POLICY 3.11

5-C I recommend that the Board approve development of the proposed revised Policy 3.11, entitled "Medical Examinations During District Employment."

[Contact: Dianne Howard, Director – Risk & Benefits Management, PX 48414.]

Development **CONSENT ITEM**

- This proposed revision sets for the circumstances under which employee medical examinations shall be required to continue employment. Those include: requirement by Federal or State law; required under employment contract; in connection with an on-the-job injury; a fitness for duty determination; and if routine job duty performance involves potential exposure to chemical hazards.

- Copies of all forms are attached for ease of reference.

- This revision also updates statutory references.

POLICY 3.11

~~PREEMPLOYMENT~~ MEDICAL EXAMINATIONS DURING DISTRICT EMPLOYMENT

1. Medical exams for employees to continue employment with the District shall be required under the following circumstances:

   a. To the extent required by Federal or State law or other School Board policies, or

   b. If required by the employee's employment contract with the School Board; or

   c. As warranted at the request of the District or the Third Party Administrator and/or the District's insurance carrier in connection with an on-the-job injury; or

   d. At the District's request for a fitness for duty determination; or

   e. If the employee, in the routine performance of his/her job duties, as determined by the District, is potentially exposed to chemical hazards, asbestos or other physical hazards. This may include but not be limited to persons in the following positions: Environmental Managers, Industrial Hygienists, Environmental Specialists, Environmental Technicians, Painters, Pesticide Operators and body shop workers. The medical exams within this sub-paragraph (c) shall be completed within 90 days of employment and annually, thereafter.

   f. For those employees that may be required to wear a respirator during their performance of duties, PBSD Form 1981 Section I shall be completed by the employees supervisor and be carried by the employee to the physician who will complete Section II as part of the environmental physical. Form PBSD 1594 will have been submitted at the pre-employment physical.

   g. Form PBSD 1980 will be submitted to the physician for the annual physical.

2. The District may require that an employee undergo a drug test under the conditions set forth in School Board Policies 3.96 or 3.961.

~~1. The preemployment medical examinations required in 3.10 shall be administered for the following purposes:~~

~~a. To determine whether an applicant meets the physical requirements of the position for which the applicant has applied. If the results of the examination indicate that the applicant is not able to safely or fully perform the duties of the position and reasonable accommodations cannot be made, then the applicant shall be so advised. An applicant may reapply for a similar position, subject to another preemployment medical examination, when the applicant's condition~~

~~improves to the extent that the applicant meets the physical requirements of the position or reasonable accommodations can be made. An applicant who is determined medically unsuitable to perform a particular position is not prohibited from applying for other positions for which the applicant may be qualified if the applicant meets the safety and performance requirements of the other positions.~~

b. ~~To determine whether an applicant is a user of drugs which are illegal and/or may affect performance.~~

2. ~~For the purposes of this Policy, drugs shall mean "Controlled Substance" as defined in accordance with Chapter 893, Florida Statutes.~~

3. ~~Initial positive drug results will require a confirmation test. If the confirmation test supports the initial positive findings, these findings will be reviewed with the applicant. The applicant will not be eligible for employment.~~

4. ~~Applicants for employment who refuse to consent to a preemployment medical examination or who test positive for drugs shall not be medically released for employment for any position including those positions which do not require a preemployment medical examination.~~

5. ~~Where an applicant tests positive for drugs, that applicant may reapply for any position not less than 90 calendar days from the date employment was denied, provided the applicant cooperates with the district's counseling and rehabilitation requirements which include:~~

a. ~~Report to an approved referral agency for professional evaluation and counseling at the applicant's expense,~~

b. ~~Provide satisfactory evidence, as determined by the Superintendent, that there is no drug addiction or there has been full rehabilitation from addiction, and~~

c. ~~Retest negative prior to employment.~~

6. ~~Preemployment medical examination results are confidential and are not to be disclosed except to the extent required by law.~~

STATUTORY AUTHORITY: Fla. Stat. §§ 1001.32(2); 1001.41(1) & (2); 1001.42 (5) & (25); 1001.43 (11); 1012.23 (1) ~~120.53, 230.22(1), 231.001, F.S~~.
LAWS IMPLEMENTED: Fla. Stat. §§ 1001.42 (5); 1012.23 (1); 1012.32 ~~230.23(5), F.S~~.
HISTORY: 1/20/88; __/___2009

Legal Signoff:

The Legal Department has reviewed proposed Policy 3.11 and finds it legally sufficient for development by the Board.

_____ _____

Attorney Date

APPENDIX B

THE SCHOOL DISTRICT OF PALM BEACH COUNTY

Respirator Medical Evaluation Questionnaire

It is mandatory that you complete this form. 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. Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination. Type or print this form.

Part A. Section 1.

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

EMPLOYEE NAME *(last, first, middle initial)*	AGE	SEX	HEIGHT	WEIGHT
			ft. in.	lbs.
JOB TITLE			TODAYS DATE	
			/ /	

Provide a telephone number where you can be reached by the health care professional who reviews this questionnaire *(including area code)*. Also, provide the best time to telephone you at this number.

Telephone number (_____) _____ - _____ extension *(if applicable)* _____ time _____

1. Has your employer told you how to contact the health care professional who will review this questionnaire*?*
   ☐ Yes ☐ No
2. Check the type of respirator you will use *(check all that apply)*
   ☐ N, R, or P disposable respirator *(filter-mask, non-cartridge type only)*
   ☐ Other type *(for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).*
3. Have you worn a respirator? ☐ Yes ☐ No
   If yes, what type(s) _____

Part A. Section 2.

Questions 1 through 9 in this section must be answered by every employee who has been selected to use any type of respirator.

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? *(check all that apply)*
   ☐ a. Seizures
   ☐ b. Diabetes
   ☐ c. Allergic reactions that interfere with your breathing
   ☐ d. Claustrophobia *(fear of closed-in places)*
   ☐ e. Trouble smelling odors *(except when you had a cold)*
3. Have you ever had any of the following pulmonary or lung problems? *(check all that apply)*
   ☐ a. Asbestosis
   ☐ b. Asthma
   ☐ c. Chronic bronchitis
   ☐ d. Emphysema
   ☐ e. Pneumonia
   ☐ f. Tuberculosis
   ☐ g. Silicosis
   ☐ h. Pneumothorax *(collapsed lung)*
   ☐ i. Lung cancer
   ☐ j. Broken ribs
   ☐ k. Any chest injuries or surgeries
   ☐ l. Any other lung problem that you've been told about

Respirator Medical Evaluation Questionnaire
(continued)

EMPLOYEE NAME *(last, first, middle initial)*

4. Do you currently have any of the following symptoms of pulmonary or lung illness? *(check all that apply)*

   ☐ a. Shortness of breath
   ☐ b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline
   ☐ c. Shortness of breath when walking with other people at an ordinary pace on level ground
   ☐ d. Have to stop for breath when walking at your own pace on level ground
   ☐ e. Shortness of breath when washing or dressing yourself
   ☐ f. Shortness of breath that interferes with your job
   ☐ g. Coughing that produces phlegm *(thick sputum)*
   ☐ h. Coughing that wakes you early in the morning
   ☐ i. Coughing that occurs mostly when you are lying down
   ☐ j. Coughing up blood in the last month
   ☐ k. Wheezing
   ☐ l. Wheezing that interferes with your job
   ☐ m. Chest pain when you breathe deeply
   ☐ n. Any other symptoms that you think may be related to lung problems

5. Have you ever had any of the following cardiovascular or heart problems? *(check all that apply)*

   ☐ a. Heart attack
   ☐ b. Stroke
   ☐ c. Angina
   ☐ d. Heart failure
   ☐ e. Swelling in your legs or feet *(not caused by walking)*
   ☐ f. Heart arrhythmia *(heart beating irregularly)*
   ☐ g. High blood pressure
   ☐ h. Any other heart problem that you've been told about

6. Have you ever had any of the following cardiovascular or heart symptoms? *(check all that apply)*

   ☐ a. Frequent pain or tightness in your chest
   ☐ b. Pain or tightness in your chest during physical activity
   ☐ c. Pain or tightness in your chest that interferes with your job
   ☐ d. In the past two years, have you noticed your heart skipping or missing a beat
   ☐ e. Heartburn or indigestion that is not related to eating
   ☐ f. Any other symptoms that you think may be related to heart or circulation problems

7. Do you currently take medication for any of the following problems? *(check all that apply)*

   ☐ a. Breathing or lung problems
   ☐ b. Heart trouble
   ☐ c. Blood pressure
   ☐ d. Seizures

8. Has wearing a respirator caused any of the following problems? *(check all that apply)*
   If you have never used a respirator check this box ☐ and move on to the next question.

   ☐ a. Eye irritation
   ☐ b. Skin allergies or rashes
   ☐ c. Anxiety that occurs only when you use the respirator
   ☐ d. Unusual weakness or fatigue
   ☐ e. Any other problem that interferes with your use of a respirator

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-face piece 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

Respirator Medical Evaluation Questionnaire
(continued)

EMPLOYEE NAME *(last, first, middle initial)*

11. Do you currently have any of the following vision problems?

☐ a. Wear contact lenses ☐ c. Color blindness
☐ b. Wear glasses ☐ d. Any other eye or vision problem

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? *(check all that apply)*

☐ a. Difficulty hearing ☐ b. Wear a hearing aid ☐ c. Any other hearing or ear problem

14. Have you ever had a back injury? ☐ Yes ☐ No

15. Do you currently have any of the following musculoskeletal problems? *(check all that apply)*

☐ a. Weakness in any of your arms, hands, legs, or feet
☐ b. Back pain
☐ c. Difficulty fully moving your arms and legs
☐ d. Pain or stiffness when you lean forward or backward at the waist
☐ e. Difficulty fully moving your head up or down
☐ f. Difficulty fully moving your head side to side
☐ g. Difficulty bending at your knees
☐ h. Difficulty squatting to the ground
☐ i. Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs
☐ j. Any other muscle or skeletal problem that interferes with using a respirator

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 (If "yes" *explain)*

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

3. Have you ever worked with any of the materials, or under any of the conditions, listed below: *(check all that apply)*

☐ a. Asbestos
☐ b. Silica *(e.g., in sandblasting)*
☐ c. Tungsten/cobalt *(e.g., grinding or welding this material)*
☐ d. Beryllium
☐ e. Aluminum
☐ f. Coal *(for example, mining)*
☐ g. Iron
☐ h. Tin
☐ i. Dusty environments
☐ j. Any other hazardous exposures

Describe these exposures

Respirator Medical Evaluation Questionnaire
(continued)

EMPLOYEE NAME *(last, first, middle initial)*

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):*

8. Have you ever worked on a HAZMAT (Hazardous Materials) 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

10. Will you be using any of the following items with your respirator(s)? *(check all that apply)*
    ☐ a. HEPA Filters ☐ b. Canisters *(for example, gas masks)* ☐ c. Cartridges

11. How often are you expected to use the respirator(s)? *(check all that apply)*
    ☐ a. Escape only (no rescue) ☐ c. Less than 5 hours per week ☐ e. 2 to 4 hours per day
    ☐ b. Emergency rescue only ☐ d. Less than 2 hours per day ☐ f. Over 4 hours per day

12. During the period you are using the respirator(s), what is your work effort? *(check one only)*

    ☐ a. **Light**
    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**
    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 bunk 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**
    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.).*

Respirator Medical Evaluation Questionnaire
(continued)

EMPLOYEE NAME *(last, first, middle initial)*

13. Will you be wearing protective clothing and or equipment *(other than the respirator)* when you are 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° degrees F)*? ☐ Yes ☐ No

15. Will you be working under humid conditions? ☐ Yes ☐ No

16. Describe the work you will be doing while you are using your respirator(s).

    _____
    _____
    _____

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

    _____
    _____
    _____

18. Provide the following information for each toxic substance that you'll be exposed to when you're using your respirator(s):

    a. Name of the first toxic substance _____

    b. Estimated maximum exposure level per shift _____

    c. Duration of exposure per shift _____

    d. Name of the second toxic substance _____

    e. Estimated maximum exposure level per shift _____

    f. Duration of exposure per shift _____

    g. Name of the third toxic substance _____

    h. Estimated maximum exposure level per shift _____

    i. Duration of exposure per shift _____

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

    _____

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

    _____
    _____
    _____

THE SCHOOL DISTRICT OF PALM BEACH COUNTY
RESPIRATORY PROTECTION PROGRAM

APPENDIX D-2

Respirator Evaluation

EMPLOYEE NAME *(last, first, middle initial)*	SOCIAL SECURITY NUMBER
	[redacted] - [redacted] -

To maintain compliance with 29 CFR 1910.134, Respiratory Protection Standard, and ensure your safety and health, answer the following questions.

1. Has there been a change in either your job title or job responsibilities that no longer require the use of a respirator since the environmental physical you had last year?

   ☐ YES ☐ NO

2. Since your last physical examination for respirator use, have you had any changes in your personal medical condition which would affect your ability to continue the use of a respirator?

   ☐ YES ☐ NO

_____ _____

SIGNATURE OF EMPLOYEE *DATE*

THE SCHOOL DISTRICT OF PALM BEACH COUNTY
DEPARTMENT OF EMPLOYEE BENEFITS & RISK MANAGEMENT

APPENDIX D-1

Medical Evaluation for Respirator Use

Section I to be completed by the employees supervisor and Section II by the appointed physician.

SECTION I

EMPLOYEE NAME *(last, first, middle initial)*	SOCIAL SECURITY NUMBER - -	DATE OF BIRTH / /	AGE	GENDER
EMPLOYEE JOB TITLE	TYPE OF WORK PERFORMED			
SUPERVISOR NAME *(last, first, middle initial)*	SCHOOL / DEPARTMENT			

Substance(s) necessitating respirator use

_____

_____

Type(s) of respirator(s) used *(complete for each type to be used, showing name / model)*

_____

_____

AIR-PURIFYING		
NON-POWERED	POWERED	AIRLINE

ATMOSPHERE-SUPPLYING	
SCBA OPEN CIRCUIT	SCBA CLOSED CIRCUIT

Respirator face piece type *(check one)* ☐ full ☐ ½ ☐ ¼ ☐ other _____

Type of work performed _____

Level of work effort while wearing respirator ☐ light ☐ moderate ☐ heavy

Extent of respirator use ☐ daily ☐ at least weekly ☐ less than once a week ☐ rarely or emergency only

Estimated length of time of respirator use per session

average _____ hours maximum _____ hours emergency _____ hours

Special work considerations

- ☐ Special need for visual or auditory acuity
- ☐ High temperature
- ☐ High places
- ☐ Additional protective equipment / clothing (est. wgt. _____)
- ☐ Confined space
- ☐ Exposure to other airborne concentrations
- ☐ Exposure to highly toxic material
- ☐ Other _____

Has employee received training in use and limitations of respirator? ☐ Yes ☐ No

SECTION II

Medical assessment for respirator use under work conditions described above

☐ Medically released ☐ No restrictions ☐ Specific restrictions *(see below)* ☐ No use permitted

Comments / Restrictions _____

_____

Employee data provided by

_____ _____
SIGNATURE *DATE*

_____
PRINT NAME AND TITLE

Medical evaluation by

_____ _____
SIGNATURE OF PHYSICIAN *DATE*

_____
PRINT NAME