiovascular or heart symptoms?
a. Frequent pain or tightness in your chest: ....Yes No
b. Pain or tightness in your chest during physical activity: ....Yes No
c. Pain or tightness in your chest that interferes with your job: ....Yes No
d. In the past two years, have you noticed your heart skipping or missing a beat: ....Yes No
e. Heartburn or indigestion that is not related to eating: ....Yes No
f. 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?
a. Breathing or lung problems: ....Yes No
b. Heart trouble: ....Yes No
c. Blood pressure: ....Yes No
d. Seizures (fits): ....Yes No

8. Has your wearing a respirator caused any of the following problems? (If you've never used a respirator, check the following space __ and go to question 9:)
a. Eye irritation: ....Yes No
b. Skin allergies or rashes: ....Yes No
c. Anxiety that occurs only when you use the respirator: ....Yes No
d. Unusual 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 who will review this questionnaire about your answers to this questionnaire: ....Yes No

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.

10. Have you ever lost vision in either eye (temporarily or permanently): ....Yes No

11. Do you currently have any of the following vision problems?
a. Wear contact lenses: ....Yes No
b. Wear glasses: ....Yes No
c. Color blind: ....Yes No
d. Any other eye or vision problem: ....Yes No

12. Have you ever had an injury to your ears, including a broken ear drum: ....Yes No

13. Do you currently have any of the following hearing problems?
a. Difficulty hearing: ....Yes No
b. Wear a hearing aid: ....Yes No
c. Any other hearing or ear problem: ....Yes No

14. Have you ever had a back injury: ....Yes No

15. Do you currently have any of the following musculoskeletal problems?
a. Weakness in any of your arms, hands, legs, or feet: ....Yes No
b. Back pain: ....Yes No

c. Difficulty fully moving your arms and legs: .... Yes No
d. Pain or stiffness when you lean forward or backward at the waist: .... Yes No
e. Difficulty fully moving your head up or down: .... Yes No
f. Difficulty fully moving your head side to side: .... Yes No
g. Difficulty bending at your knees: .... Yes No
h. Difficulty squatting to the ground: .... Yes No
i. Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs: .... Yes No
j. Any other muscle or skeletal problem that interferes with using a respirator: .... Yes No

Part B Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen: .... Yes No
If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions: .... Yes No

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals: .... Yes No

If "yes," name the chemicals if you know them:______________________________

____

____

3. Have you ever worked with any of the materials, or under any of the conditions, listed below:
a. Asbestos: .... Yes No
b. Silica (e.g., in sandblasting): .... Yes No
c. Tungsten/cobalt (e.g., grinding or welding this material): .... Yes No
d. Beryllium: .... Yes No
e. Aluminum: .... Yes No
f. Coal (for example, mining): .... Yes No
g. Iron: .... Yes No
h. Tin: .... Yes No
i. Dusty environments: .... Yes No
j. Any other hazardous exposures: .... Yes No

If "yes," describe these exposures:__________________________________

____

____

4. List any second jobs or side businesses you have:____________________________

____

5. List your previous occupations:____________________________________

____

6. List your current and previous hobbies:________________________________

7. Have you been in the military services? ....Yes No
If "yes," were you exposed to biological or chemical agents (either in training or combat): ....Yes No

8. Have you ever worked on a HAZMAT team? ....Yes No

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications): ....Yes No

If "yes," name the medications if you know them:____

10. Will you be using any of the following items with your respirator(s)?
- a. HEPA Filters: ....Yes No
- b. Canisters (for example, gas masks): ....Yes No
- c. Cartridges: ....Yes No

11. How often are you expected to use the respirator(s) (circle "yes" or "no" for all answers that apply to you)?:
- a. Escape only (no rescue): ....Yes No
- b. Emergency rescue only: ....Yes No
- c. Less than 5 hours per week: ....Yes No
- d. Less than 2 hours per day: ....Yes No
- e. 2 to 4 hours per day: ....Yes No
- f. Over 4 hours per day: ....Yes No

12. During the period you are using the respirator(s), is your work effort:

a. Light (less than 200 kcal per hour): ....Yes No

If "yes," how long does this period last during the average shift:___________hrs.___________mins.
Examples of a light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1-3 lbs.) or controlling machines.

b. Moderate (200 to 350 kcal per hour): ....Yes No

If "yes," how long does this period last during the average shift:___________hrs.___________mins.
Examples of moderate work effort are sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; walking on a level surface about 2 mph or down a 5-degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.

c. Heavy (above 350 kcal per hour): ....Yes No

If "yes," how long does this period last during the average shift:___________hrs.___________mins.
Examples of heavy work are lifting a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).

13. Will you be wearing protective clothing and or equipment (other than the respirator) when you're using your respirator: ....Yes No

If "yes," describe this protective clothing and or equipment:____________________________________

14. Will you be working under hot conditions (temperature exceeding 77 deg. F): ....Yes No

15. Will you be working under humid conditions: ....Yes No

16. Describe the work you'll be doing while you're using your respirator(s):

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases):

____

____

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):
Name of the first toxic substance:______________________

Estimated maximum exposure level per shift:______________________

Duration of exposure per shift______________________

Name of the second toxic substance:______________________

Estimated maximum exposure level per shift:______________________

Duration of exposure per shift:______________________

Name of the third toxic substance:______________________

Estimated maximum exposure level per shift:______________________

Duration of exposure per shift:______________________

The name of any other toxic substances that you'll be exposed to while using your respirator:

____

____

____

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security):

____

____

DRUG & ALCOHOL GENERAL BRIEFING FORM

The collection of your breath and urine specimens will be conducted under applicable Federal Department of Transportation (DOT) Regulations and company policy. These procedures allow for individual privacy in all cases except in the case of urine collection for the detection of drugs if there is reason to believe that a particular individual may have altered or substituted the specimen. In this instance, the collection site person will procure the necessary authorization to perform an observed collection using same gender collector. This precaution is taken to ensure that a second specimen is not adulterated or diluted during that collection process. Urine specimens will follow a strict chain of custody and security procedure.

The procedures for collection of breath and urine samples are as follows:

> The donor must be positively identified through presentation of a photo ID (company pass, drivers' license) or supervisor identification.
>
> All unnecessary outer clothing is to be removed such as, but not limited to, jackets, coats, vests and sweaters. All personal belongings including, but not limited to, purses, briefcases, shopping bags, duffle bags and backpacks will remain with outer garments. You may maintain your wallet.
>
> Urine samples will be collected in secured bathrooms, some which may have stalls or otherwise partitioned areas which provide for privacy.

Employees are required to cooperate with the collection procedures and provide undiluted, unadulterated non-substituted urine samples. If employees are unable to provide adequate urine within the 3 hours period allotted; and after consuming no more than 40 ounces of fluid, the testing procedures will be discontinued. The employee will be referred to a Company Medical Facility for a physical examination. The Company doctor will then document the physical findings and determine if the inability to provide a urine sample is based upon a valid medical condition. Failure to provide a sufficient quantity of urine without a valid medical explanation is considered a refusal to cooperate.

Likewise, breath samples are to be provided as requested in order to register an adequate deep lung sample on the Evidential Breath Testing Device. If an employee is unable to provide an adequate breath sample, that employee will be referred to a Company Medical Facility for a physical examination. The Company doctor will then document the physical findings and determine if the inability to provide a breath sample is based upon a valid medical condition. If no valid medical condition exists, the failure to provide an adequate breath sample will be considered a refusal.

X ______________________________

-over-

EMPLOYEE'S RESPONSIBILITY DURING THE COLLECTION PROCESS

The employee is to remain with the collection site person at all times keeping the urine specimen in full view. All labels, seals and forms that are associated with the collection of the sample for drug testing are to be completed by the employee as requested by the collection site person.

If, after laboratory analysis the specimen is found to contain any drugs of abuse, the results will be disclosed to the Medical Review Officer (MRO). It is at this time that the employee can introduce any medical documentation of legally prescribed medications that would explain the results of the test.

Test results which are deemed positive after an interview with the MRO can be retested by another SAMSHA Certified Laboratory. The request for the retest must be submitted in writing to the MRO within 72 hours.

Likewise, employees are to cooperate with the collection procedure for alcohol testing. Appropriate Alcohol Testing Forms are to be signed by the employee as directed by the collection site person. Refusal to sign Step 2 of the Alcohol Testing Form is considered a refusal to test under Department of Transportation Regulations and Corporate-Wide Policy for a Drug and Alcohol-Free Workplace.

Employee records will be maintained as to provide a high degree of privacy. Records concerning employee's collections are available only upon written request according to Federal Regulations governing Privacy and as per DOT Regulations.

However, the results of a drug test may be disclosed without your prior written consent to the following people or for the following reasons:

The Company Medical Review Officer.

The Employee Assistance Program or (other designated Substance Abuse Professionals).

A management official having authority to participate in adverse personnel action against you.

To defend the Company, the state of New Jersey or the U.S. Government against any challenge brought by the employee designate.

If, at any time, a question or concern is raised about the collection procedure, the employee is to bring it to the attention of the collection site personnel person, MRO or Medical Services Department.

It is the policy of NJ Transit to encourage employee to voluntarily seek help prior to being discovered to be in violation of Federal DOT Regulations and company policy. NJ Transit provides Employee Assistance Program (EAP) services for any employee troubled by alcohol and/or drug problems. The EAP is a free program, confidential and professional. To speak to a NJ Transit EAP counselor, call 1(800) 338-2673 or (908) 272-4276.