TULSA PARKS

Drug Testing Procedure

Carey Goldman (with H.R.) will contact you to schedule your appointment for your drug test.

City Medical is located at 1638 South Main Street, Tulsa, OK. 74119

City Medical is the only site where the test can be taken.

- City Medical hours:
  - Monday - Thursday 7 a.m. to 11 a.m. & 1 p.m. to 4 p.m.
    Arrive no later than 10:30 a.m. or 3 p.m.
  - Friday 7 a.m. to Noon
    Arrive no later than 11 a.m.

If you arrive later than what is noted, you may be asked to return at a later date.

Bring with you:

- Picture ID
- Completed Medical Paperwork Packet

Employment will not begin until notification has been received that you are “ok” to hire, this usually takes about three days.

Staff can be called to submit to an additional drug test when there is reasonable suspicion.

Complete attached paperwork before going to City Medical for your drug test.

RECEIPT VERIFICATION
TO BE RETAINED IN PERSONNEL FILE

The undersigned, an applicant for hiring by the City of Tulsa, hereby acknowledged that they have received a copy of an have read this copy of the City of Tulsa's **Drug Testing Policy**. This Policy 109 in the City of Tulsa's Safety and Health Manual.

_____ _____
SIGNATURE DATE

_____
NAME (PRINT)

_____
DEPARTMENT

PRE-PLACEMENT QUESTIONAIRE

(It is your responsibility as a new employee to read and understand the following questions - please do not hesitate to ask questions for clarification)

1. Are you currently under the care of a health professional?

   Yes____ No____

2. Are you currently receiving disability payments from any source?

   Yes____ No____

3. Are you currently involved in litigation regarding personal injury or physical impairment?

   Yes____ No____

4. Have you received medical treatment for repetitive-motion injury (carpal tunnel, tendonitis, etc.)?

   Yes____ No____

5. Have you ever been determined to have **Permanent Impairment or Permanent Disability (PPD or PTD)** resulting from a job-related injury or illness? (i.e. received Monetary compensation or a settlement following a workers' compensation injury). Answering "Yes" **does not** automatically disqualify you for the job in which you were hired to do.

   Yes____ No____

   If you answered yes, please list the nature and approximate date of each injury/illness below:

   _____
   _____
   _____
   _____

I hereby declare that the answers to the above questions are, to the best of my knowledge, accurate, true and complete. I hereby authorize the City of Tulsa to obtain from my former employers and from public records all data needed to support these answers. I understand that false or misleading information provided by me in the application process with the City of Tulsa may result in denial or termination of employment.

_____ _____
Signature Date

_____ _____
Print Name SSN

Name: _____
First Middle Last

Home Address:_____

_____

Phone Number:_____ DOB:_____

SSN:_____ Race: _____

Emergency Contact: _____

Relationship to Emergency Contact: _____

Emergency Contact Phone Number: _____

Date:_____ **Chart #**_____

_____

NAME **SSN**

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING

NAME OF PERSONAL PHYSICIAN:_____

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____

DATE:_____

PERSONAL INFORMATION

Confidential Record: In formation contained here will not be released except when you have authorized us to do so.

Last Name First Middle Birth Date Social Security #

_____

Address City State Zip Home Phone Business Phone

_____

Occupation Company Name Sex Age Marital Status

M F S M D W

Person to Notify in Case of Emergency_____Relationship_____

Address_____Phone Number_____

Date of Last Physical Examination_____Doctor_____

Personal Physician_____Address_____

City of Tulsa Medical Division Health History and Medication Record

Today's Date:	Job Title:	
Name:	SS#:	BD:
Address:	Race:	Phone:
City, St, Zip		Cell:

Describe your Military Service:

__ Served in U.S. Military __ Served in Other Military __ Was in Combat (as civilian or Military) __ No Military Service

Indicate if you are allergic to:

__ No Allergies __ Dusts
__ Fumes __ Pollens or grasses __ Immunization shots __ Eggs or Feathers
__ Other Foods __ Penicillin __ Sulfa Drugs __ Any Other

Food or Drug Allergies:			

Are you currently or in the past taking any of the following prescription medications? N = now P = past

__ Tranquilizers __ Blood Pressure Medicine __ Diabetes Medicine __ Thyroid
__ Diet pills __ Blood Thinners __ Digitalis/heart medicine __ Diuretic
__ Estrogen/female hormone __ Male hormones __ Cortisone related drugs __ Birth control pills
__ Antihistamines __ Nitroglycerin/coronary __ Sedative/sleeping pills __ Gout medication
__ Cholesterol medication

Currently taking:			

Are you currently or in the past taking any of the following non-prescription medications?

__ Aspirin	__ Antacid	__ Laxatives	__ Antihistamines
__ Sedatives	__ Cold tablets	__ Headache remedies	
Currently taking:			

Which statement describes your sleep habits?

__ Sleep is adequate __ Sleep soundly all night __ Recent change/sleep habit __ Have trouble sleeping
__ Waken early and can't get back to sleep
Usual nights sleep: __ 3-5 hours __ 5-7 hours __ 7-9 hours
__ over 9 hours

Please describe your exercise:

Summer: __ Irregular or none __ Light __ Moderated
__ Heavy, irregular __ Heavy, regular
Winter: __ Irregular or none __ Light __ Moderated
__ Heavy, irregular __ Heavy, regular
While exercising do you have:
__ Dizziness __ Shortness of breath __ Chest Pain __ Leg Cramps

How much of the following do you drink each day?

Cofee - cups
__ None __ 1-4 __ 5-10 __ Over 10
Tea - cups
__ None __ 1-4 __ 5-10 __ Over 10
Soft Drinks
__ None __ 1-4 __ 5-10 __ Over 10
__ Mainly Drink Diet Soft Drink __ Mainly Drink Decaffeinated Coffee

City of Tulsa Medical Division Health History and Medication Record		
Today's Date:	Job Title:	
Name:	SS#:	BD:
Address:	Race:	Phone:
City, St, Zip		Cell:

Indicate which statement describes your use of alcohol:

__ Never have drunk __ Used to drink but stopped __ Drink occasionally __At least one drink each day

How much do / did you drink during an average week (drinks of liquor, bottles of beer, glasses of wine)

__ Less than 7 __ 7-14 __ 15-25 __ 26-35
__ Over 35

And how long (years)?

__ Less than 1 __ 1-4 __ 5-10 __ 11-20
__ Over 20

Describe your weight or weight change:

__ Proper weight __ Overweight __ Underweight __ Gained weight recently
__ Lost weight recently

Describe your eating habits or diet:

__ Not on a diet __ On a high calorie diet __ On a low calorie diet __ On a low sugar diet
__ On a low cholesterol diet __ On a low sugar diet __ on a low salt diet __ On a diet for ulcers

Indicate which statement describes your use of tobacco:

__ Have never smoked __ Smoke cigarettes __ Stopped smoking cigarettes __ Smoke a pipe or cigar

If you have ever smoked cigarettes indicate packs per day

__ Less than ½ __ ½ to 1 __ 1-2 __ Over 2
How many years __ Less than 1 __ 1 to 5 __ 11 to 15
__ Over 12

Please indicate if you or your spouse have ever experienced any of the following:

__ Miscarriages __ Spontaneous Abortions __ Still births __ Premature births
__ Difficulty becoming pregnant __ Fetal deformities __ Multiple births

Have you or your spouse ever had any sterility tests performed? __ yes __ no

Have any of your children experienced any of the following? __ Sudden infant death __ Physical defect
__ Mental defect __ emotional defect __ Childhood cancer

Indicate if you have had any major or serious accident or injury such as:

__ Amputation __ Concussion __ Penetrating wounds __ Thermal burn
__ Crushing injury __ Fracture __ Laceration __ Chemical burn
__ Other:

Have been made ill by, injured by, or frequently exposed to:

Organic Dusts: __ Grain __ Fungus __ Wool or cotton

Inorganic Dusts: __ Asbestos __ Clay __ Cement
__ Rock __ Sand __ Coal

Gases __ Carbon Monoxide __ Hydrogen Sulfide __ Phosgene
__ Ammonia __ Acetylene __ Hydrogen Floride __ Sulfur Dioxide
__ Chlorine __ LPG __ Vinyl Chloride __

City of Tulsa Medical Division Health History and Medication Record

Today's Date:	Job Title:	
Name:	SS#:	BD:
Address:	Race:	Phone:
City, St, Zip		Cell:

Vapors:	__ Gasoline/Petroleum Distilla	__ Tetraethyl Lead	__ Benzene
__ Methyl Ethyl Ketone	__ Carbon Disulphide	__ Carbon Tetrachloride	__ Toluene
__ Mercury	__ Degreasing Solvents	__ Ethyl Mercaptan	__ Methyl Alcohol
__ Phenol or cresol	__ Toluene Di-isocyanate (TDI)	__ Furfural	
Mists:	__	__	__
Fumes:	__	__	__
Heat, perspire heavily on job	__	__	__
Noise:	__	__	__

Radiation exposure injury or treatment:

__ Radiation treatment injury	__ Industrial radiation injury	__ Internal radiation treatment	__ External radiation treatment (X-ray, colbalt, etc)

__ Have you ever been an x-ray isotope technician? __ Did you work with radar waves or microwaves?

Radiation Exposure occurred (years ago)?

__ Less than 5	__ 6 to 10	__ 11 to 25	__ Over 25

Indicate which statement(s) describe your use of a respirator on your job:

__ Am required to wear a respirator in my present job.
__ Have been required to wear a respirator in prior jobs.

If you are required to wear a respirator in your present job, please indicate how often:

__ 30 or fewer days per year
__ Over 30 days per year

MEDICAL HISTORY:

Eye / Ear / Nose / Throat:

__ Failing Vision	__ Eye infections - frequent	__ Glaucoma	__ Cataracts
__ Double Vision	__ Severe decrease in vision		
__ Ringing/buzzing in ear	__ Ear infections - frequent	__ Hearing loss: R or L	__ Pain in ears
__ Dizziness/fainting	__ Sinus trouble	__ Nose bleeds	__ Hayfever/seasonal allergies
__ Swollen glands	__ Sore throat	__	__

Neurology:

__ Headaches-frequent	__ Convulsions/seizures	__ Tremor/hands shaking	__ Muscle weakness
__ Numbness/tingling sensation	__ Mental/emotional disease	__ Definite change in Mood or personality	
__ Weakness in 1 arm or hand	__ Weakness in 1 arm & 1 leg	__ Weakness in both legs	__ Trouble remembering

Pulmonary:

__ Pneumonia	__ Bronchitis/chronic cough	__ Asthma/wheezing	__ Frequent colds
__ Short of breath at rest	__ Short of breath with exertion	__ Short of breath & chest pain	
__ More comfortable propped up in bed		__ Short of breath - wakes me up at night	

City of Tulsa Medical Division Health History and Medication Record

Today's Date:	Job Title:	
Name:	SS#:	BD:
Address:	Race:	Phone:
City, St, Zip		Cell:

Cardiovascular:

__ Chest Pain __ Chest pain at rest __ Chest pain with exertion __ Chest pain relieved by rest
__ Chest pain relieved by sit __ Swollen ankles __ Leg pain - walking __ Varicose veins/phlebitis
__ High blood pressure __ Heart murmur __ Heart attack __ Heart failure
__ Irregular heart rhythm __ Poor circulation in legs __ Stroke

Blood system:

__ Easily bruisability __ Anemia __ Other inherited blood disorders
__ Other blood disease

Gastrointestinal:

__ Loss of appetite __ Difficulty swallowing __ indigestion/heartburn __ Peptic ulcer
__ Persistent nausea __ Vomitting __ Diarrhea __ Constipation
__ Gall bladder trouble __ Abdominal pain chronic __ Jaundice __ Hepatitis
__ Cirrhosis __ Doarrjea __ Constipation __ Change in bowel habits
__ Change in size or shape of bowel movement __ Diverticulosis __ Crohn's
__ Colitis __ Bloody or tarry stools __ Hemorrhoids __ Hernia
__ Hernia, rupture __ Lactose intolerance

Musculoskeletal:

__ Arthritis __ Rheumatism __ Osteoporosis __ Gout
__ Foot pain __ Cold/numb feet __ Back pain/recurrent __ Bone fracture/joint injury
__ Cartilage degeneration __ Herniated disk disease __ Pain in upper back __ Pain in lower back

Integumentary:

__ Rashes/hives __ Bruise easily __ Psoriasis/eczema __ Hair loss

Endocrine:

__ High blood sugar __ High blood uric acid __ High blood cholesterol or blood fats

Genitourinary:

__ Frequent urination __ Loss of bladder control __ Painful urination __ Kidney stones
__ Decrease in flow __ Overnight - more than twice __ Urethral discharge __ Blood in urine
__ Veneral disease __ Menstrual dysfunction __ Sexual dysfunction __ Prostate disease
__ Sore on genitals __ Pain, swelling in testicles
Females: pregnant? __ Yes __ No
Planning pregnancy? __ Yes __ No
_____ Number of pregnancies _____ Live Births _____ Abortions _____ Miscarriages

Mental Health:

__ Phobias __ Nervousness/anxiety __ Depression __ Memory Loss
__ Measles __ Frequent infections __ Tuberculosis __ Cancer

City of Tulsa Medical Division Health History and Medication Record

Today's Date:	Job Title:	
Name:	SS#:	BD:
Address:	Race:	Phone:
City, St, Zip		Cell:

Family History	**Father**	**Mother**	**Children**	**Siblings**	**Father's Parents**	**Mother's Parents**
Alcoholism	_____	_____	_____	_____	_____	_____
Asthma	_____	_____	_____	_____	_____	_____
Bleeding disorder	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____
Epilepsy/convulsions	_____	_____	_____	_____	_____	_____
Hair loss	_____	_____	_____	_____	_____	_____
Heart disease	_____	_____	_____	_____	_____	_____
Mental illness	_____	_____	_____	_____	_____	_____
Migraine	_____	_____	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Thyroid disease	_____	_____	_____	_____	_____	_____
Other diseases:						

Are there any health / medical concerns that you wish to discuss with the physician?

_____

_____

_____

_____

_____

Emergency contact:_____

Relationship to emergency contact:_____

Emergency contact phone number:_____

Signature:_____

HEARING HISTORY

TUL-4419-A

NAME	SOCIAL SECURITY NO.	DATE	DOB	AGE	SEX

DEPARTMENT	JOB TITLE	YEARS OF SERVICE

QUESTION	YES	NO
Do you work in a noisy environment?		
Do you wear any kind of hearing protection at work?		
Do you wear any kind of hearing protection at home?		
Are hearing protectors available in your work area?		
Have you within the last 24 hours: Been exposed to loud noise without ear protection?		
Had a cold, flu, or sinus condition?		
Taken medication or antibiotics?		

INSTRUCTIONS:

1. Check the box in A, B, C, or D if any item applies to you.
2. Check the box in A if a member of your family has a hearing loss

A.	HEARING LOSS IN FAMILY	B.	DISEASES OR INFECTIONS	C.	EAR PROBLEMS AND SYMPTOMS	D.	INJURY TO HEAD OR EAR
	Mother before age 50		Measles		Medical care for ears		Severe blow to head
	Father before age 50		Mumps		Draining ears		Knocked out
	Aunts before age 50		Kidney disease		Earaches or infection		Skull fracture
	Uncles before age 50		Scarlet fever		Ear surgery		Other head injury
	Sisters before age 50		Diabetes		Hearing aid		Eardrum puncture
	Brothers before age 50		High fever as a baby		Excess ear wax		Explosion or blast
	Daughters		Allergies		Ringing in ears		Auto accident
	Sons		Meningitis		Face feels numb		Flying or skydiving
	Yourself		High blood pressure		Dizziness		Diving accident

	NO. OF YEARS
How many years did you serve in the military?	
How many years did you use artillery or fly in the military?	
How many years have you gone hunting or shooting?	
How many years have you flown an airplane?	
How many years have you listened to loud music regularly?	
How many years have used home power tools regularly?	
How many years have used home tractors or lawn mowers?	
How many years have used power boats or motorcycles?	
Have you previously worked in a noisy environment? How many year?	

NAME OF COMPANY	LAST HEARING TEST

To the best of my knowledge the above answers are correct.	SIGNATURE	DATE

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

TUL-4420-B

NAME: _____ SOC. SEC. NO: _____ _____ _____

DEPT: _____ SECTION: _____

YOUR JOB TITLE: _____

HOME PHONE #: (____) _____ Best time to phone you at this number is _____.

WORK PHONE #: (____) _____ Best time to phone you at this number is _____.

NAME OF SUPERVISOR: _____ DATE: _____

The law requires that every employee who has been selected to use any type of respirator must provide the following information.

Your age _____ Sex (circle one) Male Female Your height _____ feet _____ inches Your weight _____ lbs.

Check the type of respirator you will use (you can check more than one category):

a. ____ Filter mask, non-cartridge type only disposable respirator "N" (not oil resistant) "R" (resistant to oil) "P" (oil proof)

b. ____ Other type (half-face, full-face, powered-air purifying, supplied-air, self-contained breathing apparatus)

Have you worn a respirator (circle one) Yes No If "yes", what type(s): _____

Please circle "yes" or "no" for the following:

Do you currently smoke tobacco, or have you smoked tobacco in the last month? YES NO

Have you ever had any of the following conditions? Seizures YES NO Diabetes (sugar disease) YES NO

Allergic reactions that interfere with your breathing YES NO Claustrophobia (fear of closed in places) YES NO

Trouble smelling odors YES NO

Have you ever had any of the following pulmonary or lung problems? Asbestosis YES NO Asthma YES NO

Chronic bronchitis YES NO Emphysema YES NO Pneumonia YES NO

Tuberculosis YES NO Silicosis YES NO Pneumothorax (collapsed lung) YES NO

Lung cancer YES NO Broken ribs YES NO Any chest injuries or surgeries YES NO

Any other lung problem that you have been told about YES NO

Do you currently have any of the following symptoms of pulmonary or lung illness? Shortness of breath YES NO

Shortness of breath when walking fast on level ground or walking up a slight hill or incline YES NO

Shortness of breath when walking with other people at an ordinary pace on level ground YES NO

Have to stop for breath when walking at your own pace on level ground YES NO

Shortness of breath that interferes when washing or dressing yourself YES NO

Shortness of breath that interferes with your job YES NO Coughing that produces phlegm (thick sputum) YES NO

Coughing that wakes you early in the morning YES NO Coughing up blood in the last month YES NO

Coughing that occurs mostly when you are lying down YES NO Wheezing YES NO

Wheezing that interferes with your job YES NO Chest pain when you breathe deeply YES NO

Any other symptoms that you think may be related to lung problems YES NO

NAME: _____ SSN: _____ DATE: _____

Have you ever had any of the following cardiovascular or heart problems? Heart attack YES NO

Stroke YES NO Angina YES NO Heart failure YES NO High blood pressure YES NO

Swelling in your legs or feet (not caused by walking) YES NO Heart arrhythmia (heart beating irregularly) YES NO

Any other heart problem that you have been told about YES NO

Have you ever had any of the following cardiovascular or heart symptoms?

Frequent pain or tightness in your chest YES NO Pain or tightness in your chest during physical activity YES NO

Pain or tightness in your chest that interferes with your job YES NO

In the past two years have you noticed your heart skipping or missing a beat YES NO

Heartburn or indigestion that is not related to eating YES NO

Any other symptoms that you think may be related to heart circulation problems YES NO

Do you currently take medication for any of the following problems? Breathing or lung problems YES NO

Heart trouble YES NO Blood Pressure YES NO Seizures YES NO

If you have used a respirator, have you ever had any of the following problems? (If you have never used a respirator, check following space and go to the next question.) _____

Eye irritation YES NO Skin allergies or rashes YES NO Anxiety YES NO

General weakness or fatigue YES NO Any other problem that interferes with your use of a respirator YES NO

Would you like to talk to the City Medical health care professional who will review this questionnaire about your answers to this questionnaire? YES NO

The next six (6) questions 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.

Have you ever lost vision in either eye (temporarily or permanently) YES NO

Do you currently have any of the following vision problems? Wear contact lenses YES NO

Wear glasses YES NO Color blind YES NO Any other eye or vision problems YES NO

Have you ever had an injury to your ears, including a broken ear drum? YES NO

Do you currently have any of the following hearing problems? Difficulty hearing YES NO

Wearing a hearing aid YES NO Any other hearing or ear problems YES NO

Have you ever had a back injury? YES NO

Do you currently have any of the following musculoskeletal problems?

Weakness in any of your arms, hands, legs, or feet YES NO Back pain YES NO

Difficulty fully moving your arms and legs YES NO

Pain or stiffness when you lean forward or backward at the waist YES NO

Difficulty fully moving head up or down YES NO Difficulty fully moving your head side to side YES NO

Difficulty bending at your knees YES NO Difficulty squatting to the ground YES NO

Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs YES NO

Any other muscle or skeletal problem that interferes with using a respirator YES NO