



Shasta County Department of Support Services  
Purchasing Division  
1450 Court Street, Suite 348  
Redding, CA 96001

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Issued: April 10, 2015

## **REQUEST FOR INFORMATION (“RFI”) FOR ADMINISTERING AND PROVIDING A COMPREHENSIVE PHYSICAL EXAM PROGRAM TO THE COUNTY OF SHASTA**

**RFI Number: 15-16**

The County of Shasta through its Department of Support Services, is seeking Letters of Interest (“LOI”) in response to a RFI to provide a comprehensive physical exam program including pre-employment examinations, fit for work testing, respirator fit testing, and related services, to the County.

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### **General Overview**

- Responders must submit one (1) original and three (3) unbound copies** of the LOI. Responses must be submitted in a sealed envelope, and clearly labeled as RFI 15-16.
  - A LOI submitted in response to this RFI must be signed, dated, and received by the Department of Support Services at the address above, no later than 2:00 p.m. Monday, May 4, 2015. No postmarks, faxes or emails will be accepted.
  - For questions, additional information, or to obtain a copy of this RFI, please contact Monica Fugitt, Agency Staff Services Analyst II – Confidential, Purchasing Division, at (530) 229-8234 or [mfugitt@co.shasta.ca.us](mailto:mfugitt@co.shasta.ca.us).
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### **Timeline**

Release of RFI – Friday, April 10, 2015

Questions Deadline – Wednesday, April 29, 2015 at 2:00 p.m.

Answers Deadline – Thursday, April 30, 2015 at 2:00 p.m.

LOI Submission Deadline, – Monday, May 4, 2015 at 2:00 p.m.

*Tentative* Review of Responses Completed – Thursday, May 7, 2015

*Tentative* Interview Date for Selected Responders – Monday May 11, 2015, \*

\* The County reserves the right to interview selected responders at its sole discretion.

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## **I. OVERVIEW – RFI 15-16 – Comprehensive Physical Exam Program – April 10, 2015**

### **A. INTRODUCTION**

The Shasta County Department of Support Services – Purchasing Division (“County”), invites responses to a Request for Information (“RFI”) to provide a comprehensive physical exam program including pre-employment examinations, fit for work testing, respirator fit testing, and related services, to the County.

### **B. DEFINITIONS**

For the purposes of this Program Overview and this RFI process, the following definitions apply:

- Contract means the written agreement between the County and the Responder selected to provide a Comprehensive Physical Exam Program.
- Consultant means the person(s) or entity(ies) who/that enters into the Contract to provide a Comprehensive Physical Exam Program.
- Letter of Interest (“LOI”) means the written submission to the County in response to this RFI.
- Responder means any person or entity submitting a LOI.
- Request for Information (“RFI”) means this invitation to submit a LOI to provide a Comprehensive Physical Exam Program to the County.
- County Business Hours means 8:00 a.m. to 5:00 p.m., during County Business Days.
- County Business Days means Monday through Friday except County holidays.
- Comprehensive Physical Exam Program means pre-employment examinations, fit for work testing, respirator fit testing, and related services.

### **C. BACKGROUND AND PURPOSE**

The purpose of this RFI is to establish contracts with one or more vendors to provide a comprehensive physical exam program for use by Shasta County. Candidates for hire with Shasta County must participate in a medical examination appropriate to the position they are being considered for prior to being given a final job offer. Additionally, current employees may require a variety of services, including random or incident-related drug screening, fit for work testing, job-related testing / vaccinations, etc.

Successful Responders must possess and maintain a working knowledge of the current best practices in the medical examination field and a comprehensive understanding of the issues related to medical examinations. The successful Responders must be able to provide services during normal business hours in a timely manner at the request of the County.

### **III. RFI PROCESS, LETTER OF INTEREST FORMAT & GENERAL INFORMATION**

#### **A. SUBMISSION OF LETTERS OF INTEREST**

1. LOIs must be submitted in a **sealed** envelope, plainly marked “Response to RFI 15-16 for Administering and Providing a Comprehensive Physical Exam Program” and must be delivered to:

Shasta County Department of Support Services  
Attention: Monica Fugitt, Agency Staff Services Analyst II - Confidential, Purchasing Division  
1450 Court Street, Suite 348  
Redding, CA 96001

2. **LOIs must be received on or before 2:00PM, May 4, 2015. Late submissions will not be considered. Each submission must include one (1) original and three (3) unbound copies of the LOI. County may, in its sole discretion, determine that a LOI is non-responsive if the proper number of copies are not included and may result in rejection of the LOI. Postmarks, faxes or emails will NOT be accepted.**
3. A LOI may be withdrawn by written request received from the Responder prior to the Closing Date.
4. Responder warrants and represents that the information provided for in their LOI will remain unchanged for 90 days after the Closing Date. Responder acknowledges that County will be relying on the information contained in their LOI. LOIs submitted shall contain the Responder’s best and final offer.

#### **B. LETTER OF INTEREST FORMAT & CONTENT**

Each LOI submission must include the following:

1. A Letter of Interest form, see **Attachment A**, attached hereto and incorporated herein.
2. Responses to all minimum requirements contained in **Attachment B**, attached hereto and incorporated herein.
3. Completed pricing sheet for medical services, contained in **Attachment C**, attached hereto and incorporated herein.
4. A Statement of Experience, see **Attachment D**, attached hereto and incorporated herein.
5. Copies of insurance policies, binders, or certificates evidencing the following insurance coverage:
  - A. Comprehensive general liability (including auto and non-owned auto, bodily injury and property damage): \$1,000,000 combined single limit;
  - B. Workers’ Compensation: Statutory levels.
  - C. Errors & Omissions coverage of not less than \$1 million.

#### **C. SELECTION PROCEDURES**

1. Notwithstanding anything to the contrary in this RFI, the County reserves the right to award Contract(s) (Attachment E) to the Responder(s) whose LOI is determined by the County, in its sole discretion, to be in the best interest of the County. The County reserves the right to award one or more Contracts to one or more Responders as a result of this RFI.

2. Failure to fully comply with all of the requirements of this RFI and to provide all requested information may result in the LOI being rejected and given no consideration. The determination of compliance with the terms and conditions of this LOI will be in the County's sole judgment and its judgment will be final and conclusive.
3. After receiving the LOIs, the County will review Attachment B (Minimum Qualifications) and Attachment C (Pricing), and may schedule interviews at its sole discretion with Responders meeting minimum qualifications. Responders who meet minimum qualifications may be asked to enter into the Contract stage, at the sole discretion of the County.
4. Responders are expected to agree with terms and conditions contained within the draft contract, Attachment E, attached hereto and incorporated within. Rejection of terms and conditions contained within the contract may result in rejection of LOI, at the discretion of County.
5. If an agreement to enter into a Contract cannot be reached with the Responder(s) selected by County, then the negotiations with that Responder(s) will be terminated. Negotiations may then be opened with another Responder(s) selected by County and the process repeated, or the County may elect at any time to reject all submitted LOIs and terminate this RFI process. Once negotiations with a particular Responder(s) are terminated, the County will not reopen negotiations with that Responder(s).
6. If Responder(s) are selected and Contract(s) are negotiated with Responder(s), the County shall issue a written Notice of Intent to Award a Contract to each Responder that submitted a LOI. The County shall consider any protest or objection to the Contract award pursuant to this RFI, provided that it is submitted in writing and received by the County's contact person at the address listed in this RFI within 10 calendar days of the date stated on the County's written Notice of Intent to Award a Contract. The protest shall identify all bases on which the protest is based. Any protest or objection will be considered and resolved by the Director of Support Services, in his or her sole discretion and whose decision shall be final and conclusive. Contract(s) may be executed by the County after the expiration of the time period to protest or object, or after a final decision on any protest or objection, whichever is later.

#### **D. USE AND DISCLOSURE OF LOIs**

1. The County reserves the right to retain all LOIs that are submitted and to use any ideas in a letter regardless of whether a LOI results in a Contract to provide a Comprehensive Physical Examination Program. All LOIs will become the sole property of the County.
2. After the County issues a Notice of Intent to Award a Contract, or the County issues a Notice of Termination of RFI, all LOIs and related documents become public record, with the exception of those parts of a LOI that are clearly designated as business or trade secrets, as that term is defined by statute, and marked as "confidential" or "proprietary". Responders should not indiscriminately mark parts as business or trade secrets and doing so could result in none of the materials being considered business or trade secrets. County shall not in any way be liable or responsible for the disclosure of any LOI, or part thereof, if disclosure is required by the California Public Records Act (Government Code section 6250, et. seq.) or pursuant to law or legal process. By submitting a LOI, to the fullest extent permitted by law, a Responder agrees to save, defend, keep, hold harmless, and fully indemnify the County, its elected officials, officers, employees, agents, and volunteers from all damages, claims for damages, costs, or expenses, whether in law or in equity, that may at any time arise as a result of or related to disclosing a business or trade secret.
3. Initiation of this LOI does not commit the County to finalize a Contract with a Responder, to enter into a Contract with the Responder submitting the least costly LOI, or to pay any costs associated with the preparation of any LOI.
4. Notwithstanding any other provisions, the County reserves the right, in its sole discretion to:

- a. Accept or reject any or all LOIs, or any part(s) thereof;
  - b. Reject any submission for failure to submit the LOI in conformity with the requirements, or the terms and conditions of this RFI;
  - c. Waive any informalities or irregularities in a LOI, or to waive any deviations from the requirements, or terms and conditions of this RFI, if deemed to be in the best interest of the County;
  - d. Negotiate with a Responder or Responders; or
  - e. Terminate the RFI process.
5. Any Responder submitting a LOI understands and agrees that submission of his/her/its LOI shall constitute acknowledgment and acceptance of, and intent to comply with, all the requirements, and terms and conditions of this RFI.
  6. The County shall not be liable for, and by submitting a LOI the Responder agrees not to make any claims for, or have any right to, damages because of any misunderstanding or misrepresentation of the requirements, or terms and conditions, of this RFI, or because of any misinformation or lack of information.
  7. In the event it becomes necessary to revise any part of this RFI, an addendum will be updated on the County website.

#### E. INQUIRIES

1. To make inquiries regarding this RFI, Responders are directed to contact:

**Monica Fugitt, Agency Staff Services Analyst II - Confidential**

Shasta County Department of Support Services

1450 Court Street, Suite 348

Redding, CA 96001

Phone: (530) 229-8234

Fax: (530) 225-5345

E-Mail: [mfugitt@co.shasta.ca.us](mailto:mfugitt@co.shasta.ca.us)

2. Any Responder who attempts to influence the RFI process by interfering or colluding with other Responders and/or with any County officer, employee, or agent; or who deviates from the RFI process as set forth in the requirements, or terms and conditions, of the RFI, **may be disqualified at any time from further participation in the RFI process.** Responders may contact only the individual identified above and are specifically directed not to contact other County officer, employee, or agent on any matter related to this RFI. Failure to comply with the preceding sentence may result in a Responder being barred from consideration under this RFI. No questions regarding this RFI will be answered by other County officers, employees or agents. For purposes of this section III.E.2 of this Request, the word “officer” does not include a member of County’s Board of Supervisors.
3. Questions to County shall be submitted in an E-mail to the individual listed above. The County will not respond to any questions submitted after Wednesday, April 29, 2015 at 2:00 p.m.. Answers will be provided no later than Thursday, April 30, 2015 at 2:00 p.m.

# LETTER OF INTEREST

Due no later than Monday May 4, 2015, 2:00PM.  
Postmarks, Faxes, and Emails Will Not Be Accepted.

TO: Shasta County Department of Support Services  
Attention: Monica Fugitt, Agency Staff Services Analyst II - Confidential, Purchasing Division  
1450 Court Street, Suite 348  
Redding, CA 96001

RE: Request for Information (“RFI”) 15-16, to provide to provide a comprehensive physical exam program including pre-employment examinations, fit for work testing, and related services.

The undersigned hereby submits this Letter of Interest and supporting documentation in response to the RFI to provide a comprehensive physical exam program including pre-employment examinations, fit for work testing, and related services to the County.

COMPANY/INDIVIDUAL NAME: \_\_\_\_\_  
(Please print)

ADDRESS: \_\_\_\_\_  
(Street or Mailing) (City, State, ZIP)

TELEPHONE NUMBER: \_\_\_\_\_  
(Area Code)

PRIMARY CONTACT EMAIL ADDRESS (REQUIRED): \_\_\_\_\_

FAX NUMBER: \_\_\_\_\_  
(Area Code)

By my signature, I hereby represent that I have authority to execute this Letter of Interest and to bind the party on whose behalf execution is made. Further, I certify that all statements in this Letter of Interest and supporting documentation are true and I acknowledge that if the Letter of Interest and supporting documentation contains any false statements, the County may declare the Contract made as a result of the Letter of Interest to be void.

DATED: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

## Comprehensive Physical Exam Program

Shasta County Purchasing  
 1450 Court Street, Suite 348  
 Redding, CA 96001  
 (530) 225-5346



Vendor: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Telephone: \_\_\_\_\_  
 Contact: \_\_\_\_\_

**INSTRUCTIONS:**

- a. For all requirements, vendor to place a check mark in the appropriate column for each requirement.
- b. Vendor to supply full and complete explanation of any deviation from requirement in Column provided.
- c. Any attachment with additional information must reference the appropriate minimum qualification.

Minimum Requirements	Requirement Met?		Deviations
	Yes	No	
<b>Comprehensive Physical Exam Program Including Pre-employment Examinations, Fit for Work Testing, and Related Services</b>			
<b>A. Responder Requirements</b>			
1.	Responders must be able to provide licensed examining physicians and support staff who are experienced in occupational medicine. Proof of licensing must be provided upon County's request.		
2.	At County's sole discretion, Responders may be required to participate in an interview prior to County completing the selection process.		
3.	All services provided must comply with federal, state, and local requirements. Proof of such compliance may be required.		
4.	Responders shall be required to be insured in amounts specified by County and to provide certificates of insurance evidencing such insurance. See Attachment E of this RFI.		
5.	Responder must be able to provide services in a facility that is compliant with the Americans with Disabilities Act of 1990 (ADA). Provide all appropriate support staff, such as licensed nurses, medical technicians, etc., as well as necessary facilities, equipment, supplies, and materials.		



Minimum Requirements		Requirement Met?		Deviations
6.	Responder must ensure that Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance standards are met and secure appropriate authorization to disclose medical information with other medical providers as necessary.			
7.	Responder agrees with terms and conditions contained within the draft contract, Attachment E, attached hereto and incorporated within.			
8.	Responder must be located within a 15 mile radius of the city of Redding.			
<b>B. Service Requirements</b>				
1.	Consultant(s) shall schedule appointments for physical exams within 72 hours of the request being made.			
2.	The waiting period for County applicants/employees to receive services shall not exceed one hour.			
3.	Consultant(s) shall have a qualified physician review all detailed medical history questionnaires and specific physical demands requirements for specified employment positions. Questionnaire shall be provided by Consultant(s).			
4.	Consultant(s) shall inform County within two business days of results being available, about any irregular and pertinent test results that require additional testing or services, e.g., lab, x-ray, specialists, etc.			
5.	Consultant(s) shall consult with the applicant's/employee's personal physician if the physical examination and/or health questionnaire is inconclusive.			
6.	When necessary and after obtaining approval from County, Consultant(s) shall refer applicant/employee to appropriate providers to interpret test results or to further evaluate the applicant/employee.			
7.	Consultant(s) shall ensure written summary report of test and/or service results is neat, accurate and legible. The report shall include any specific work-related limitations that will be reviewed/considered as part of the accommodation process. The report shall not include treatment or diagnostic information. If any report sent by Consultant(s) contains information regarding a person's treatment or diagnostic information, it will be destroyed by County, and Consultant(s) shall provide a revised report to County within 24 hours.			
8.	Consultant(s) shall submit accurate, written results within 48 hours after the result is available.			
9.	Consultant(s) shall notify the applicant/employee of any recommendation for follow-up with the individual's personal physician.			
10.	Consultant(s) shall work with County to fully evaluate and respond to any appeals and provide clarification, expert testimony or assistance when necessary or requested.			

Minimum Requirements		Requirement Met?		Deviations
11.	Consultant(s) shall maintain and store all medical records, indefinitely, at no additional cost.			
12.	Consultant(s) shall keep records secure and confidential and make them available only to authorized representatives of County.			
13.	Consultant(s) shall provide a separate monthly accounting (billing) of each service for County no later than the 15th of the month following the month services were provided, and bill for specialized services separately for individual County departments.			
14.	Consultant(s) shall review at least annually, and more often if necessary, the nature and type of medical screening services being offered and make recommendations to County for improvement to ensure cost effectiveness, compliance with state and federal law, County satisfaction, and any other issue germane to services provided under this contract.			
15.	Consultant(s) shall keep County informed of recent changes in laws and judicial decisions pertinent to medical screening of potential employees.			
16.	Complete and submit Shasta County Risk management forms when/as directed by Shasta County Risk Management staff. See Attachment E for details.			

## Comprehensive Physical Exam Services

Shasta County Purchasing  
 1450 Court Street, Suite 348  
 Redding, CA 96001  
 (530) 225-5346



Vendor: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Telephone: \_\_\_\_\_  
 Contact: \_\_\_\_\_

**INSTRUCTIONS:**

- a. For each service listed in sections 1 and 2, vendor is to provide a price in the appropriate column.
- b. If a service listed in section 1 or 2 is not provided, please indicate in the price column, "not provided"
- c. Additional services offered outside of those specifically designated in sections 1 and 2 may be listed in section 3 with a corresponding price.
- d. Any attachment with additional information must reference the appropriate service.

		<b>Price</b>
<b>1.</b>	<b>Pre-employment Physical Exams</b>	
A.	Type A Physical Exam (for sedentary, non-labor intensive positions), consisting of the following: M.D. or P.A. to review completed detailed questionnaire, evaluate responses against job description (essential functions), perform routine basic physical exam (i.e., check reflexes, eyes, ears, etc.), follow-up with candidate's physician as needed. Carpal tunnel test (grip strength). Collection and preparation of urine sample	
B.	Type B Physical Exam (for labor intensive positions), consisting of the following: M.D. or P.A. to review completed detailed questionnaire, evaluate responses against job description (essential functions), perform routine basic physical exam (i.e., check reflexes, eyes, ears, etc.), follow-up with candidate's physician as needed. Audiogram Strength and Fitness 2 view lumbar spine x-ray Collection and preparation of urine sample	
C.	Type C Physical Exam (for law enforcement and fire fighter positions), consisting of the following: M.D. or P.A. to review completed detailed questionnaire, evaluate responses against job description (essential functions), perform routine basic physical exam (i.e., check reflexes, eyes, ears, etc.), follow-up with candidate's physician as needed. Audiogram Strength and Fitness 2 view lumbar spine x-ray Collection and preparation of urine sample Treadmill/EKG Stress TB Screening Spirometry	
<b>2.</b>	<b>Services performed not as part of Type A, B, or C Physical Exam</b>	
A.	Asbestos Testing	
B.	Audiogram	

		Price
C.	Blood Alcohol Test	
D.	Chest x-ray (1 view)	
E.	Chest x-ray (2 view)	
F.	Driver Physician's Health Report - DMV 546A (Stand Alone Visit)	
G.	Driver Physician's Health Report - DMV 546A (With Type C Physical)	
H.	Driver's Physical (fire)	
I.	Driver's Physical (non-fire)	
J.	Drug Screen - 9 panel	
K.	Drug Screen - non DOT	
L.	Electrocardiogram (EKG)	
M.	Hepatitis-B Surface Antibody Testing	
N.	Hepatitis-B Declination Consult	
O.	Hepatitis-B Vaccination Series (3 shots)	
P.	Phlebotomy/Venipuncture (blood draw)	
Q.	Pulmonary Function Test	
R.	Reasonable Suspicion Urine Sample Collection ("Reasonable Suspicion" as determined by County)	
S.	Respirator Fit - Office visit if necessary, including extra screening spirometry which provides an objective measurement of lung function (no x-ray required)	
T.	Respirator Fit - Review of medical questionnaire and initial evaluation of records	
U.	Respiratory Physical	
V.	Spine x-ray (2 view)	
W.	TB Screening	
<b>3.</b>	<b>Other Services</b>	

### STATEMENT OF EXPERIENCE

#### SECTION A

---

Business Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_ ZIP: \_\_\_\_\_

Business Status:

- Non Profit Corporation     
  Corporation     
  General Partnership     
  Limited Partnership  
 Sole Proprietorship     
  LLC     
  Other: \_\_\_\_\_

Name and title of officer or owner authorized to sign this Letter of Interest and any contract with the county that may result.

Name: \_\_\_\_\_ Title: \_\_\_\_\_

#### SECTION B

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Number of years in business under present business name: \_\_\_\_\_

Other Business Name(s): \_\_\_\_\_

Number of years under prior name: \_\_\_\_\_

#### SECTION C

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Number of years experience providing required, equivalent, or related services: \_\_\_\_\_

#### SECTION D

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Contracts completed during the last five years?

Year	Services	\$ Amount	Location	Contracting Agency/Entity
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____

3. \_\_\_\_\_

May we contact these entities to discuss the services provided by your company?  Yes  No

(Add additional pages if needed)

**SECTION E**

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Have you, or your company failed or refused to complete a contract or had a contract terminated early?

Yes  No

If yes, explain: \_\_\_\_\_

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(Add additional pages if needed)

**SECTION F**

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Do you or your company hold a controlling interest in any other organization, or is this company or business owned or controlled by another organization or company?  Yes  No

If yes, explain: \_\_\_\_\_

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(Add additional pages if needed. Section F does not apply to government agencies.)

**SECTION G**

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Do you, or does your company, hold or have a financial interest in any other business?  Yes  No

If yes, explain:

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(Add additional pages if needed)

**SECTION H**

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Names of persons with whom you or your company have been associated in business as partners or business associates in the last five years. (Governmental agencies are exempt)

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(Add additional pages if needed)

**SECTION I**

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Explain any litigation in connection with any contract involving you, your company, or any principle officer(s) thereof during the past 10 years (marital dissolutions, probate proceedings, and similar personal legal matters are excluded):

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(Add additional pages if needed)

**SECTION J**

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Provide a description of experience in the services to be provided, and the experience of principle individuals who will be performing services.

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(Add additional pages if needed)

**SECTION K**

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List of major equipment to be used for the direct provision of services:

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(Add additional pages if needed)

**SECTION L**

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Please attach a copy of your most recent audited or reviewed financial statements, for a fiscal period not more than 18 months old at time of submission, by an independent certified public accountant.

See California Department of Social Services, Manual of Policies and Procedures, Section 23-610(c)(15)(L) for full details of this requirement.

**SECTION M**

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Please attach a copy of the most current financial statements.

Do you or your company agree, at the request of the County, to provide letters of credit, and guarantor letters from related entities?  Yes  No

**SECTION N**

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Please provide a list of commitments, and potential commitments which may impact assets, lines of credit, guarantors letters, or otherwise affect your or your company's ability to perform including, but not limited to, any liens by any federal, state, or local agency for unpaid taxes or similar commitments.

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(Add additional pages if needed)

**SECTION O**

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If the nature of the services requires business or professional licenses, are such licenses held by you and/or your company and its staff?  Yes  No

Please list each required business or professional license:

License Number	Type	Expiration Date
<hr/>		
<hr/>		
<hr/>		

**SECTION P**

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Do you and your company agree to provide additional information as required by the County to make an informed determination of qualifications?  Yes  No

**SECTION Q**

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Do you and your company agree to permit the County, State and Federal governments to audit financial and other records pertinent to the services to be provided?  Yes  No

By signing this Statement of Experience, you are certifying that all information provided on this form and contained within your Letter of Interest are true, and you acknowledge that if the Letter of Interest contains any false statements, the County may declare any contract or agreement made as a result of the Letter of Interest to be void.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_



## [APPROVED STANDARD FORMAT]

**PERSONAL SERVICES AGREEMENT BETWEEN THE COUNTY OF SHASTA AND  
[RFI RESPONDER]**

This agreement is entered into between the County of Shasta, a political subdivision of the State of California through its Department of Support Services – Purchasing Unit (“County”) and [RFI Responder] (“Consultant”) for the purpose of administering and providing a comprehensive physical exam program (collectively, the “Parties” and individually a “Party”).

**Section 1. RESPONSIBILITIES OF CONSULTANT.**

Pursuant to the terms and conditions of this agreement, Consultant shall provide services as described in Exhibits A through E as follows:

- A. Provide licensed examining physicians and support staff who are experienced in occupational medicine. Proof of licensing must be provided upon County's request.
- B. All services provided must comply with federal, state, and local requirements. Proof of such compliance may be required.
- C. Provide services in a facility that is compliant with the Americans with Disabilities Act of 1990 (ADA).
- D. Provide all appropriate support staff, such as licensed nurses, medical technicians, etc., as well as necessary facilities, equipment, supplies, and materials.
- E. Ensure that Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance standards are met and secure appropriate authorization to disclose medical information with other medical providers as necessary.
- F. Schedule appointments for physical exams within 72 hours of the request being made.
- G. The waiting period for County applicants/employees to receive services shall not exceed one hour.
- H. Have a qualified physician review all detailed medical history questionnaires and specific physical demands requirements for specified employment positions. Questionnaire shall be provided by Consultant.
- I. Inform County within two business days of results being available, about any irregular and pertinent test results that require additional testing or services, e.g., lab, x-ray, specialists, etc.
- J. Consult with the applicant's/employee's personal physician if the physical examination and/or health questionnaire is inconclusive.

- K. When necessary and after obtaining approval from County, Consultant shall refer applicant/employee to appropriate providers to interpret test results or to further evaluate the applicant/employee.
- L. Ensure written summary report of test and/or service results is neat, accurate and legible. The report shall include any specific work-related limitations that will be reviewed/considered as part of the accommodation process. The report shall not include treatment or diagnostic information. If any report sent by Consultant contains information regarding a person's treatment or diagnostic information, it will be destroyed by County, and Consultant shall provide a revised report to County within 24 hours.
- M. Submit accurate, written results within 48 hours after the result is available.
- N. Notify the applicant/employee of any recommendation for follow-up with the individual's personal physician.
- O. Work with County to fully evaluate and respond to any appeals and provide clarification, expert testimony or assistance when necessary or requested.
- P. Maintain and store all medical records, indefinitely, at no additional cost.
- Q. Keep records secure and confidential and make them available only to authorized representatives of County.
- R. Provide a separate monthly accounting (billing) of each service for County no later than the 15th of the month following the month services were provided, and bill for specialized services separately for individual County departments.
- S. Review at least annually, and more often if necessary, the nature and type of medical screening services being offered and make recommendations to County for improvement to ensure cost effectiveness, compliance with state and federal law, County satisfaction, and any other issue germane to services provided under this contract.
- T. Keep County informed of recent changes in laws and judicial decisions pertinent to medical screening of potential employees.
- U. Complete and submit the following Shasta County Risk management forms when/as directed by Shasta County Risk Management staff (See Exhibit C for examples):
  - a. Medical Group Patient Information
  - b. Shasta County Respiratory Protection Program Cover Sheet
  - c. Shasta County Respiratory Protection Program Medical Questionnaire for Respirator Users
  - d. Respirator Assignment and Fit Test Record
  - e. T8CCR§ 1529 Appendix D Asbestos Worker Initial Medical Questionnaire

f. T8CCR§ 1529 Appendix D Asbestos Worker Periodic Medical Questionnaire

- V. Collect a urine sample from employees brought to facility by a manager when there is reasonable suspicion that they are under the influence, based on the reasonable suspicion component of the County's Drug and Alcohol Policy (see Exhibits D and E). If any ambiguity, inconsistency, or conflict exists or arises between Exhibits D and E of this agreement, the provisions in Exhibit D shall govern. If there are any inconsistencies between the agreement and Exhibit D, the agreement shall govern.

**Section 2. RESPONSIBILITIES OF COUNTY.**

County shall compensate Consultant as prescribed in sections [3] and [4] of this agreement and shall monitor the outcomes achieved by Consultant. Additionally, the County shall:

- A. Provide the necessary pre-employment testing paperwork.
- B. Call the Consultant to schedule pre-employment testing.
- C. Provide a County contact person for routine questions regarding type of test needed, appointment times, etc.

**Section 3. COMPENSATION.**

Consultant shall be paid for the services provided in this agreement, as listed on Exhibit F [Pricing Sheet, RFI Attachment B]. In no event shall compensation paid to Consultant pursuant to this agreement exceed [ Contract Maximum ] over the entire term of this agreement, including any renewal terms as provided for in Section 5 of this agreement.

Contractor's violation or breach of agreement terms may result in fiscal penalties, withholding of compensation, or termination of agreement.

**Section 4. BILLING AND PAYMENT.**

- A. Consultant shall submit to County within five days after completion of the services prescribed in section 1, an itemized statement or invoice of services rendered. County shall make payment within 30 days of receipt of Consultant's correct and approved statement or invoice.
- B. Should County, or the state or federal government, disallow any amount claimed by Contractor, Contractor shall reimburse County, or the state or federal government, as directed by County, or the state or federal government, for such disallowed cost.

**Section 5. TERM OF AGREEMENT.**

The initial term of this agreement shall be for three years beginning as of the last date it has been signed by both parties. The term of this agreement shall be automatically renewed for two additional one-year terms at the end of the initial term, under the same

terms and conditions unless written notice of non-renewal is provided by either Party to the other Party at least 30 days prior to the expiration of the initial term or the then current term. Notwithstanding the foregoing, County shall not be obligated for payments hereunder for any future County fiscal year unless or until County's Board of Supervisors appropriates funds for this agreement in County's budget for that County fiscal year. In the event that funds are not appropriated for this agreement, then this agreement shall end as of June 30 of the last County fiscal year for which funds for this agreement were appropriated. For the purposes of this agreement, the County fiscal year commences on July 1 and ends on June 30 of the following year. County shall notify Consultant in writing of such non-appropriation at the earliest possible date.

**Section 6. TERMINATION OF AGREEMENT.**

- A. If Consultant materially fails to perform Consultant's responsibilities under this agreement to the satisfaction of County, or if Consultant fails to fulfill in a timely and professional manner Consultant's responsibilities under this agreement, or if Consultant violates any of the terms or provisions of this agreement, then County shall have the right to terminate this agreement for cause effective immediately upon the County giving written notice thereof to Consultant. If termination for cause is given by County to Consultant and it is later determined that Consultant was not in default or the default was excusable, then the notice of termination shall be deemed to have been given without cause pursuant to paragraph B of this section.
- B. County may terminate this agreement without cause on 30 days written notice to Consultant.
- C. County may terminate this agreement immediately upon oral notice should funding cease or be materially decreased during the term of this agreement.
- D. County's right to terminate this agreement may be exercised by the Director of Support Services or the County Executive Officer.
- E. Should this agreement be terminated, Consultant shall promptly provide to County any and all finished and unfinished reports, data, studies, photographs, charts, and other documents prepared by Consultant pursuant to this agreement.
- F. If this agreement is terminated, Consultant shall only be paid for services satisfactorily completed and provided prior to the effective date of termination.

**Section 7. ENTIRE AGREEMENT; AMENDMENTS; HEADINGS; EXHIBITS/APPENDICES.**

- A. This agreement supersedes all previous agreements relating to the subject of this agreement and constitutes the entire understanding of the parties hereto. Consultant shall be entitled to no other benefits other than those specified herein. Consultant specifically acknowledges that in entering into and executing this

agreement, Consultant relies solely upon the provisions contained in this agreement and no others.

- B. No changes, amendments, or alterations to this agreement shall be effective unless in writing and signed by both parties. However, minor amendments that do not result in a substantial or functional change to the original intent of this agreement and do not cause an increase to the maximum amount payable under this agreement may be agreed to in writing between Consultant and the Director of Support Services, provided that the amendment is in substantially the same format as the County's standard format amendment contained in the Shasta County Contracts Manual (Administrative Policy 6-101).
- C. The headings that appear in this agreement are for reference purposes only and shall not affect the meaning or construction of this agreement.
- D. If any ambiguity, inconsistency, or conflict exists or arises between the provisions of this agreement and the provisions of any of this agreement's exhibits or appendices, the provisions of this agreement shall govern.

**Section 8. NONASSIGNMENT OF AGREEMENT; NON-WAIVER.**

Inasmuch as this agreement is intended to secure the specialized services of Consultant, Consultant may not assign, transfer, delegate, or sublet any interest herein without the prior written consent of County. The waiver by County of any breach of any requirement of this agreement shall not be deemed to be a waiver of any other breach.

**Section 9. EMPLOYMENT STATUS OF CONSULTANT.**

Consultant shall, during the entire term of this agreement, be construed to be an independent contractor, and nothing in this agreement is intended nor shall be construed to create an employer-employee relationship, a joint venture relationship, or to allow County to exercise discretion or control over the professional manner in which Consultant performs the work or services that are the subject matter of this agreement; provided, however, that the work or services to be provided by Consultant shall be provided in a manner consistent with the professional standards applicable to such work or services. The sole interest of County is to insure that the work or services shall be rendered and performed in a competent, efficient, and satisfactory manner. Consultant shall be fully responsible for payment of all taxes due to the State of California or the federal government that would be withheld from compensation if Consultant were a County employee. County shall not be liable for deductions for any amount for any purpose from Consultant's compensation. Consultant shall not be eligible for coverage under County's workers' compensation insurance plan nor shall Consultant be eligible for any other County benefit. Consultant must issue W-2 and 941 Forms for income and employment tax purposes, for all of Consultant's assigned personnel under the terms and conditions of this agreement.

**Section 10. INDEMNIFICATION.**

To the fullest extent permitted by law, Consultant shall indemnify and hold harmless County, its elected officials, officers, employees, agents, and volunteers against all claims, suits, actions, costs, expenses (including, but not limited to, reasonable attorney's fees of County Counsel and counsel retained by County, expert fees, litigation costs, and investigation costs), damages, judgments, or decrees arising from the work or the provision of services undertaken pursuant to this agreement by Consultant, or by any of Consultant's subcontractors, any person employed under Consultant, or under any subcontractor, or in any capacity, except when the injury or loss is caused by the sole negligence or intentional wrongdoing of County. Consultant shall also, at Consultant's own expense, defend the County, its elected officials, officers, employees, agents, and volunteers, against any claim, suit, action, or proceeding brought against County, its elected officials, officers, employees, agents, and volunteers, arising from the work or the provision of services undertaken pursuant to this agreement by Consultant, or any of Consultant's subcontractors, any person employed under Consultant, or under any Subcontractor, or in any capacity. Consultant shall also defend and indemnify County for any adverse determination made by the Internal Revenue Service or the State Franchise Tax Board and/or any other taxing or regulatory agency and shall defend, indemnify, and hold harmless County with respect to Consultant's "independent contractor" status that would establish a liability on County for failure to make social security deductions or contributions or income tax withholding payments, or any other legally mandated payment. The provisions of this paragraph are intended to be interpreted as broadly as permitted by applicable law. This provision shall survive the termination, expiration, or cancellation of this agreement.

**Section 11. INSURANCE COVERAGE.**

- A. Without limiting Consultant's duties of defense and indemnification, Consultant and any subcontractor shall obtain, from an insurance carrier authorized to transact business in the State of California, and maintain continuously during the term of this agreement Commercial General Liability Insurance, including coverage for owned and non-owned automobiles, and other insurance necessary to protect the County and the public with limits of liability of not less than \$1 million combined single limit bodily injury and property damage; such insurance shall be primary as to any other insurance maintained by County.
  
- B. Consultant and any subcontractor shall obtain and maintain continuously required Workers' Compensation and Employer's Liability Insurance to cover Consultant, subcontractor, Consultant's partner(s), subcontractor's partner(s), Consultant's employees, and subcontractor's(s') employees with an insurance carrier authorized to transact business in the State of California covering the full liability for compensation for injury to those employed by Consultant or subcontractor. Each such policy shall be endorsed to state that the Workers' Compensation carrier waives its right of subrogation against the County, its elected officials, officers, employees, agents, and volunteers which might arise in connection with this agreement. Consultant hereby certifies that Consultant is aware of the provisions of section 3700 of the Labor Code, which requires every employer to insure against liability for workers' compensation or to undertake self-insurance in accordance with the provisions of the Labor Code, and Consultant shall comply

with such provisions before commencing the performance of the work or the provision of services pursuant to this agreement.

- C. Consultant shall obtain and maintain continuously a policy of Errors and Omissions coverage with limits of liability of not less than \$1 million.
- D. Consultant shall require subcontractors to furnish satisfactory proof to County that liability and workers' compensation and other required types of insurance have been obtained and are maintained similar to that required of Consultant pursuant to this agreement.
- E. With regard to all insurance coverage required by this agreement:
  - (1) Any deductible or self-insured retention exceeding \$25,000 for Consultant or subcontractor shall be disclosed to and be subject to approval by the County Risk Manager prior to the effective date of this agreement.
  - (2) If any insurance coverage required hereunder is provided on a "claims made" rather than "occurrence" form, Consultant or subcontractor shall maintain such insurance coverage with an effective date earlier or equal to the effective date of this agreement and continue coverage for a period of three years after the expiration of this agreement and any extensions thereof. In lieu of maintaining post-agreement expiration coverage as specified above, Consultant or subcontractor may satisfy this provision by purchasing tail coverage for the claims-made policy. Such tail coverage shall, at a minimum, provide the insurance coverage required hereunder for claims received and reported three years after the expiration date of this agreement.
  - (3) All insurance (except workers' compensation and professional liability) shall include an endorsement or an amendment to the policy of insurance which names *Shasta County, its elected officials, officers, employees, agents, and volunteers as additional insureds* and provides that coverage *shall not be reduced or canceled without 30 days written prior notice certain to the County*. Any available insurance proceeds in excess of the specified minimum limits and coverage pursuant to the terms of this agreement shall be applicable to the Additional Insured. The additional insureds coverage shall be equal to Insurance Service Office endorsement CG 20 10 for on-going operations, and CG 20 37 for completed operations.
  - (4) Each insurance policy (except for workers' compensation and professional liability policies), or an endorsement thereto, shall contain a "separation of insureds" clause which shall read:

"Separation of Insureds.

Except with respect to the Limits of Insurance, and any rights or duties specifically assigned in this Coverage Part to the first Named Insured, this insurance applies:

- a. As if each Named Insured were the only Named Insured; and
  - b. Separately to each suit insured against whom a claim is made or suit is brought.”
- (5) Consultant shall provide the County with an endorsement or amendment to Consultant’s policy of insurance as evidence of insurance protection before the effective date of this agreement.
- (6) The insurance coverage required herein shall be in effect at all times during the term of this agreement. In the event any insurance coverage expires at any time during the term of this agreement, Consultant shall provide, at least 20 days prior to said expiration date, a new endorsement or policy amendment evidencing insurance coverage as provided for herein for not less than the remainder of the term of this agreement or for a period of not less than one year. In the event Consultant fails to keep in effect at all times insurance coverage as herein provided and a renewal endorsement or policy amendment is not provided within 10 days of the expiration of the endorsement or policy amendment in effect at inception of this agreement, County may, in addition to any other remedies it may have, terminate this agreement upon the occurrence of such event.
- (7) If the endorsement or amendment does not reflect the limits of liability provided by the policy of insurance, Consultant shall provide County a certificate of insurance reflecting those limits.
- (8) Any of Consultant’s Excess Insurance shall contain a provision that such coverage shall also apply on a primary and non-contributory basis for the benefit of the County.

**Section 12. NOTICE OF CLAIM; APPLICABLE LAW; VENUE.**

- A. If any claim for damages is filed with Consultant or if any lawsuit is instituted concerning Consultant’s performance under this agreement and that in any way, directly or indirectly, contingently or otherwise, affects or might reasonably affect County, Consultant shall give prompt and timely notice thereof to County. Notice shall be prompt and timely if given within 30 days following the date of receipt of a claim or 10 days following the date of service of process of a lawsuit. This provision shall survive the termination, expiration, or cancellation of this agreement.



- B. Any dispute between the parties, and the interpretation of this agreement, shall be governed by the laws of the State of California. Any litigation shall be venued in Shasta County.

**Section 13. COMPLIANCE WITH LAWS; NON-DISCRIMINATION.**

- A. Consultant shall observe and comply with all applicable federal, state, and local laws, ordinances, and codes that relate to the work or services to be provided pursuant to this agreement.
- B. Consultant shall not discriminate in employment practices or in the delivery of services on the basis of race, color, creed, religion, national origin, sex, age, marital status, sexual orientation, medical condition (including cancer, HIV, and AIDS) physical or mental disability, use of family care leave under either the Family & Medical Leave Act or the California Family Rights Act, or on the basis of any other status or conduct protected by law.
- C. Consultant represents that Consultant is in compliance with and agrees that Consultant shall continue to comply with the Americans with Disabilities Act of 1990 (42 U.S.C. sections 12101, *et seq.*), the Fair Employment and Housing Act (Government Code sections 12900, *et seq.*), and regulations and guidelines issued pursuant thereto.
- D. No funds or compensation received by Contractor under this agreement shall be used by Contractor for sectarian worship, instruction, or proselytization. No funds or compensation received by Contractor under this agreement shall be used to provide direct, immediate, or substantial support to any religious activity.

**Section 14. ACCESS TO RECORDS; RECORDS RETENTION.**

- A. County, federal, and state officials shall have access to any books, documents, papers, and records of Consultant that are directly pertinent to the subject matter of this agreement for the purpose of auditing or examining the activities of Consultant or County. Except where longer retention is required by federal or state law, Consultant shall maintain all records for five years after County makes final payment hereunder. This provision shall survive the termination, expiration, or cancellation of this agreement.
- B. Consultant shall maintain appropriate records to insure a proper accounting of all funds and expenditures pertaining to the work performed or the services provided pursuant to this agreement. Consultant shall maintain records providing information that account for all funds and expenses related to the provision of services provided pursuant to this agreement. Access to these records shall be provided to County during working days, 8:00 a.m. to 5:00 p.m. and at other times upon reasonable notice by County, and upon request of state and federal agencies charged with the administration of programs related to the work or services to be provided pursuant to this agreement.

- C. Consultant agrees to accept responsibility for receiving, replying to, and/or complying with any audit exception by appropriate federal, state, or County audit directly related to the provisions of this agreement. Consultant agrees to repay County the full amount of payment received for duplicate billings, erroneous billings, audit exceptions, or false or deceptive claims. Consultant agrees that County may withhold any money due and recover through any appropriate method any money erroneously paid under this agreement if evidence exists of less than full compliance with this agreement including, but not limited to, exercising a right of set-off against any compensation payable to Consultant.

**Section 15. COMPLIANCE WITH CHILD, FAMILY, AND SPOUSAL SUPPORT REPORTING OBLIGATIONS.**

Consultant's failure to comply with state and federal child, family, and spousal support reporting requirements regarding Consultant's employees or failure to implement lawfully served wage and earnings assignment orders or notices of assignment relating to child, family, and spousal support obligations shall constitute a default under this agreement. Consultant's failure to cure such default within 90 days of notice by County shall be grounds for termination of this agreement.

**Section 16. LICENSES AND PERMITS.**

Consultant, and Consultant's officers, employees, and agents performing the work or services required by this agreement, shall possess and maintain all necessary licenses, permits, certificates, and credentials required by the laws of the United States, the State of California, the County of Shasta, and all other appropriate governmental agencies, including any certification and credentials required by County. Failure to maintain the licenses, permits, certificates, and credentials shall be deemed a breach of this agreement and constitutes grounds for the termination of this agreement by County.

**Section 17. PERFORMANCE STANDARDS.**

Consultant shall perform the work or services required by this agreement in accordance with the industry and/or professional standards applicable to Consultant's work or services.

**Section 18. CONFLICTS OF INTEREST.**

Consultant and Consultant's officers and employees shall not have a financial interest, or acquire any financial interest, direct or indirect, in any business, property, or source of income that could be financially affected by or otherwise conflict in any manner or degree with the performance of the work or services required under this agreement.

**Section 19. NOTICES.**

- A. Except as provided in section 6.C. of this agreement (oral notice of termination due to insufficient funding), any notices required or permitted pursuant to the terms and provisions of this agreement shall be given to the appropriate Party at

the address specified below or at such other address as the Party shall specify in writing Such notice shall be deemed given: (1) upon personal delivery; or (2) if sent by first class mail, postage prepaid, two days after the date of mailing.

If to County: Director of Support Services  
1450 Court Street, Suite 348  
Redding, CA 96001  
Phone: (530) 225-5515  
Fax: (530) 225-5345

If to Consultant: [RFI Responder]

- B. Any oral notice authorized by this agreement shall be given to the persons specified in Section 19.A. and shall be deemed to be effective immediately.

**Section 20. AGREEMENT PREPARATION.**

It is agreed and understood by the parties that this agreement has been arrived at through negotiation and that neither Party is to be deemed the Party which created any uncertainty in this agreement within the meaning of section 1654 of the Civil Code.

**Section 21. COMPLIANCE WITH POLITICAL REFORM ACT.**

Consultant shall comply with the California Political Reform Act (Government Code, sections 81000, *et seq.*), with all regulations adopted by the Fair Political Practices Commission pursuant thereto, and with the County's Conflict of Interest Code, with regard to any obligation on the part of Consultant to disclose financial interests and to recuse from influencing any County decision which may affect Consultant's financial interests. If required by the County's Conflict of Interest Code, Consultant shall comply with the ethics training requirements of Government Code sections 53234, *et seq.*

**Section 22. PROPERTY TAXES.**

Consultant represents and warrants that Consultant, on the date of execution of this agreement, (1) has paid all property taxes for which Consultant is obligated to pay, or (2) is current in payments due under any approved property tax payment arrangement. Consultant shall make timely payment of all property taxes at all times during the term of this agreement.

**Section 23. CONFIDENTIALITY.**

During the term of this agreement, both parties may have access to information that is confidential or proprietary in nature. Both parties agree to preserve the confidentiality of and to not disclose any such information to any third party without the express written consent of the other Party or as required by law. This provision shall survive the termination, expiration, or cancellation of this agreement.

**Section 24. CONFIDENTIALITY OF PATIENT INFORMATION.**

All information and records obtained in the course of providing services under this agreement shall be confidential, and Consultant and all of Consultant's employees, volunteers, agents, and officers shall comply with state and federal requirements regarding confidentiality of patient information (including, but not limited to, section 5328 of the Welfare and Institutions Code; Civil Code section 56.10; the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the regulations adopted pursuant thereto; Title 42, Code of Federal Regulations, Part 2; and Title 45, Code of Federal Regulations, section 205.50). All applicable regulations and statutes relating to patients' rights shall be adhered to. This provision shall survive the termination, expiration, or cancellation of this agreement. This provision shall survive the termination, expiration, or cancellation of this agreement.

**Section 25. HIPAA ADDENDUM.**

Attached to this agreement as Exhibit A, and incorporated by reference, is an Addendum that constitutes a Business Associate Agreement as required by the federal Health Insurance Portability and Accountability Act.

**Section 26. APPLICATION OF OTHER AGREEMENTS.**

Consultant and contractor's officers, agents, employees, and volunteers, and any of contractor's/consultant's subcontractors shall comply with all terms and provisions imposed upon any subcontractor of County by the Assurance of Compliance Agreement between the County of Shasta and [RFI Responder], attached to this agreement as Exhibit B and incorporated by this reference.

**Section 27. SEVERABILITY.**

If any portion of this agreement or application thereof to any person or circumstance is declared invalid by a court of competent jurisdiction or if it is found in contravention of any federal or state statute or regulation or County ordinance, the remaining provisions of this agreement, or the application thereof, shall not be invalidated thereby and shall remain in full force and effect to the extent that the provisions of this agreement are severable.

***[SIGNATURE PAGE FOLLOWS]***

**IN WITNESS WHEREOF**, County and Consultant have executed this agreement on the dates set forth below. By their signatures below, each signatory represents that he/she has the authority to execute this agreement and to bind the Party on whose behalf his/her execution is made.

**COUNTY OF SHASTA**

Date: \_\_\_\_\_

\_\_\_\_\_  
Chairman of the Board of Supervisors  
Board of Supervisors  
County of Shasta, State of California

ATTEST:

LAWRENCE G. LEES  
Clerk of the Board of Supervisors

By: \_\_\_\_\_  
Deputy

Approved as to form:

**RISK MANAGEMENT APPROVAL**

RUBIN E. CRUSE, JR  
County Counsel

By: \_\_\_\_\_

\_\_\_\_\_  
By:

**CONSULTANT**

Date: \_\_\_\_\_

By: \_\_\_\_\_  
[RFI Responder] \_\_\_\_\_  
Tax I.D.#: [RFI Responder Tax I.D.#]

[APPROVED STANDARD FORMAT]

**ADDENDUM TO CONTRACT/AGREEMENT**  
**(HIPAA Business Associate Agreement)**  
*(Revised 5/9/13)*

This Addendum is attached to, and incorporated into the agreement, entitled Personal Services Agreement for the purpose of administering and providing a comprehensive physical exam program, between the County of Shasta and [RFI Responder], dated \_\_\_\_\_.

**Definitions.**

All terms and phrases used, but not otherwise defined in this Addendum, shall have the same meaning as those terms are defined in 45 Code of Federal Regulations, subtitle A, subchapter C, parts 160 and 164. All section references in this Addendum are to Title 45 of the Code of Federal Regulations unless otherwise specified.

- (a) *Business Associate.* “Business Associate” shall mean the party with whom County of Shasta is contracting, as referenced above.
- (b) *Underlying Agreement.* “Underlying Agreement” shall mean the agreement or contract between the County of Shasta and the Business Associate, to which this Addendum is attached and incorporated.
- (c) *Covered Entity.* “Covered Entity” shall mean the covered components of the County of Shasta hybrid entity which are subject to the standards for privacy and security of Title 45, Code of Federal Regulations, subchapter C, Parts 160 and 164.

**Obligations and Activities of Business Associate.**

**Business Associate shall:**

- (a) Not use or disclose Protected Health Information (PHI), or Electronic Protected Health Information (EPHI), other than as permitted or required by this Addendum or as required by law.
- (b) Use appropriate safeguards and comply with Subpart C of Title 45, Code of Federal Regulations, Part 164 with respect to EPHI, to prevent use or disclosure of PHI or EPHI other than as provided for by this Addendum and the Underlying Agreement.
- (c) If a pattern of activity or practice of an agent, including a subcontractor, constitutes a material breach or violation of the requirements of this Addendum

and/or the Underlying Agreement, cure the breach or end the violation, as applicable, and if such steps are unsuccessful, terminate the subcontract or other agreement.

- (d) Report, as soon as reasonably practicable, to Covered Entity's Privacy and or Security Officer any use or disclosure of PHI or EPHI not provided for by this Addendum and/or the Underlying Agreement of which it becomes aware, including breaches of unsecured PHI as required in Section 164.410. This report will include at least the following information: (a) the nature of the non-permitted or violating use or disclosure or Security Incident; and (b) the PHI and EPHI used or disclosed. This does not relieve Business Associate of his/her/their continuing obligations under the agreement or any State or Federal reporting requirements.
- (e) Ensure that any agent, including a subcontractor, to whom it provides PHI or EPHI received from, or created or received by Business Associate on behalf of Covered Entity, agrees to the same restrictions and conditions that apply through this Addendum and the Underlying Agreement to Business Associate with respect to such information.
- (f) Provide access, at the request of Covered Entity, and in the time and manner designated by Covered Entity, to PHI and EPHI information in a designated record set, to Covered Entity or, as directed by Covered Entity, to an individual in order to meet the requirements under Section 164.524.
- (g) Make any amendment(s) to PHI and EPHI in a designated record set that the Covered Entity directs or agrees to make pursuant to Section 164.526 at the request of Covered Entity or an individual, and in the time and manner designated by Covered Entity.
- (h) Make internal practices, books, and records, including policies and procedures and PHI and EPHI, relating to the use and disclosure of PHI and EPHI received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, or to the Secretary (i.e., the Secretary of Health and Human Services [HHS], or to any officer or employee of HHS to the authority involved has been delegated), in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the law.
- (i) Document disclosures of PHI and EPHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures in accordance with Section 164.528.
- (j) Provide to Covered Entity or an individual, in the time and manner designated by Covered Entity, information collected of disclosures of PHI and EPHI, to permit Covered Entity to respond to a request by an individual for an accounting of disclosures in accordance with Section 164.528.

- (k) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI and EPHI that it creates, receives, maintains, or transmits on behalf of the Covered Entity, as required by law. In addition, Business Associate shall ensure that any agent, including a subcontractor, to whom it provides PHI or EPHI agrees to implement reasonable and appropriate safeguards to protect it.
- (l) Ensure that all employees of Business Associate that handle or access PHI or EPHI undergo annual training regarding the safeguarding of PHI and EPHI.
- (m) To the extent Business Associate is to carry out one or more of Covered Entity's obligation(s) under Subpart E of Title 45, Code of Federal Regulations, Part 164, comply with the requirements of Subpart E that apply to Covered Entity in the performance of such obligations.

#### **Permitted Uses and Disclosures by Business Associate.**

Except as otherwise limited in this Addendum and the Underlying Agreement, Business Associate may use or disclose PHI and EPHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Underlying Agreement, provided that such use or disclosure would not violate the law if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.

#### **Obligations of Covered Entity.**

- (a) Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with Section 164.520, to the extent that such limitation(s) may affect Business Associate's use or disclosure of PHI and EPHI.
- (b) Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose PHI and EPHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI and EPHI.
- (c) Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI and EPHI that Covered Entity has agreed to in accordance with Section 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI and EPHI.

#### **Permissible Requests by Covered Entity.**

Covered Entity shall not request Business Associate to use or disclose PHI and EPHI in any manner that would not be permissible under the law if done by Covered Entity.



## **Term and Termination.**

The provisions of this Addendum shall supersede the provisions of the Underlying Agreement insofar as they relate to the term and termination of the Underlying Agreement.

- (a) *Term.* The provisions of this Addendum shall be effective as of the Effective Date of the Underlying Agreement and shall terminate when all of the PHI and EPHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity or, if it is infeasible to return or destroy, protections are extended to such information, in accordance with the termination provisions in this Addendum.
- (b) *Termination for Cause.* Upon County of Shasta's knowledge of a material breach by Business Associate of the provisions of this Addendum, County of Shasta may terminate this Addendum and the Underlying Agreement immediately upon oral notice.
- (c) *Effect of Termination.*
  - (1) Except as provided in paragraph (2) of this provision, upon termination of this Addendum and the Underlying Agreement, for any reason, Business Associate shall return or destroy, in a confidential manner, all PHI and EPHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI and EPHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of said PHI and EPHI.
  - (2) In the event that Business Associate determines that returning or destroying the PHI and EPHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon the agreement of Covered Entity that return or destruction is infeasible, Business Associate shall extend the protections of this Addendum to such PHI and EPHI and limit further uses and disclosures to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI and EPHI.

## **Miscellaneous**

- (a) *Amendment.* The Parties agree to take such action as is necessary to amend this Addendum and the Underlying Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and the regulations enacted pursuant thereto. Any such amendment may be signed on

behalf of the County of Shasta by the County Executive Officer, or his or her designee(s).

- (b) Survival. The respective rights and obligations of Business Associate under the provision of this Addendum entitled “Effect of Termination” shall survive the termination of the Underlying Agreement.
- (c) Interpretation. Any ambiguity in this Addendum and the Underlying Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.



**ASSURANCE OF COMPLIANCE WITH THE SHASTA COUNTY  
HEALTH AND HUMAN SERVICES AGENCY, DEPARTMENT OF  
SOCIAL SERVICES NONDISCRIMINATION IN STATE AND FEDERALLY  
ASSISTED PROGRAMS**

Agreement to administer and provide a comprehensive physical exam program.  
[ RFI Responder ]

HEREBY AGREES to comply with Titles VI and VII of the federal Civil Rights Act of 1964, as amended; Section 504 of the federal Rehabilitation Act of 1973, as amended; the federal Age Discrimination Act of 1975, as amended; the federal Food Stamp Act of 1977 as amended, and in particular section 272.6 thereof; Title II of the federal Americans with Disabilities Act of 1990, as amended; the Unruh Civil Rights Act, California Civil Code, section 51, as amended; California Government Code, sections 11135 - 11139.5, as amended; California Government Code, section 12940, as amended; Chapter 7, of Division 5, or Title 1 of the California Government Code, commencing with section 4450, as amended; Title 22, California Code of Regulations, sections 98000 – 98413; Title 24, California Code of Regulations, section 3105; the Dymally-Alatorre Bilingual Services Act (California Government Code, sections 7290 – 7299.8), as amended; section 1808 of the Interethnic Adoption Provisions of the Small Business Job Protection Act of 1996, as amended; and all other applicable federal and state laws, as well as their implementing regulations (including title 45 of the Code of Federal Regulations (CFR) Parts 80, 84, and 91; 7 CFR, Part 15; and 28 CFR, Part 42), by ensuring that employment practices and the administration of public assistance and social services programs are nondiscriminatory, to the effect that no person shall, because of ethnic group identification, age, sex, color, disability, medical condition, national origin, race, ancestry, sexual orientation, marital status, religion, religious creed or political belief, be excluded from participation in or be denied the benefits of, or be otherwise subject to discrimination under, any program or activity receiving federal or state financial assistance; and HEREBY GIVES ASSURANCE to immediately take any measures necessary to effectuate this Assurance of Compliance.

THIS ASSURANCE OF COMPLIANCE is given in consideration of and for the purpose of obtaining any and all federal and state assistance; and CONTRACTOR HEREBY GIVES ASSURANCE THAT administrative methods/procedures which have the effect of subjecting individuals to discrimination or defeating the objectives of Chapter 21-100 of the California Department of Social Services (CDSS) Manual of Policies and Procedures will be prohibited.

BY GIVING THIS ASSURANCE OF COMPLIANCE, Contractor agrees to compile data, maintain records, and submit reports as required, to permit effective enforcement of the aforementioned laws, rules, and regulations and permit authorized CDSS and/or federal government personnel, during normal working hours, to review such records, books, and accounts as needed to ascertain compliance. If there are any violations of this Assurance of Compliance, CDSS shall have the right to invoke fiscal sanctions or other legal remedies in accordance with California Welfare and Institutions Code section 10605, or California Government Code sections 11135 – 11139.5, as amended, or any other laws or regulations, or the issue may be referred to the appropriate federal agency for further compliance action and enforcement of this Assurance of Compliance.

THIS ASSURANCE OF COMPLIANCE is binding on Contractor as long as Contractor is receiving federal or state funding pursuant to the agreement to which this Assurance of Compliance is attached.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Contractor's Signature

## RESPIRATORY PROTECTION PROGRAM REQUIREMENTS

This Respiratory Protection Program Requirements notice is included in order to ensure consistency of service for respiratory protection and compliance with the medical evaluation requirements of the Shasta County Respiratory Protection Program (Chapter 13 of the Shasta County Injury and Illness Prevention Program Plan).

### **Definitions.**

Terms used, but not otherwise defined in this Exhibit C, shall have the same meaning as those terms as defined in the Shasta County Respiratory Protection Program, which is Chapter 13 of the Shasta County Injury and Illness prevention Program Plan.

- a) Asbestos Worker: "Asbestos Worker" shall mean any employee of Shasta County whose job duties involve exposure to friable asbestos and requires the use of a respirator as protection from the exposure to asbestos.
- b) Asbestos Worker's Initial Medical Evaluation: "Asbestos Worker's Initial Medical Evaluation" shall mean the initial medical evaluation as required by Section 1529 of Title 8 of the California Code of Regulations, involving:
  - a. the completion of a nine page questionnaire (example E of this Exhibit) by the employee,
  - b. a medical examination by the PLHCP,
  - c. a lung function evaluation using spirometric test methods and
  - d. a chest X-ray.

This evaluation shall be performed on initial assignment to a job function involving exposure to friable asbestos requiring the wearing of a respirator.

- c) Asbestos Worker's Periodic Medical Evaluation: "Asbestos Worker's Periodic Medical Evaluation" shall mean the annual medical evaluation as required by Section 1529 of Title 8 of the California Code of Regulations, involving:
  - a. the completion of a three page questionnaire (example F of this Exhibit) by the employee,
  - b. a medical examination by the PLHCP,
  - c. a lung function evaluation using spirometric test methods and
  - d. a chest X-ray.

This evaluation shall be performed each year subsequent to the initial evaluation.

- d) N95 Test: "N95 Test" is the colloquial term used by [Medical Provider] to describe to their employees the Qualitative Fit test as described in Section 5144 of Title 8 of the California Code of Regulations and using irritant smoke evaluation.

- e) Respiratory Protection Program Cover Sheet: the "Respiratory Protection Cover Sheet" shall be a sheet (example B of this Exhibit) that is used to identify to the employee and to the PLHCP the required evaluations and documentation and shall identify the location to which the invoice for services is to be sent.
- f) Respirator Wearer: "Respirator Wearer" shall mean any employee of Shasta County who is required to wear any of the respirators as defined in Chapter 13 of the Shasta County Injury and Illness Prevention Program Plan, unless that employee performs work involving exposure to asbestos.
- g) Respirator Wearer's Medical Evaluation: "Respirator Wearer's Medical Evaluation" shall mean the medical evaluation as required by Section 5144 of Title 8 of the California Code of Regulations, involving:
  - a. the completion of a five page questionnaire (example C of this Exhibit) by the employee,
  - b. review of the questionnaire by a Physician or Other Licensed Health Care Professional (PLHCP) and
  - c. the performance of any additional evaluations deemed necessary by the PLHCP.

This evaluation shall be performed on initial assignment to a job function requiring the wearing of a respirator and every two years thereafter. The results of this test are subjective, and shall be reported by [Medical Provider] on the Respirator Assignment and Fit Test Record (example D of this Exhibit).

- h) Medical Group Patient Information Form: "Medical Group Patient Information Form" shall be the form used by [Medical Provider] to obtain required basic medical information from their patients. An example of this form is provided as example A of this Exhibit.
- i) SCBA Test: "SCBA Test" is the colloquial term used by [Medical Provider] to describe to their employees the Quantitative Fit test as described in Section 5144 of Title 8 of the California Code of Regulations and using the Portacount measuring device. The results of this test are printed by the evaluating machine and shall be furnished by [Medical Provider] to the requesting department on completion of all testing and evaluations.
- j) Shasta County Respirator Assignment and Fit Test Record: "Shasta County Respirator Assignment and Fit Test Record" shall be the document used to provide information regarding the employee's assignment, the respiratory hazards of that assignment and the type of respirator to be used by the employee. The information on fit test results and medical evaluations shall be furnished by the PLHCP and returned to the requesting department on completion of all medical evaluations and testing. This document is provided as example D of this Exhibit.

### **Responsibilities of Shasta County**

- a) Upon identifying the need for a medical evaluation under the terms of this Addendum, the Departmental Safety Coordinator (or other designated individual) within the County

Department shall contact the [Medical Provider] receptionist and schedule an appointment for each individual needing the evaluation.

- b) The Departmental Safety Coordinator (or other designated individual) shall furnish the employee with the appropriate documentation for the evaluation being performed, and shall request that the employee complete the documentation prior to reporting to [Medical Provider] for the evaluation.
  - a. The appropriate documentation shall always include a properly completed Respiratory Protection Program Cover Sheet.
  - b. The appropriate information shall always include a properly completed Medical Group Patient Information Form.
  - c. The appropriate information shall always include a properly completed Respirator Assignment and Fit Test Record.
- c) The County shall ensure that employees who are part of the Respiratory Protection Program:
  - a. Complete the required documentation and report to [Medical Provider] for the required evaluations.
  - b. Make every reasonable effort to be timely.
  - c. Take to [Medical Provider] the respirator which has been assigned to them, for use in the Fit Test.
  - d. Provide to [Medical Provider] the completed documentation package.
  - e. Cooperate fully with the requirements of [Medical Provider] personnel to ensure that the required evaluations are completed in the shortest practical time.

**Responsibilities of [Medical Provider]**

- a) Set appointments as required by the requesting Department.
- b) Perform required evaluations, examinations and testing as stipulated on the Respiratory Protection Program Cover Sheet carried by the employee.
- c) Complete the necessary documentation and furnish the results to the requesting department. Documentation of results shall include:
  - a. An original completed Respirator Assignment and Fit Test Record.
  - b. A copy of the actual results obtained during any Quantitative Fit Tests.
- d) Submit an invoice for the services performed to the address shown on the Respiratory Protection Program Cover Sheet.
- e) Furnish a copy of completed "Shasta County Respirator Assignment and Fit Test Record" forms to Shasta County Risk Management by fax to 530-225-5251 within three working days of Fit Test.

**EXAMPLES:**

- EXAMPLE A            Medical Group Patient Information Form
- EXAMPLE B            Respiratory Protection Program Cover Sheet
- EXAMPLE C            Respiratory Protection Program Medical Questionnaire for Respirator Users
- EXAMPLE D            Respirator Assignment and Fit Test Record
- EXAMPLE E            Asbestos Worker's Initial Medical Evaluation
- EXAMPLE F            Asbestos Worker's Periodic Medical Evaluation

### MEDICAL PROVIDER NAME

1710 Churn Creek Road  
Tel. (530) 646-4242

Redding, CA 96002  
Fax (530) 646-4243

### PATIENT QUESTIONNAIRE

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone # (\_\_\_\_\_) \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
SEX **M / F** (circle one)

Occupation: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Phone # (\_\_\_\_\_) \_\_\_\_\_  
DL # \_\_\_\_\_  
Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

#### Have you ever had any of the following?

- |   | Yes   | No    |
|---|-------|-------|
| 1. Any injury which caused you to lose time from work within the last 5 years?                                | _____ | _____ |
| 2. Received disability or released from the Armed Forces for medical or health reasons?                       | _____ | _____ |
| 3. Have you ever received or intend to apply for a pension or compensation (including worker's compensation). | _____ | _____ |
| 4. Are you currently under a doctor's care for any conditions?  | _____ | _____ |
| 5. Have you been denied employment or insurance for health reasons?   | _____ | _____ |
| 6. Tuberculosis or other lung trouble?  | _____ | _____ |
| 7. Hepatitis or jaundice?   | _____ | _____ |
| 8. Cancer or tumors?  | _____ | _____ |
| 9. Asthma?  | _____ | _____ |
| 10. Allergies? ___mild___moderate___severe  | _____ | _____ |
| 11. Diabetes?   | _____ | _____ |
| 12. Anemia, Leukemia or other blood disorders?  | _____ | _____ |
| 13. Any disorder of the nervous system?   | _____ | _____ |
| 14. Epilepsy or convulsions?  | _____ | _____ |
| 15. Severe headaches?   | _____ | _____ |
| 16. Heart trouble including circulatory?  | _____ | _____ |
| 17. Varicose veins?   | _____ | _____ |
| 18. Hernia?   | _____ | _____ |
| 19. Gall bladder trouble?   | _____ | _____ |

- |  | Yes   | No    |
|--|-------|-------|
| 27. Stomach, ulcer or other digestive problems?  | _____ | _____ |
| 28. Skin problems?   | _____ | _____ |
| 29. Back pain or back injury?  | _____ | _____ |
| 30. Kidney or urinary problems?  | _____ | _____ |
| 31. Have you ever worked for an employer who required periodic physical or routine blood/urine test? | _____ | _____ |
| 32. Have you ever had to change jobs for health reasons?   | _____ | _____ |
| 33. Do you currently have any conditions that may limit you to perform any type of task or job?      | _____ | _____ |
| 34. Are you currently partially disabled or impaired in any way (other than corrected vision)?       | _____ | _____ |
| 35. Have you ever received a disability retirement From a civilian job?                              | _____ | _____ |
| 36. Have you ever developed illness or symptoms, which you think, were related to your work?         | _____ | _____ |
| 37. Have you ever worked with a substance which made your nose, chest or sinuses congested?          | _____ | _____ |
| 38. Mental illness or nervous breakdown?   | _____ | _____ |
| 39. Have you ever worked with a substance that irritated you skin or caused a rash?                  | _____ | _____ |
| 40. How many day of work did you miss in the Last 12 months due to your health _____ days            |       |       |

#### Have you ever had the following?

- |                               |       |       |
|-------------------------------|-------|-------|
| 20. A CT Scan                 | _____ | _____ |
| 21. A Myelogram               | _____ | _____ |
| 22. A MRI Scan                | _____ | _____ |
| 23. Back X-rays               | _____ | _____ |
| 24. Seen a chiropractor       | _____ | _____ |
| 25. Seen an Orthopedic doctor | _____ | _____ |
| 26. Seen a Neurosurgeon       | _____ | _____ |

- |   |       |       |
|---|-------|-------|
| 41. Have you ever received hazardous duty or environmental pay? | _____ | _____ |
| 42. Do you smoke?   | _____ | _____ |
| 43. Do you drink coffee?  | _____ | _____ |
| 44. Do you drink alcohol?                                       | _____ | _____ |
| 45. Could you be or are you pregnant?                           | _____ | _____ |
| 46. Date of last menses _____                                   |       |       |

**47. Please continue on reverse side of this form.**

#### Please identify by number and explain questions you answered "yes"

# \_\_\_\_\_  
# \_\_\_\_\_  
# \_\_\_\_\_  
# \_\_\_\_\_  
# \_\_\_\_\_  
# \_\_\_\_\_



# \_\_\_\_\_

**Medication History**

MEDICATION	NOW TAKING		TAKEN LAST YEAR		REASON
	YES	NO	YES	NO	

**Work History**

**List your last four jobs. Indicate the job title, work description and any health hazards.**

NAME OF EMPLOYER	From MO/YR	To MO/YR	DESCRIPTION OF WORK	REASON FOR LEAVING

**Surgical History**

Have you ever had surgery?  YES  NO

TYPE OF SURGERY	YEAR	NAME OF SURGEON	LOCATIONS OF HOSPITAL	COMPLICATIONS, IF ANY

**Hospitalization History**

Have you ever been hospitalized?  YES  NO

If "yes", please complete the following information about each hospitalization.

PART OF BODY AFFECTED	NATURE OF ILLNESS OR REASON FOR STAY	DATE MO/YR	WORK RELATED? Y/N	If "YES" EMPLOYERS NAME

**In case of injury, notify** \_\_\_\_\_ **Tel#** \_\_\_\_\_

**Address** \_\_\_\_\_ **Relationship** \_\_\_\_\_

The above information is true and complete to the best of my knowledge. I understand some of this information may cause me to be declared ineligible for some employment benefits.

I also agree to be examined and treated by staff physicians and the clinic staff, which may include evaluation, X-rays, laboratory work, or other special studies.

I understand the information I make known to MEDICAL CLINIC NAME staff and any information discovered during the course of clinic's examination may be released to the employer or prospective employer for purposes of determining suitability for placement in employment.

DATED \_\_\_\_\_ WITNESS \_\_\_\_\_

SIGNATURE \_\_\_\_\_

**ATTENTION:** 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.

Rev 6/11

SAMPLE



## **SHASTA COUNTY RESPIRATORY PROTECTION PROGRAM COVER SHEET**

The employee carrying this documentation is a participant in the Shasta County Respiratory Protection Program, and is required to have the following evaluations performed (identified by a check in the applicable box):

- Respirator Wearer's Medical Evaluation
- Asbestos Worker's Initial Medical Evaluation
- Asbestos Worker's Periodic Medical Evaluation
- Respirator fit testing using quantitative method ("SCBA test")
- Respirator fit testing using qualitative test method ("N95 test")

Attached to this form are the documents that are required to accomplish the necessary evaluation (identified by a check in the applicable box):

- RIOH Medical Group Patient Information Form
- Shasta County Respirator Wearer Medical Questionnaire (5 pages)
- Shasta County Asbestos Worker Initial Medical Questionnaire (9 pages)
- Shasta County Asbestos Worker Periodic Medical Questionnaire (3 pages)
- Shasta County Respirator Assignment and Fit Test Record  
*(to be completed and returned to the requesting department on completion of all required testing, examinations and evaluations)*

Send invoice for this service to:

Dept. of Support Services, 1450 Court Street, Ste 348, Redding, CA 96001-1676 Attention: Personnel

**Shasta County Respiratory Protection Program**  
**Medical Questionnaire for Respirator Users**

Employee's Name \_\_\_\_\_ Date \_\_\_\_\_

Home address: \_\_\_\_\_ Department \_\_\_\_\_

\_\_\_\_\_ Address: \_\_\_\_\_

\_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_ Job Title: \_\_\_\_\_

SSN: \_\_\_\_\_ Number of Years Worked for the Department. \_\_\_\_\_

**To the Employee:** Can you read? (Check one): Yes No

Your Supervisor 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 supervisor 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. Sex (circle one): Male / Female
2. Your height: \_\_\_\_ ft. \_\_\_\_ in.
3. Your weight: \_\_\_\_ lbs.
4. Is it okay for the health care professional who reviews this questionnaire to contact you at one of the telephone numbers listed above? Yes \_\_\_\_\_ No \_\_\_\_\_  
If No is checked, please list the telephone number where you can be reached. \_\_\_\_\_
5. What is the best time to reach you at this number? \_\_\_\_\_
6. Has your supervisor told you how to contact the health care professional who will review this questionnaire? Yes \_\_\_\_\_ No \_\_\_\_\_
7. 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. \_\_\_\_\_ Half- or full-face piece air-purifying type
  - c. \_\_\_\_\_ Powered-air purifying, supplied-air
  - d. \_\_\_\_\_ Self-contained breathing apparatus (SCBA)

8. Have you worn a respirator? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If "yes," what type(s):
- \_\_\_\_\_ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
  - \_\_\_\_\_ Half- or full-face piece air-purifying type
  - \_\_\_\_\_ Powered-air purifying, supplied-air
  - \_\_\_\_\_ Self-contained breathing apparatus (SCBA)

**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")**

- Do you currently smoke tobacco, or have you smoked tobacco in the last month: Yes No
  - If yes, what quantity (how many cigarettes per day)? \_\_\_\_\_
  - If you did smoke tobacco and quit, how long has it been since you last smoked? \_\_\_\_\_
- 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:	Yes	No
- 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
- 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 incline:	Yes	No
c. Shortness of breath when walking with others 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. If you've used a respirator, have you ever had any of the following problems?<br>(If you've never used a respirator, go to question 9) |     |    |
| 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 who will review this questionnaire about your answers to this questionnaire?    | Yes | No |

**Part B.**

1. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals? Or have you come into skin contact with hazardous chemicals? Yes No

If "yes," circle or name them:

- a. Asbestos: Yes No
- b. Silica (e.g., in sandblasting): Yes No
- c. Lead: Yes No
- d. Pesticides: Yes No
- e. Glues and Adhesives: Yes No
- f. Clandestine Drug Labs: Yes No
- g. Dusty Environments: Yes No
- h. Other: \_\_\_\_\_

2. List any second jobs or side businesses you have: \_\_\_\_\_

3. List your previous occupations: \_\_\_\_\_

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

5. Other than medications 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: \_\_\_\_\_

6. 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

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

- a. Light? Yes No

If "yes," how long does this period last during the average shift: \_\_\_\_\_ hours \_\_\_\_\_ minutes.

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: Yes No

If "yes," how long does this period last during the average shift?: \_\_\_\_\_ hours. \_\_\_\_\_ minutes.

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 Yes      No  
 If "yes," how long does this period last during the average shift: \_\_\_\_\_ hrs. \_\_\_\_\_ minutes.

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.).

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

9. Will you be working under humid conditions?: Yes      No

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

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

**Part C. (Full-Facepiece Respirators and SCBAs)**

**Questions 1 to 6 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.**

- |   |     |    |
|---|-----|----|
| 1. Have you ever lost vision in either eye (temporarily or permanently)?: | Yes | No |
| 2. 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 |
| 3. Have you ever had an injury to your ears, including a broken ear drum? | Yes | No |



- |  |     |    |
|--|-----|----|
| 4. 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 |
| 5. Have you ever had a back injury?:   | Yes | No |
| 6. 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. 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 |

CERTIFICATION: I certify that I have provided true and complete information concerning my health.

---

Employee Signature

---

Date

# SHASTA COUNTY

## RESPIRATOR ASSIGNMENT AND FIT TEST RECORD

**EXHIBIT C**  
*Example D*

EMPLOYEE NAME: DEPT: DATE:
JOB DESCRIPTION:
CONTAMINANTS:
RESPIRATOR TYPE, MAKE & MODEL:
<p style="text-align: center;"><b>MEDICAL EVALUATION RESULTS:</b></p> <p>This is to certify that the above named employee was examined in accordance with the provisions of Title 8 CCR Section(s) 1529 and/or 5144. This document provides the results of the medical examination and included as part of a written opinion that I have not detected any medical conditions that: 1) would place any of these employee(s) at an increased risk of material health impairment from exposure to airborne hazards (including asbestos fibers), and 2) would not limit the use of negative pressure respirators. I have informed the employee of the results of the medical examination. I also certify that the employer supplied me with all information required by T8CCR 1529 and/or 5144.</p> <p style="text-align: center;"><input type="checkbox"/> is physically capable</p> <p style="text-align: center;"><input type="checkbox"/> is NOT physically capable</p> <p style="text-align: center;">of using a negative-pressure, air supplied respirator and/or powered air purifying respirator subject to the following restrictions:</p> <p><input type="checkbox"/> Respirator use should be limited to air-supplied or powered air purifying respirators using positive pressure</p> <p><input type="checkbox"/> No respirator use if wheezing or shortness of breath are evident</p>
<p style="text-align: center;"><b>FIT TEST RESULTS:</b></p> <p style="text-align: center;"><input type="checkbox"/> SATISFACTORY</p> <p style="text-align: center;"><input type="checkbox"/> UNSATISFACTORY</p> <p style="text-align: center;"><i>(attach actual results if the test was performed using Quantitative test methods)</i></p>
REMARKS: Sensitivity Test =

NAME OF PERSON CONDUCTING TEST \_\_\_\_\_

SIGNATURE \_\_\_\_\_



**T8CCR§1529 APPENDIX D**  
**ASBESTOS WORKER INITIAL MEDICAL QUESTIONNAIRE**

1. NAME \_\_\_\_\_
2. SOCIAL SECURITY #  

1	2	3	4	5	6	7	8	9
---	---	---	---	---	---	---	---	---
3. CLOCK NUMBER  

10	11	12	13	14	15
----	----	----	----	----	----
4. PRESENT OCCUPATION \_\_\_\_\_
5. PLANT \_\_\_\_\_
6. ADDRESS \_\_\_\_\_
7. \_\_\_\_\_  

(Zip Code)
8. TELEPHONE NUMBER \_\_\_\_\_
9. INTERVIEWER \_\_\_\_\_
10. DATE \_\_\_\_\_  

16	17	18	19	20	21
----	----	----	----	----	----
11. DATE OF BIRTH \_\_\_\_\_  

MONTH	DAY	YEAR	22	23	24	25	26	27
-------	-----	------	----	----	----	----	----	----
12. Place of Birth \_\_\_\_\_
13. Sex  
 1. Male \_\_\_\_\_  
 2. Female \_\_\_\_\_
14. What is your marital status?  
 1. Single \_\_\_\_\_                      3. Widowed \_\_\_\_\_  
 2. Married \_\_\_\_\_                      4. Separated/Divorced \_\_\_\_\_
15. Race  
 1. White \_\_\_\_\_                      4. Hispanic \_\_\_\_\_  
 2. Black \_\_\_\_\_                      5. Indian \_\_\_\_\_  
 3. Asian \_\_\_\_\_                      6. Other \_\_\_\_\_
16. What is the highest grade completed in school? \_\_\_\_\_  
 (For example 12 years is completion of high school)

OCCUPATIONAL HISTORY

17A. Have you ever worked full time (30 hours per week or more for 6 months or more?)

1. Yes \_\_\_\_\_
2. No \_\_\_\_\_

*ATTACHMENT A TO ADDENDUM ON RESPIRATORY PROTECTION*

IF YES TO 17A:

B. Have you ever worked for a year or more in any dusty job?  
1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_ 3. Does Not Apply \_\_\_\_\_

Specify job/industry \_\_\_\_\_

Total Years Worked \_\_\_\_\_

Was dust exposure:  
1. Mild \_\_\_\_\_ 2. Moderate \_\_\_\_\_ 3. Severe \_\_\_\_\_

C. Have you even been exposed to gas or chemical fumes in your work?  
1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_

Specify job/industry \_\_\_\_\_

Total Years Worked \_\_\_\_\_

Was exposure:  
1. Mild \_\_\_\_\_ 2. Moderate \_\_\_\_\_ 3. Severe \_\_\_\_\_

D. What has been your usual occupation or job - the one you have worked at the longest?

1. Job occupation \_\_\_\_\_

2. Number of years employed in this occupation \_\_\_\_\_

3. Position/job title \_\_\_\_\_

4. Business, field or industry \_\_\_\_\_

*(Record on lines the years in which you have worked in any of these industries. e.g. 1960-1969)*

Have you ever worked: YES . . . . NO

E. In a mine?..... [ ] [ ]

F. In a quarry? ..... [ ] [ ]

G. In a foundry? ..... [ ] [ ]

H. In a pottery? ..... [ ] [ ]

I. In a cotton, flax or hemp mill? ..... [ ] [ ]

J. With asbestos? ..... [ ] [ ]

18. PAST MEDICAL HISTORY

A. Do you consider yourself to be in good health? . [ ] [ ]

If "NO", state reason \_\_\_\_\_

B. Have you any defect of vision? ..... [ ] [ ]

If "YES", state nature of defect \_\_\_\_\_

C. Have you any hearing defect? ..... [ ] [ ]

If "YES", state nature of defect \_\_\_\_\_

D. Are you suffering from or have you ever suffered from:

a. Epilepsy (or fits, seizures, convulsions)? [ ] [ ]

b. Rheumatic fever?..... [ ] [ ]

c. Kidney disease? ..... [ ] [ ]

d. Bladder disease? ..... [ ] [ ]

- e. Diabetes? ..... [ ] [ ]
- f. Jaundice? ..... [ ] [ ]

19. CHEST COLDS AND CHEST ILLNESSES

19A. If you get a cold, does it usually go to your chest? (Usually means more than 1/2 the time)

- 1. Yes \_\_\_\_\_
- 2. No \_\_\_\_\_
- 3. Don't get colds \_\_\_\_\_

20A. During the past 3 years, have you had any chest illnesses that have kept you off work, indoors at home, or in bed?

- 1. Yes \_\_\_\_\_
- 2. No \_\_\_\_\_

IF YES TO 20A

B. Did you produce phlegm with any of these chest illnesses?

- 1. Yes \_\_\_\_\_
- 2. No \_\_\_\_\_
- 3. Does not apply \_\_\_\_\_

C. In the last 3 years, how many such illnesses with (increased) phlegm did you have which lasted a week or more?

Number of illnesses \_\_\_\_\_ No such illnesses \_\_\_\_\_

21. Did you have any lung trouble before the age of 16?

- 1. Yes \_\_\_\_\_
- 2. No \_\_\_\_\_

22. Have you ever had any of the following?

1A. Attacks of bronchitis?

- 1. Yes \_\_\_\_\_
- 2. No \_\_\_\_\_
- 3. Does not apply \_\_\_\_\_

IF YES TO 1A:

B. Was it confirmed by a doctor?

- 1. Yes \_\_\_\_\_
- 2. No \_\_\_\_\_

C. At what age was your first attack?

Age in Years \_\_\_\_\_ Does Not Apply \_\_\_\_\_

2A. Pneumonia (include bronchopneumonia)?

- 1. Yes \_\_\_\_\_
- 2. No \_\_\_\_\_

IF YES TO 2A:

B. Was it confirmed by a doctor?

- 1. Yes \_\_\_\_\_
- 2. No \_\_\_\_\_
- 3. Does not apply \_\_\_\_\_

C. At what age did you first have it?

Age in Years \_\_\_\_\_ Does Not Apply \_\_\_\_\_

3A. Hay fever?

- 1. Yes \_\_\_\_\_
- 2. No \_\_\_\_\_

IF YES TO 3A:

B. Was it confirmed by a doctor?

- 1. Yes \_\_\_\_\_
- 2. No \_\_\_\_\_
- 3. Does not apply \_\_\_\_\_

C. At what age did it start?

Age in Years \_\_\_\_\_ Does Not Apply \_\_\_\_\_

23A. Have you ever had chronic bronchitis?

1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_

IF YES TO 23A:

B. Do you still have it?

1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_ 3. Does not apply \_\_\_\_\_

C. Was it confirmed by a doctor?

1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_ 3. Does not apply \_\_\_\_\_

D. At what age did it start?

Age in Years \_\_\_\_\_ Does Not Apply \_\_\_\_\_

24A. Have you ever had emphysema?

1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_

IF YES TO 24A:

B. Do you still have it?

1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_ 3. Does not apply \_\_\_\_\_

C. Was it confirmed by a doctor?

1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_ 3. Does not apply \_\_\_\_\_

D. At what age did it start?

Age in Years \_\_\_\_\_ Does Not Apply \_\_\_\_\_

25A. Have you ever had asthma?

1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_

IF YES TO 25A:

B. Do you still have it?

1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_ 3. Does not apply \_\_\_\_\_

C. Was it confirmed by a doctor?

1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_ 3. Does not apply \_\_\_\_\_

D. At what age did it start?

Age in Years \_\_\_\_\_ Does Not Apply \_\_\_\_\_

E. If you no longer have it, at what age did it stop?

Age Stopped \_\_\_\_\_ Does Not Apply \_\_\_\_\_

26. Have you ever had:

A. Any other chest illness?

1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_

If yes, please specify \_\_\_\_\_

B. Any chest operations?

1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_

If yes, please specify \_\_\_\_\_

C. Any chest injuries?

1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_

If yes, please specify \_\_\_\_\_

27A. Has a doctor ever told you that you had heart trouble?

1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_

IF YES TO 27A:

C. Have you ever had treatment for heart trouble in the past 10 years?

1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_ 3. Does not apply \_\_\_\_\_

28A. Has a doctor ever told you that you had high blood pressure?

1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_

IF YES TO 28A:

B. Have you ever had treatment for high blood pressure (hypertension) in the past 10 years?

1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_ 3. Does not apply \_\_\_\_\_

29. When did you last have your chest X-rayed? (Year) \_\_\_\_\_

30. Where did you last have your chest X-rayed (if known)?

\_\_\_\_\_
What was the outcome? \_\_\_\_\_

FAMILY HISTORY

31. Were either of your natural parents ever told by a doctor that they had a chronic lung condition such as:

	FATHER			MOTHER		
	1. Yes	2. No	3. Don't Know	1. Yes	2. No	3. Don't Know
A. Chronic Bronchitis?	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
B. Emphysema?	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
C. Asthma?	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
D. Lung cancer?	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
E. Other chest conditions?	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
F. Is parent currently alive?	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

G. Please Specify

_____	Age if Living	_____	Age if Living
_____	Age at Death	_____	Age at Death
_____	Don't Know	_____	Don't Know

H. Please specify cause of death

\_\_\_\_\_

\_\_\_\_\_

COUGH

32A. Do you usually have a cough? (Count a cough with first smoke or on first going out doors. Exclude clearing of throat) [If no, skip to question 32C.]

1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_

B. Do you usually cough as much as 4 to 6 times a day 4 or more days out of the week?

1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_

C. Do you usually cough at all on getting up or first thing in the morning?

1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_

D. Do you usually cough at all during the rest of the day or at night?

1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_

IF YES TO ANY OF ABOVE (32A, B, C, OR D), ANSWER THE FOLLOWING. IF NO TO ALL, CHECK DOES NOT APPLY AND SKIP TO NEXT PAGE.

E. Do you usually cough like this on most days for 3 consecutive months or more during the year?

1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_ 3. Does not apply \_\_\_\_\_

F. For how many years have you had the cough?

Number of Years \_\_\_\_\_ Does Not Apply \_\_\_\_\_

33A. Do you usually bring up phlegm from your chest?

(Count phlegm with the first smoke or on first going out of doors. Exclude phlegm from the nose. Count swallowed phlegm.) (If no, skip to 33C)

1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_

B. Do you usually bring up phlegm like this as much as twice a day 4 or more days out of the week?

1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_

C. Do you usually bring up phlegm at all on getting up or first thing in the morning?

1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_

D. Do you usually bring up phlegm at all during the rest of the day or at night?

1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_

IF YES TO ANY OF THE ABOVE (33A, B, C, OR D), ANSWER THE FOLLOWING: IF NO TO ALL, CHECK DOES NOT APPLY AND SKIP TO 34A.

E. Do you bring up phlegm like this on most days for 3 consecutive months or more during the year?

1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_ 3. Does not apply \_\_\_\_\_

F. For how many years have you had trouble with phlegm?

Number of Years \_\_\_\_\_ Does Not Apply \_\_\_\_\_



EPISODES OF COUGH AND PHLEGM

34A. Have you had periods or episodes of (increased\*) and phlegm lasting for 3 weeks or more each year?

\*(For persons who usually have cough and/or phlegm)

1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_

IF YES TO 34A

B. For how long have you had at least 1 such episode per year?

Number of Years \_\_\_\_\_ Does Not Apply \_\_\_\_\_

WHEEZING

35A. Does you chest ever sound wheezy or whistling

1. When you have a cold? 1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_

2. Occasionally apart from colds? 1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_

3. Most days or nights? 1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_

IF YES TO 1, 2, or 3 in 35A

B. For how many years has this been present?

Number of Years \_\_\_\_\_ Does Not Apply \_\_\_\_\_

36A. Have you ever had an attack of wheezing that has made you feel short of breath?

1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_

B. How old were you when you had your first such attack?

Age in Years \_\_\_\_\_ Does Not Apply \_\_\_\_\_

C. Have you had 2 or more such episodes?

1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_ 3. Does not apply \_\_\_\_\_

D. Have you ever required medicine or treatment for the(se) attack(s)?

1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_ 3. Does not apply \_\_\_\_\_

BREATHLESSNESS

37. If disabled from walking by any condition other than heart or lung disease, please describe and proceed to question 39A.

Nature of condition(s)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

38A. Are you troubled by shortness of breath when hurrying on the level or walking up a slight hill?

1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_

IF YES TO 38A

B. Do you have a walk slower than people of your age on the level because of breathlessness?

1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_ 3. Does not apply \_\_\_\_\_

C. Do you ever have to stop for breath when walking at your own pace on the level?

1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_ 3. Does not apply \_\_\_\_\_

D. Do you ever have to stop for breath after walking about 100 yards (or after a few minutes) on the level?

1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_ 3. Does not apply \_\_\_\_\_

E. Are you too breathless to leave the house or breathless on dressing or climbing one flight of stairs?

1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_ 3. Does not apply \_\_\_\_\_

TOBACCO SMOKING

39A. Have you ever smoked cigarettes? (No means less than 20 packs of cigarettes or 12 oz. of tobacco in a lifetime or less than 1 cigarette a day for 1 year.)

1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_

IF YES TO 39A

B. Do you now smoke cigarettes (as of one month ago)

1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_ 3. Does not apply \_\_\_\_\_

C. How old were you when you first started regular cigarette smoking?

Age in Years \_\_\_\_\_ Does Not Apply \_\_\_\_\_

D. If you have stopped smoking cigarettes completely, how old were you when you stopped?

Age stopped \_\_\_\_\_ Check if still smoking \_\_\_\_\_ Does not apply \_\_\_\_\_

E. How many cigarettes do you smoke per day now?

Cigarettes per day \_\_\_\_\_ Does not apply \_\_\_\_\_

F. On the average of the entire time you smoked, how many cigarettes did you smoke per day?

Cigarettes per day \_\_\_\_\_ Does not apply \_\_\_\_\_

G. Do or did you inhale the cigarette smoke?

- 1. Does not apply \_\_\_\_\_
- 2. Not at all \_\_\_\_\_
- 3. Slightly \_\_\_\_\_
- 4. Moderately \_\_\_\_\_
- 5. Deeply \_\_\_\_\_

40A. Have you ever smoked a pipe regularly?

(Yes means more than 12 oz. of tobacco in a lifetime.)

1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_

IF YES TO 40A:

B. 1. How old were you when you started to smoke a pipe regularly?

Age \_\_\_\_\_

2. If you have stopped smoking a pipe completely, how old were you when you stopped?

Age stopped \_\_\_\_\_ Check if still smoking pipe \_\_\_\_\_ Does not apply \_\_\_\_\_

C. On the average over the entire time you smoked a pipe how much pipe tobacco did you smoke per week?

Ounces per week \_\_\_\_\_ Does not apply \_\_\_\_\_  
(a standard pouch of tobacco contains 1 1/2 oz.)

D. How much pipe tobacco are you smoking now?

Ounces per week \_\_\_\_\_ Not currently smoking a pipe \_\_\_\_\_

E. Do you (or did you) inhale the pipe smoke?

1. Never smoked \_\_\_\_\_
2. Not at all \_\_\_\_\_
3. Slightly \_\_\_\_\_
4. Moderately \_\_\_\_\_
5. Deeply \_\_\_\_\_

41A. Have you ever smoked cigars regularly? (Yes means more than 1 cigar a week for a year)

1. Yes \_\_\_\_\_ 2. No \_\_\_\_\_

IF YES TO 41A

FOR PERSONS WHO HAVE EVER SMOKED CIGARS

B. 1. How old were you when you started smoking cigars regularly?

Age \_\_\_\_\_

2. If you have stopped smoking cigars completely, how old were you when you stopped?

Age stopped \_\_\_\_\_ Check if still smoking cigars \_\_\_\_\_ Does not apply \_\_\_\_\_

C. On the average over the entire time you smoked cigars, how many cigars did you smoke per week?

Cigars per week \_\_\_\_\_ Does not apply \_\_\_\_\_

D. How many cigars are you smoking per week now?

Cigars per week \_\_\_\_\_ Check if not smoking cigars currently \_\_\_\_\_

E. Do you (or did) you inhale the cigar smoke?

1. Never smoked \_\_\_\_\_
2. Not at all \_\_\_\_\_
3. Slightly \_\_\_\_\_
4. Moderately \_\_\_\_\_
5. Deeply \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



**T8CCR§1529 APPENDIX D**  
**ASBESTOS WORKER PERIODIC MEDICAL QUESTIONNAIRE**

1. NAME \_\_\_\_\_

2. SOCIAL SECURITY #

                                                         

3. CLOCK NUMBER

                       

4. PRESENT OCCUPATION \_\_\_\_\_

5. PLANT \_\_\_\_\_

6. ADDRESS \_\_\_\_\_

7. \_\_\_\_\_

(Zip Code)

8. TELEPHONE NUMBER \_\_\_\_\_

9. INTERVIEWER \_\_\_\_\_

10. DATE \_\_\_\_\_

                       

11. What is your marital status?

- |                  |                             |
|------------------|-----------------------------|
| 1. Single _____  | 3. Widowed _____            |
| 2. Married _____ | 4. Separated/Divorced _____ |

OCCUPATIONAL HISTORY

12A. In the past year, did you work full time (30 hours per week or more) for 6 months or more?

- |              |             |
|--------------|-------------|
| 1. Yes _____ | 2. No _____ |
|--------------|-------------|

IF YES TO 12A:

12B. In the past year, did you work in a dusty job?

- |              |             |                         |
|--------------|-------------|-------------------------|
| 1. Yes _____ | 2. No _____ | 3. Does Not Apply _____ |
|--------------|-------------|-------------------------|

12C. Was dust exposure:

- |               |                   |                 |
|---------------|-------------------|-----------------|
| 1. Mild _____ | 2. Moderate _____ | 3. Severe _____ |
|---------------|-------------------|-----------------|

12D. In the past year, were you exposed to gas or chemical fumes in your work?

- |              |             |
|--------------|-------------|
| 1. Yes _____ | 2. No _____ |
|--------------|-------------|

12E. Was exposure:

- |               |                   |                 |
|---------------|-------------------|-----------------|
| 1. Mild _____ | 2. Moderate _____ | 3. Severe _____ |
|---------------|-------------------|-----------------|

12F. In the past year, what was your:

- |                         |
|-------------------------|
| 1. Job occupation _____ |
|-------------------------|

2. Position/job title \_\_\_\_\_

13. RECENT MEDICAL HISTORY

13A. Do you consider yourself to be in good health?

Yes \_\_\_\_\_ 2. No \_\_\_\_\_

If "NO", state reason \_\_\_\_\_

13B. In the past year, have you developed:	YES	NO
Epilepsy (or fits, seizures, convulsions)? ...	[ ]	[ ]
Rheumatic fever?.....	[ ]	[ ]
Kidney disease? .....	[ ]	[ ]
Bladder disease? .....	[ ]	[ ]
Diabetes? .....	[ ]	[ ]
Jaundice? .....	[ ]	[ ]
Cancer?.....	[ ]	[ ]

14. CHEST COLDS AND CHEST ILLNESSES

14A. If you get a cold, does it usually go to your chest? (Usually means more than 1/2 the time)

1.Yes \_\_\_\_\_ 2. No \_\_\_\_\_ 3. Don't get colds \_\_\_\_\_

15A. During the past year, have you had any chest illnesses that have kept you off work, indoors at home, or in bed?

1.Yes \_\_\_\_\_ 2. No \_\_\_\_\_

IF YES TO 15A

15B. Did you produce phlegm with any of these chest illnesses?

1.Yes \_\_\_\_\_ 2. No \_\_\_\_\_ 3. Does not apply \_\_\_\_\_

15C. In the past year, how many such illnesses with (increased) phlegm did you have which lasted a week or more?

Number of illnesses \_\_\_\_\_ No such illnesses \_\_\_\_\_

16. RESPIRATORY SYSTEM

in the past year, have you had:

	Yes or No	Further comment on positive answers
Asthma	_____	_____
Bronchitis	_____	_____
Hay Fever	_____	_____
Other Allergies	_____	_____

Pneumonia	_____	_____
Tuberculosis	_____	_____
Chest Surgery	_____	_____
Other Lung Problems	_____	_____
Heart Disease	_____	_____
Do you have:		
Frequent colds	_____	_____
Chronic Cough	_____	_____
Shortness of breath when walking or climbing one flight of stairs	_____	_____
Do you:		
Wheeze	_____	_____
Cough up phlegm	_____	_____
Smoke cigarettes	_____	_____
Packs per day _____	How many years _____	

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## CHAPTER 31. ALCOHOL-FREE AND DRUG-FREE WORKPLACE POLICY

SECTION 31.1. POLICY. The County of Shasta recognizes that the use of drugs or alcohol in the workplace can create health and safety problems for employees and the public they serve. Therefore, it is the County's policy that:

A. Alcohol intoxication or the unlawful manufacture, unlawful distribution, unlawful dispensing, unlawful possession or unlawful use of any controlled substance is prohibited in the workplace, while on duty, on standby for duty or while in uniform.

B. Each County employee will be notified that as a condition of employment the employee is required to:

1. Abide by this policy; and

2. Notify the County of any criminal drug or alcohol statute conviction (including a plea of nolo contendere) for a violation that occurred in the workplace, while on duty or on standby for duty or while in uniform, no later than five days after such conviction.

3. The County will take one or both of the following actions within 30 days of receiving notice of an employee being alcohol- or drug-impaired on the job or of the employee's conviction of an alcohol- or drug-related offense described in Paragraph B.2.:

a. Require the employee to participate in an alcohol or drug abuse rehabilitation program approved by a federal, state, or local health or law enforcement agency;

b. Take appropriate personnel action against the employee consistent with these Personnel Rules and relevant MOU.

4. The focus of this policy is substance abuse prevention through educating employees about the dangers of alcohol and drug abuse, and encouraging rehabilitation of those employees who have such problems. However, this policy does not preclude taking disciplinary action when appropriate. The decision whether to take disciplinary action will be made on a case-by-case basis.

5. The County shall conduct drug/alcohol abuse awareness programs that inform employees about the dangers of drug and alcohol abuse in the workplace, the availability of drug and alcohol counseling and rehabilitation programs, the County's policy of maintaining a drug-free and alcohol-free workplace, and the penalties that may be imposed upon employees for alcohol or drug violations.

6. The County, through its drug/alcohol abuse awareness program and/or Employee Assistance Program (EAP), shall provide referral to substance abuse counseling services or educational services as appropriate.

7. A County employee shall be subject to drug and alcohol testing during working hours upon the appointing authority's or the appointing authority's designee's

determination that there is reasonable suspicion that the employee is currently impaired due to the use of drugs or alcohol. The conditions of and procedures for testing are described in Section 31.2.

8. "Reasonable suspicion" is a belief based on objective facts and reasonable inferences drawn from those facts sufficient to lead a reasonably prudent person to suspect that an employee is under the influence of drugs or alcohol so that the employee's ability to perform the functions of the job is impaired or the employee's ability to perform the job safely is reduced. Any of the following, alone or in combination, may give rise to reasonable suspicion that the employee is currently under the influence of alcohol or a drug and is impaired:

- a. Slurred or excessively rapid speech;
- b. Alcohol odor on breath or clothing;
- c. Unsteady standing, walking or movement;
- d. Pupils dilated or constricted or difficulty focusing eyes;
- e. An accident involving County property or equipment;
- f. A physical altercation;
- g. A verbal altercation; provided, however, such altercation shall not, by itself, be considered a basis for reasonable suspicion;
- h. A pattern of unusual behavior, such as hyperactivity, mood swings, hostility, absentmindedness, lethargy or withdrawal;
- i. Ingestion of alcohol or an illegal drug while on County premises or while on duty;
- j. Possession of alcohol, an open container, illegal drugs or drug paraphernalia;
- k. Substandard work performance, including increased errors or absenteeism, a decrease in quantity or quality of work performed, or deterioration of work relationships; provided, however, that substandard work performance shall not, by itself, be considered a basis for reasonable suspicion;
- l. Information obtained from a reliable person with direct personal knowledge.

9. The County shall abide by the requirements of the Drug-Free Workplace Act of 1988 (PL. 100-690).

10. This policy shall be applied without bias or prejudice.



11. Each County employee will receive a copy of this policy.

## SECTION 31.2. TESTING.

A. Whenever an appointing authority or designee determines that reasonable suspicion, as defined in policy in Section 31.1.B., exists to believe that an employee is currently impaired by a drug or alcohol in violation of the County's Alcohol-Free and Drug-Free Workplace Policy, or any other law, ordinance, resolution or policy, the appointing authority or designee may, with the prior concurrence of the Personnel Director, or his/her designee, and County Counsel or their designees, require the employee to immediately submit to a urine test or, if the designated laboratory can take blood tests, at the employee's option, a blood test. The urine or blood sample will be analyzed at a laboratory with which the County contracts for drug and/or alcohol testing, or if such laboratory is not available, any other reputable laboratory equipped and licensed to provide such services.

1. A urine or blood sample shall be given by the employee at the designated laboratory or a County facility. The blood or urine samples will be split, sealed and labeled in the employee's presence. One of the samples will be screened using the Immuno-assay technique. If a positive finding is made, that sample will be analyzed using LC/MS/MS chromatography. The other sample will be secured by the laboratory so that the employee may obtain an independent analysis if he/she so chooses.

- a. If the initial test result is negative, the laboratory report, test result and test memorandum shall be destroyed unless the employee makes a written request that the material be placed in a confidential file. Laboratory reports, test results, and the test memorandum shall not appear in the employee's regular personnel file unless disciplinary action is imposed; information of this nature will otherwise be contained in a separate confidential medical folder and securely kept under the control of the Personnel Director, or his/her designee. Such information shall not be divulged to any third party or agency without the express written consent of the employee. However, such information may be disclosed to an arbitrator or the Board of Employee Appeals or any other hearing officer in the course of disciplinary proceedings. Reports of test results may be disclosed to Shasta County management strictly on a need-to-know basis.

- b. A copy of the test results and any laboratory report shall be given to the tested employee. The initial test and the County's confirming test shall be conducted at County expense.

2. Within two County business days of receiving a copy of the test results, the employee may submit to the appointing authority or designee a written explanation which may be accompanied by copies of prescriptions, counselor's reports or other documentation concerning the employee's test results.

3. The appointing authority or designee shall arrange for the employee's transportation to and from the laboratory or County facility for the test. The appointing

authority or his/her designee shall also arrange for transporting the employee home after the test should the employee appear incapable of safely or competently completing his/her shift.

4. An employee's refusal to submit to a drug/alcohol test may be considered a willful violation of a reasonable order by a superior officer and may be a ground for disciplinary action.

5. An employee's voluntary inquiries concerning or participation in a drug or alcohol rehabilitation program shall be considered confidential.

B. Whenever reasonably feasible, prior to requiring the employee to submit to testing, the appointing authority or designee shall give the employee the opportunity to be seen by a peace officer trained in the recognition of drug and alcohol abuse to confirm that reasonable suspicion exists. The employee may, at his/her option, waive the right to be seen by the peace officer.

C. As soon as practicable, but no later than the end of the County's next working day, the appointing authority or his/her designee involved in the case shall prepare a memorandum which states the facts which gave rise to reasonable suspicion. The memorandum shall be reviewed and signed by the Personnel Director or his/her designee, and County Counsel or their designees. The memorandum need not be prepared prior to the employee submitting to testing, shall be completed prior to the County considering the results of testing performed under this policy. A copy of the memorandum shall be given to the employee.

D. For purposes of the testing of Sheriff's Office sworn or safety sensitive personnel, refer to the Sheriff's Office Alcohol Free and Drug Free Workplace Policy. For purposes of the testing of any other employee, "designee" shall include only management employees.

### SECTION 31.3. SAMPLE COLLECTION AND TESTING PROCEDURES.

A. Sample collection and drug and alcohol testing shall be conducted in accordance with the provisions of this policy by a reputable contracted provider equipped and licensed to provide such. The collection of samples and testing under this policy shall be conducted by the contractor and comply with the following standards and procedures:

B. Sample Collection.

1. The collection of all test samples shall be done in a medically appropriate manner designed to protect the safety and privacy of the applicant, as well as the integrity and identity of the sample in accordance with SAMHSA (Substance Abuse and Mental Health Services Administration).

2. The collection will be conducted by the vendor at a location to be determined by the vendor. The vendor will assure that the designated collection site has all the necessary personnel, materials, equipment, facilities, and supervision to provide for the collection, security, temporary storage, and shipping or transportation of samples to the testing laboratory.

3. No unauthorized personnel shall be permitted in any part of the designated collection site when samples are collected or stored.

4. The Personnel Director, or his/her designee, or designee shall review and concur in advance with any decision by a collection site person to obtain a urine sample under the direct observation of a same gender collection site person based on a reason to believe that the employee may tamper with the sample to be provided and/or the collection equipment.

C. Testing Procedures.

1. Initial and confirmation drug testing shall be completed in accordance with SAMHSA standards.

2. Substances to be tested and test standards (as currently published by SAMHSA) are as follows:

Initial Test Cutoff Concentration

	(nanograms/milliliter)
Marijuana metabolites	50
Cocaine metabolites	300
Opiate metabolites	2000
Phencyclidine	25
Amphetamines	1000
Ethanol	20

Confirmatory Test Cutoff Concentration

	(nanograms/milliliter)
Marijuana metabolite (1)	15
Cocaine metabolite (2)	150
Opiates:	
Morphine	2000
Codeine	2000
6-Acetylmorphine (4)	10
Phencyclidine	25
Amphetamines:	
Amphetamine	500
Methamphetamine (3)	500
Ethanol	20

Footnotes:

(1) Delta-9-tetrahydrocannabinol-9-carboxylic acid

(2) Benzoyllecgonine

(3) Specimen must also contain amphetamine at a concentration greater than or equal to 200 nanograms/milliliter

(4) Test for 6-AM when morphine concentration exceeds 2000 nanograms/milliliter

If and when SAMHSA standards change, the standards as set forth in this policy will change to coincide with those set forth by SAMHSA.

1. Testing may be conducted for other drugs or controlled substances (e.g. LSD, etc.) when there is reasonable suspicion to believe that an employee has used other substances. Such additional testing must be approved by the Personnel Director, or his/her designee.

2. If the test is positive, the laboratory will notify the MRO (Medical Review Officer - a physician responsible for reviewing positive drug and/or alcohol from testing performed by the laboratory) and the MRO will review applicant's medical history, and review any other relevant biological factors. If there is not a current MRO in place, the Personnel Director, or his/her designee, may seek review from another qualified person or entity.

3. The MRO will review medical information supplied by the applicant when a positive test could have resulted from legally prescribed medication. The MRO will have the discretion to accept evidence in any manner the MRO deems most efficient or necessary. Evidence to justify a positive result may include, but is not limited to, a valid prescription or a verification of a valid prescription from the applicant's physician. The burden is on the employee to provide the MRO with proof of such information.

4. If the MRO determines there is no justification (reference #5 above) for a positive result, such result will then be considered a verified positive result. The contractor will then immediately report the positive result to the Personnel Director or his/her designee, by telephone and follow up with written confirmation.

**Reasonable Suspicion  
Urine Sample Collection Process**

- (1) A department manager will take the employee to medical facility for sample collection. After the sample is collected, the department manager will escort the employee home (or elsewhere as appropriate).
- (2) Medical facility will use the collection kits provided by Public Health and store the sample appropriately until the sample can be transported to the Public Health lab.
- (3) Medical facility will mark the chain of custody form with a red marker and call the Public Health lab to alert them that the sample will be forthcoming.
- (4) Medical facility will call the courier to transport the sample as a special delivery, or include in a regular run of daily pre-employment samples as appropriate.