

INITIAL TEST ENTRY FORM



1 2 3 4
5 6 7 8

TO BE COMPLETED BY EMPLOYEE OR PERSONNEL OFFICE:

Company Name

Last, First Name

Sex M / F Birthdate / /
MM DD YY

Clock Shift

Dept. Job

Language ENG / SPAN / PORTG / VIET

Noise Level Exp. (if known)

TO BE COMPLETED BY EMPLOYEE:

	Yes	No	Have you ever been exposed to any of the following non-occupational noise sources?	Yes	No
Have you had any hearing problems in the last 3 months?	<input type="checkbox"/>	<input type="checkbox"/>	Snowmobiles/Power Boats/		
Hearing Loss of Long Duration ...	<input type="checkbox"/>	<input type="checkbox"/>	Motorcycles?	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss Recurrent.....	<input type="checkbox"/>	<input type="checkbox"/>	Power Tools/Chain Saws?.....	<input type="checkbox"/>	<input type="checkbox"/>
Ear Surgery.....	<input type="checkbox"/>	<input type="checkbox"/>	Farm Machinery?	<input type="checkbox"/>	<input type="checkbox"/>
Ear Injury	<input type="checkbox"/>	<input type="checkbox"/>	Hunting, Trap or Skeet Shooting?.....	<input type="checkbox"/>	<input type="checkbox"/>
Draining Ears or Ear Infections ...	<input type="checkbox"/>	<input type="checkbox"/>	Exposure to loud music?.....	<input type="checkbox"/>	<input type="checkbox"/>
Ear Malformation.....	<input type="checkbox"/>	<input type="checkbox"/>	Flying?	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Aid.....	<input type="checkbox"/>	<input type="checkbox"/>	Military Service?	<input type="checkbox"/>	<input type="checkbox"/>
Mumps.....	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever seen a doctor about an ear or hearing problem?	<input type="checkbox"/>	<input type="checkbox"/>
Measles.....	<input type="checkbox"/>	<input type="checkbox"/>	Were you ever exposed to loud noise in previous jobs?	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Have you worked in noise today?	<input type="checkbox"/>	<input type="checkbox"/>
Head Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Have you worn hearing protection today? .	<input type="checkbox"/>	<input type="checkbox"/>
With Unconsciousness.....	<input type="checkbox"/>	<input type="checkbox"/>	__ none __ plugs __ muffs __ both		
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a headcold today?	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Ringing Ears	<input type="checkbox"/>	<input type="checkbox"/>
Do You Work With Chemicals	<input type="checkbox"/>	<input type="checkbox"/>			

TO BE COMPLETED BY TECHNICIAN:

NONE / P / M / BOTH Y / N

Protection 14 hr. quiet

I do hereby state that the facts in the above form are true to the best of my knowledge and information.

Signature of Employee _____ Date ____/____/____
June 2010

INITIAL TEST ENTRY FORM



1 2 3 4
5 6 7 8

TO BE COMPLETED BY EMPLOYEE OR PERSONNEL OFFICE:

Company Name

Last, First Name

Sex M / F Birthdate / /
MM DD YY

Clock Shift

Dept. Job

Language ENG / SPAN / PORTG / VIET

Noise Level Exp. (if known)

TO BE COMPLETED BY EMPLOYEE:

	Yes	No	Have you ever been exposed to any of the following non-occupational noise sources?	Yes	No
Have you had any hearing problems in the last 3 months?	<input type="checkbox"/>	<input type="checkbox"/>	Snowmobiles/Power Boats/		
Hearing Loss of Long Duration ...	<input type="checkbox"/>	<input type="checkbox"/>	Motorcycles?	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss Recurrent.....	<input type="checkbox"/>	<input type="checkbox"/>	Power Tools/Chain Saws?.....	<input type="checkbox"/>	<input type="checkbox"/>
Ear Surgery.....	<input type="checkbox"/>	<input type="checkbox"/>	Farm Machinery?	<input type="checkbox"/>	<input type="checkbox"/>
Ear Injury	<input type="checkbox"/>	<input type="checkbox"/>	Hunting, Trap or Skeet Shooting?.....	<input type="checkbox"/>	<input type="checkbox"/>
Draining Ears or Ear Infections ...	<input type="checkbox"/>	<input type="checkbox"/>	Exposure to loud music?.....	<input type="checkbox"/>	<input type="checkbox"/>
Ear Malformation.....	<input type="checkbox"/>	<input type="checkbox"/>	Flying?	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Aid.....	<input type="checkbox"/>	<input type="checkbox"/>	Military Service?	<input type="checkbox"/>	<input type="checkbox"/>
Mumps.....	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever seen a doctor about an ear or hearing problem?	<input type="checkbox"/>	<input type="checkbox"/>
Measles.....	<input type="checkbox"/>	<input type="checkbox"/>	Were you ever exposed to loud noise in previous jobs?	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Have you worked in noise today?	<input type="checkbox"/>	<input type="checkbox"/>
Head Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Have you worn hearing protection today? .	<input type="checkbox"/>	<input type="checkbox"/>
With Unconsciousness.....	<input type="checkbox"/>	<input type="checkbox"/>	__ none __ plugs __ muffs __ both		
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a headcold today?	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Ringing Ears	<input type="checkbox"/>	<input type="checkbox"/>
Do You Work With Chemicals	<input type="checkbox"/>	<input type="checkbox"/>			

TO BE COMPLETED BY TECHNICIAN:

NONE / P / M / BOTH Y / N

Protection 14 hr. quiet

I do hereby state that the facts in the above form are true to the best of my knowledge and information.

Signature of Employee _____ Date ____/____/____
June 2010