Morenci Safe Production Standard	Standard # 5.2	
	OHSAS 18001:2007	4.4.6
Occupational Health Program	Revision #	02
	Revision Date	06/28/2013
	Effective Date	11/01/2010
	Document Owner	Industrial Hygiene

Review:	Approvals:
Manager/Health and Safety: 10/01/2012	*GM/Administration: 10/01/2012*

1.0 PURPOSE:

1.1 The purpose of this program is the prevention and early detection of occupational diseases and facilitate the placement of workers according to their physical, mental and emotional capabilities in work which they perform with an acceptable degree of efficiency and without endangering their own safety of that of others. Provide prompt medical care for all work-related illnesses and manage the medical care to expedite the employee's return to work. It will also establish a baseline to which further evaluations can be compared to and to assess the physical condition of workers on an annual basis or as often as regulatory requirements or internal policy dictates.

1.2 For employees covered by specific physical qualification standards, this protocol is designed and implemented to ensure that an employee:

- Meets any job-related medical requirements, including the physical demands (strength, mobility and flexibility analyses) of a specified job.
- In conjunction with Health & Safety training, can properly perform the essential functions of a job without any direct threat to self or others.
- Complies with any regulatory agency or company-mandated requirements in order to prevent and monitor adverse health effects of exposure to workplace physical, chemical or biological hazards.
- Receives prompt information about any impact of workplace hazards on his/her present health status

2.0 SCOPE:

2.1 This program applies to Freeport McMoRan Copper & Gold Morenci Operations employees and contractors. The Occupational Health Program and the employees enrolled in them are based on the exposure(s) identified through the Industrial Hygiene Department and the physical demands analysis provided by the Human Resources Department for each job position.

3.0 TERMS, DEFINITIONS AND ABBREVIATIONS

Exposed Worker is any worker that is exposed to physical, chemical, biological or ergonomic agents during their normal workday.

Occupational Disease is the name given to a permanent or temporary pathological state that a worker acquires as a result of workplace exposure to physical, chemical, biological or ergonomic agents.

FMMO: Freeport McMoRan Copper & Gold Morenci Operations

CFR: Code of Federal Regulations

MSHA: Mining Safety & Health Administration

OSHA: Occupational Safety & Health Administration

RME: Report of Medical Evaluation

ADA: Americans with Disabilities Act

4.0 RESPONSIBILITIES:

4.1 Manager of Safety and Health

- Provide the resources required to adequately manage the program;
- Verify the implementation of activities under the Occupational Health Program;
- Assess the results in conjunction with the Industrial Hygiene Department and conduct periodic reviews of all staff exposed to any pollutants;
- Review and update this program due to operational developments or changes in legislation;
- Maintain updated records of results as it pertains to legal requirements;
- Coordinate with Managers, Human Resources and Legal to submit any evidence of occupational disease.

4.2 Supervisors and Managers

- Schedule employee for testing in conjunction with the Human Resources or Industrial Hygiene department, see Appendix J for the divisional testing dates and Appendix K Occupational Health Testing Requirements Matrix;
- Utilize the web based calendar on the Safety and Health Share Point to schedule employees;
- Provide employees with the necessary resources needed to attend the appointments;
- Ensure follow up appointments are attendedIdentify hazardous materials in their work areas.

4.3 Industrial Hygiene

- Maintain updated records of results as it pertains to legal requirements;
- Assist in the identification of employees to be offered medical evaluations based on exposure monitoring and risk assessment;

- Act as a liaison between the company and the Occupational Provider to ensure that the examinations performed by the health care professional are focused on the relevant workplace risks and to ensure the appropriate controls are implemented to address work related illnesses;
- Act as a resource for assisting the various Divisions to successfully manage the Occupational Health Program.

4.4 Manager of Human Resources

- Provide the provisions of the law regarding the physical demands for each occupation in conjunction with the Industrial Hygiene Department;
- Ensure that the occupational medical examination is carried out whether new employee or internal transfer;
- Provide the occupational health testing facility with the necessary employment information necessary to carry out the requirements of the Occupational Health Protocol;
- Ensure that results of medical examinations are considered prior to employee beginning work.
- Provide the requirements for the periodical medical exam of employees in conjunction with the Industrial Hygiene Department based on the risk assessment and physical demands of the job position;
- Contact Industrial Hygiene and the Occupational Health Clinic when an approved requisition has been received for a new position within a department so a physical demand / job capability study can be conducted;
- Maintain updated records of results as it pertains to legal requirements;
- Manage the care, rehabilitation, and return to work for Occupational disease.

4.5 Gila Health Resources Occupational Medicine

- Shall ensure compliance with the FMMO Occupational Health Program and following of procedures and protocol and inform Industrial Hygiene of any deficiencies or errors;
- Discuss special cases of health with the appropriate management, Occupational Health and Safety and Human Resources personnel;
- Keep prevalence statistic of occupational diseases or illnesses;
- Maintain and keep prevalence statistics of occupational illnesses or diseases;
- Maintain records of all examinations for all employees rendered service;
- Provide OH&S and HR personnel with necessary information to maintain legal requirements of the program.

5.0 STANDARDS OF PERFORMANCE

5.1 Medical Examinations

Occupational Health Programs are designed to identify individuals who are or could be affected by exposures in the workplace, to prevent further exposure, and to provide medical treatment is necessary. The program is a multidisciplinary approach. It requires physicians, nurses, industrial hygienist, human resources and property wide management to implement this program. For Freeport McMoRan Morenci Operations, there are three categories of occupational medical examinations: Initial (pre-placement), Interval (periodic), and Exit. The following testing will be performed by an approved facility. Pre-placement evaluations may be performed at different approved locations.

5.1.1 Initial (Pre-Placement)

Includes post-offer, pre-placement for new employees, as well as those employees who transfer to a job with significantly different job duties or potential workplace exposures from previous job duties or workplace exposures. The pre-placement medical examinations evaluates whether the employee:

- Is capable of performing the essential job functions with or without reasonable accommodation.
- Has a health condition that poses a direct threat to the safety of that individual or others.
- Meet the medical surveillance testing requirements of regulatory agencies.

5.1.2 Interval (Periodic)

This examination may be performed to meet a regulatory agency or company-mandated testing requirement. It can also be used to reassess whether an employee has a medical condition that may result from workplace activities and exposures, or impact his/her ability to perform the essential job functions of a current job.

5.1.3 Exit

Conducted after termination of specific job titles.

5.2 Physical Demands Analysis Testing and Maneuvers

1.	**Head Turn A/P & Lat**	Chin up, down and over each shoulder
2.	**Overhead Lift (15 pounds)**	Lift to elbows fully extended
3.	**90° Deep Knee Bends**	Squat to 90° at knee

4.	**Hand/Wrist Movement w/grip**	Finger separation; flex hand 90° at wrist; grip strength
5.	**Walk/Climb Steps (4)**	Climb steps without assistance

5.3 Summary of Regulatory Agency Medical Examination Requirements

Table 1: OSHA Respiratory protection: 29 CFR 1910.134(e)

Initial exam	Medical examination to include Respirator Health Questionnaire (appendix D) Follow-up evaluation if "yes" response to any question 1-8 in Section 2, Part A of questionnaire Licensed health-care professional (LHCP) determines what medical tests, consultations and procedures are needed for evaluation Respirator training and quiz Physical examination and pulmonary function tests
Interval exam	Prior to annual fit testing: Respirator health questionnaire review by employee Employee completes new respirator health questionnaire every 5 years Routine spirometry every 2 years Respirator training and quiz Additional testing to be determined by the health-care provider based on questionnaire responses Required if any of the following occur: • Employee reports signs or symptoms related to ability to wear respirator • Re-evaluation requested by LHCP or supervisor or respirator program administrator • Program evaluation or observations during fit testing suggest the need • Change in workplace conditions results in substantial physiological burden
Exit exam	None required

Table 2: OSHA Occupationnel Noise Expo sure 29 CFR 1910.95 (g)

Initial exam	Include employees with noise exposure (8hr TWA) >=85 dB Audiometric history questionnaire (appendix E) Baseline audiogram (valid baseline within 6 months of first exposure)
Interval exam	At least annually while noise exposure (8hr TWA) >=85dB Audiometric history questionnaire (appendix E) Audiogram Retest within 30 days for Significant Threshold Shift (STS) with audiologist, ENT or MD review of retest
Exit exam	No requirement

Table 3: OSHA National Emphasis Program–Crystalline Silica 29 CPL 03-00-007

Initial exam	Medical examination if exposure >=50% of PEL including: Occupational and medical history to include Silica Questionnaire (appendix F) Physical examination emphasizing respiratory system PA chest X-ray with B reading Screening spirometry (PFT)

Interval exam	Occupational and medical history to include Silica Questionnaire (appendix F) Physical examination emphasizing respiratory system PA chest X-ray with B reading Frequency of exam depends on duration of crystalline silica exposure: • Exposure <15 years → every 3 years • Exposure 15 to 19 years → every 2 years • Exposure >=20 years → every year
Exit exam	PA chest X-ray with B reading

Table 4: US DOT FMCSA Driver Examination 49 CFR 391.41

Initial exam (prior to driving)	See Form 649-F (6045) which outlines content and test requirements for: Health history with medical examiner comments Vision, hearing testing, blood pressure/pulse rate, urinalysis Physical demands analysis Physical examination
Interval exam	Every 2 years, unless qualified for only 3, 6 or 12 months See Form 649-F (6045) which outlines content and test requirements for: Health history with medical examiner comments Vision, hearing testing, blood pressure/pulse rate, urinalysis Physical examination Physical demands analysis
Exit exam	None

Table 5: Crane Operator (National Commission for the Certification of Crane Operators)

Pre-placement	Medical and occupational history Vision screen, including color vision and peripheral vision Audiometric testing, urinalysis, electrocardiogram Physical examination
Interval	Exam every 2 years unless qualified for shorter duration based on previous examination finding Medical and occupational history Vision screen, including color vision and peripheral vision Audiometric testing, urinalysis, electrocardiogram Physical examination
Exit	None

Table 6: Lead 29 CFR 1910.1025

Pre-placement	Employee who are or may be exposed above the Action Level for 30 days/year Medical and occupational history Physical examination Blood lead (PbB) and zinc protoporphyrin (ZPP) Complete blood count, serum urea nitrogen, serum creatinine, routine urinalysis with microscopic examination
Interval	PbB and ZPP annually if last PbB <40 ug/dL PbB and ZPP every 6 months, if last PbB >40 ug/dL PbB and ZPP every 2 months if last PbB between 40 ug/dL and removal level If employee removed from exposure, PbB and ZPP every month
Exit	None

Table 7: Asbestos 29 CFR 1910.1001

Pre-placement	Medical and occupational history OSHA asbestos health questionnaire (appendix G) Physical examination Spirometry PA chest X-ray with B-reading
Interval	Medical and occupational history Abbreviated OSHA questionnaire (appendix H) Physical examination Spirometry PA chest X-ray with B-reading – frequency based on years since first exposure to asbestos and age of employee
Exit	Required if more than 1 year since last exam

Table 8 Other Physical, Chemical and Biological Health Surveillance Requirements

Agent	Regulatory Reference	Medical Assessment Criteria	Frequency
Blood Borne Pathogens	OSHA 29 CFR 1910.130	Employees reasonably anticipated to be exposed to Hep A or Hep B	Vaccinations

Radiation	OSHA 29 CFR 1910.97 1910.1096	All employees involved in the inspection or maintenance of radiation sources	Quarterly review of levels using dose badges
Chemical agents, particulates, gases, organic vapors, mists and fumes.	Various OSHA MSHA standards	Any employee who has exposure to and whose concentrations is equal to or more than one half of the permissible exposure limit for the work day will be incorporated into the program	Based upon Exposure.

5.4 Respirator Fit Testing

Respirator fit tests will be conducted annually to ensure the respirator fits in such a manner that does not permit leakage around the seal of the face piece and in accordance with OSHA 29 CFR 1910.134. All employees who are required to wear a respirator due to exposure will be included in the Respiratory Protection Program. Employees who voluntarily wear a respirator are not mandated to be included in the program.

5.5 Return to Work

Employees who are off of work due to an occupational illness will report to the Human Resource Department. Human Resources will direct the employee through the rehabilitation and care process as well as evaluate the RME.

RME with release with no restrictions - Employee needs to obtain an RME from the Occupational Health Provider and report to the Human Resources Office for clearance to return to work. RME with release to restricted duty

RME with release to restricted duty - Once an employee obtains an RME from the Occupational Health Provider which indicates they can return to work with some sort of restriction, employee will need to report to the Human Resources Department. HR will review the restrictions and compare to the physical demands analysis to ascertain compatibility of performing the essential functions of the position. If the modified duty within the restrictions is available, the employee may be returned to work in accordance with the work readiness program for up to 90 days. If the employee is not released within the 90 days, HR will review and move forward with the appropriate possible accommodations.

5.6 Training

All miners will be trained in health issues during New Miner, Experienced Miner and Annual Refresher in accordance with CFR 30 part 48. It will be each areas responsibility to train all employees exposed to the individual chemicals in accordance with CFR 30 part 47.

6.0 REFERENCE DOCUMENTS

6.1 29 CFR 1910.134 OSHA Respiratory Protection Regulations

6.2 30 CFR Part 62 MSHA Occupational Noise Exposure Regulations

6.3 29 CPL 03-00-007 OSHA National Emphasis Program – Crystalline Silica

6.4 49 CFR 391.41 US DOT FMCSA Driver Examination

6.5 National Commission for the Certification of Crane Operators

6.6 29 CFR 1910.1025 OSHA Lead Protection Regulations

7.0 RECORDS

Name of the Document	Responsible for Control	Records Retention
Immunization Records	Gila Health Resources	Permanent
Audiograms	Gila Health Resources / Industrial Hygiene	Termination of employment + 30 years or 75 years after date of hire
Blood Lead Levels	Gila Health Resources	Permanent
Occupationally Induced Illnesses	Health and Safety	Permanent
Employee Monitoring and Testing	Gila Health Resources / Industrial Hygiene	Permanent
Radiation Monitoring	Industrial Hygiene	Permanent
Employee Medical File	Gila Health Resources	Permanent
Vision Testing Results	Gila Health Resources / Human Resources	Permanent
CDL Certifications	Gila Health Resources / Area Requesting	Permanent
Crane / Boom Physicals	Gila Health Resources / Technical Training	Permanent
MSHA 5000-23 for health related training	Health & Safety / Technical Training	Duration of employment + 10 years

8.0 APPENDICES

8.1 Appendix A Medical Evaluation Checklist

8.2 Appendix B Occupational Medical Exam Certification

8.3 Appendix C Medical/Occupational Health Questionnaire

8.4 Appendix D Respirator Health Questionnaire

8.5 Appendix E Audiometric History Questionnaire

8.6 Appendix F Silica Questionnaire

8.7 Appendix G Report of Medical Evaluation

8.8 Appendix H Asbestos Health Questionnaire

8.9 Appendix I Abbreviated Asbestos Questionnaire

8.10 Appendix J Interval Testing Schedule

8.11 Appendix K Interval Testing Requirements by Similar Exposure Group

9.0 REVIEW AND CHANGE

All changes, modifications and/or revisions must be documented on the table below:

Description of Changes to this Document
Review and Reformatted-no policy changes-on 9/10/2012 Garth Graham
Added 1.2 under purposes to reflect corporate policy 9/28/2012 Garth Graham
Included Physical Demands Analysis provided by HR under 2.1 9/28/2012 Garth Graham
4.4 Manager of Human Resources added two responsibilities-ensure that the occupational medical examination is carried out whether new employee or internal transfer and Provide the occupational health testing facility with the necessary employment information to carry out the requirments of the occupational health protocol 9/28/2012 Garth Graham
5.1 changed the names of the occupational health testing Initial (pre-placement), Interval (periodic) and Exit examinations. 9/28/2012 Garth Graham
Added 5.1.1 Initial Testing, 5.1.2 Interval Testing and 5.1.3 Exit Testing 9/28/2012 Garth Graham
Added Tables 1-6 in 5.2 and 5.3 to define various interval, initial and exit testing to be done for

specific hazards and job titles 9/28/2012 Garth Graham
Deleted Noise and Lead from table 5.8 since these are included in Table 2 and Table 6 of 5.3 9/28/2012 Garth Graham
Added reference documents to 7.0 9/28/2012 Garth Graham
Added and revised all of the appendices (A through K) based on corporate policy, Morenci Industrial Hygiene and Morenci Human Resources needs. 9/28/2012 Garth Graham
Updated records table – S. Elias 06/28/2013 Rev. 02

Appendix A Medical Evaluation Checklist

Medical Evaluation Checklist

Examinee name: _____

Examinee ID# _____

Job location: _____

Job title: _____

Type of health examination (circle one): Initial (Pre-placement) Retest

Interval (Periodic) Exit

Please complete the examination elements checked below.

Date and initial all items completed

Items to be completed **Items completed**

HISTORY AND PHYSICAL EXAM	**Date completed**	**Initials**
□ Medical history form	___/___ /20__	
□ Occupational history form	___/___ /20__	
□ Respirator health questionnaire	___/___ /20__	
□ Silica health questionnaire	___/___ /20__	
□ Physical examination	___/___ /20__	
□ PDA/functional capacity evaluation	___/___ /20__	

VISION AND HEARING - attach reports, tracings	**Date completed**	**Initials**
□ Vision: near, far, color, depth, visual field	___/___ /20__	
Vision tester model:_____		
□ Hearing history and audiogram	___/___ /20__	
Audiometer model:_____		
Audiometric booth:_____		

LABORATORY STUDIES - attach all reports	**Date completed**	**Initials**
□ CBC without differential	___/___ /20__	
□ Comprehensive metabolic profile	___/___ /20__	
□ Urinalysis (dipstick)	___/___ /20__	
□ Electrocardiogram - 12-lead resting	___/___ /20__	
□ Chest X-ray - PA	___/___ /20__	
□ Screening spirometry	___/___ /20__	

EXAMINATION SUMMARY

□ Report of medical evaluation	___/___ /20__	
□ Arizona CDL medical report 40-1501	___/___ /20__	

ADDITIONAL COMMENTS

CERTIFICATION OF PROVIDER

Examiner's name/title (MD, DO): _____

State license #: _____

Office street address: _____

Office city, state, zip: _____

Office phone: _____

Office fax: _____

Appendix B Occupational Medical Exam Certification

OCCUPATIONAL MEDICAL EXAM CERTIFICATION

Name:

Company: Freeport-McMoRan Copper & Gold

Employee Number:

Department:

Position:

Work Location:

Date of Medical Exam:

Type of Medical Exam: ☐ Post-Offer Pre-placement ☐ Other

Examined By:

This document is to certify that the aforementioned individual has undergone a medical exam, the results of which indicate he/she

☐ can perform the essential functions

☐ can perform the essential functions with the following restrictions: _____

_____

☐ cannot perform the essential functions

for the position and work location identified on this document at the time of the medical exam and in accordance with the Occupational Medical Protocol of Freeport-McMoRan Copper & Gold, NA.

Signature of Doctor _____

Name of Doctor _____

Date _____

To notify the scheduling site Human Resources Department of the results of this examination, please **return only this form** **(without additional information or records).**

Appendix C Medical/Occupational Health Questionnaire

Medical/Occupational Health Questionnaire

To the examinee: Your responses to this health questionnaire are important for evaluating your ability to perform the essential functions of your job position. A health-care professional will review your questionnaire responses with you.

Please CIRCLE or PRINT your answers. If you need help with a question, please ask for clarification.

YOUR NAME _____Today's date ____/____/20_____

Your date of birth: ____/____/_____ Employee ID#: _____

HOME street address_____

City_____ State_____ Zip_____

Telephone: Day ( ) _____-_____ Evening ( ) _____-_____

Your personal physician's name _____

City_____State_____ Month/year of last health exam____/____

Job title _____

Human Resources Contact_____

SECTION A: At the <u>PRESENT TIME</u> are you:

Yes No *(Check YES or NO for each question)*

□	□	1. Affected in your ability to work by any health problem?
□	□	2. Restricted in any work activity due to an injury or other health problem?
□	□	3. Restricted in any way in doing strenuous physical activity?
□	□	4. Restricted in any way from driving vehicles or operating equipment (except wearing glasses)?
□	□	5. Chewing or smoking tobacco products, including cigarettes and cigars?

SECTION B: In the past 5 YEARS have you been DIAGNOSED WITH or TREATED FOR:

Yes No *(Check YES or NO for each question, and CIRCLE the health condition(s) that apply)*

□	□	6. Disease or injury of joints, muscles, or bones, including leg cramps, arthritis, gout, tendonitis, carpal tunnel syndrome?
□	□	7. Back pain or sciatica, whiplash injury?
□	□	8. Asthma or breathing problems, emphysema, persistent cough, coughing up blood, tuberculosis, persistent hoarseness?
□	□	9. Heart problems, including high blood pressure, irregular or rapid pulse, chest pain, abnormal electrocardiogram (heart tracing), heart attack, heart murmur, pacemaker, bypass surgery?
□	□	10. Stomach or intestinal problems, including hernia, gallstones, gallbladder problems, colitis, stomach ulcer, bleeding from rectum?
□	□	11. Liver problems, including hepatitis, yellow jaundice, cirrhosis, enlarged liver?
□	□	12. Kidney or bladder problems, including stones, blood or sugar in urine, frequent urination?
□	□	13. Nervous system problems, including headaches, migraines, seizures, epilepsy, balance problems, hearing difficulty, fainting?
□	□	14. Skin problems, including rash from soaps or chemicals, acne, skin cancer?
□	□	15. Allergies to dust, chemicals, bee stings, insect stings?
□	□	16. Allergies to medications?

Please explain all YES answers in SECTIONS A and B:

SECTION C: Please list all medications – prescription and over-the-counter – you currently take:

Print the medication name Dose (mg) Times/day

SECTION D: Do you have any CURRENT limitation or work restriction in:

Yes No *(Check YES or NO for each question, and CIRCLE the health condition(s) that apply)*

□	□	16. VISION that affects reading, seeing distant objects, distinguishing colors, or judging depth and IS NOT CORRECTED when wearing prescription eyeglasses?
□	□	17. HEARING that affects understanding spoken words, requires the use of a hearing aid, or requires that you avoid excessive noise?
□	□	18. The use of either HAND that affects gripping or holding objects firmly or handling objects with your fingers?
□	□	19. Either ARM, SHOULDER, ELBOW or WRIST that affects the strength or motion of your arm?
□	□	20. Either FOOT, KNEE or LEG that affects standing, walking, squatting, kneeling, climbing stairs, working on ladders, walking on slippery or uneven surfaces?
□	□	21. Bending or turning your NECK, or holding your head in certain positions?
□	□	22. Use of your BACK to lift, bend, or move heavy objects?
□	□	23. Maintaining your BALANCE or equilibrium?
□	□	24. Working at heights, or working around and operating moving machinery?
□	□	25. Allergies to dust, chemicals, bee stings, insect stings?

SECTION E: Have you EVER:

Yes No *(Check YES or NO for each question, and CIRCLE the health condition(s) that apply)*

□	□	26. Lost work time due to any injury or illness?
□	□	27. Changed jobs due to a health issue – illness or injury?
□	□	28. Been treated for a recurring (keeps occurring) mental health or substance abuse problem?

□	□	29. Worked with high dust levels, excessive or prolonged noise?
□	□	30. Worked with hazardous chemicals, including lead, mercury, cadmium, cobalt?

Please explain all YES answers in SECTIONS D and E:

Employee certification: I understand and agree that the information provided is accurate and subject to verification. A material misrepresentation or omission of fact in my health questionnaire may be reason for refusal of employment or, if employed, termination.

_____ _____

Print your name Sign your name

Appendix D Respirator Use Questionnaire

Respirator Use Questionnaire

PRINT your name: _____ Employee ID#_____

To the employee:

Y	**N**	Can you read this questionnaire? (***Circle Y**-es **or N**-o)* If **NO,** please ask for assistance.

This questionnaire must be answered by any employee using any type of respirator. It complies with regulations of the US Occupational Safety and Health Administration (OSHA). The questions are required by OSHA and cannot be changed. Freeport must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain medical confidentiality, Freeport or your supervisor must not look at or review your answers. Freeport 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** your responses or **CIRCLE Y**-es or **N-**o*

____/_____/20____	A1-1. Today's date (mm/dd/20yy)
_____ years old	A1-3. Your age (to nearest year)
[male] [female]	A1-4. Your gender (*Circle male or female*)
_____feet _____inches	A1-5. Your height
_____pounds	A1-6. Your weight
_____	A1-7. Your job title

Area code: _____ _____-_____	A1-8. The area code and phone number where you can be reached by the health-care professional who reviews this questionnaire
_____ [am] / [pm]	A1-9. The best time to phone you at this number
[Yes] [No]	A1-10. Has Freeport told you how to contact the health-care professional who will review this questionnaire? *(Circle Yes or No)*

PART A - SECTION 2 (mandatory)

Questions A2-1 to A2-3 must be answered by every employee who has been selected to use **ANY TYPE** of respirator.

Y	**N**	**A2-1 Do you *currently* smoke tobacco, or have you smoked tobacco in the last month?**
		A2-2 Have you *ever had* any of the following conditions?
Y	**N**	A2-2a Seizures (fits)
Y	**N**	A2-2b Diabetes (sugar disease)
Y	**N**	A2-2c Allergic reactions that interfere with your breathing
Y	**N**	A2-2d Claustrophobia (fear of closed-in places)
Y	**N**	A2-2e Trouble smelling odors
		A2-3 Have you *ever had* any of the following pulmonary or lung problems?
Y	**N**	A2-3a Asbestosis
Y	**N**	A2-3b Asthma
Y	**N**	A2-3c Chronic bronchitis
Y	**N**	A2-3d Emphysema
Y	**N**	A2-3e Pneumonia
Y	**N**	A2-3f Tuberculosis

Y	**N**	A2-3g Silicosis
Y	**N**	A2-3h Pneumothorax (collapsed lung)
Y	**N**	A2-3i Lung cancer
Y	**N**	A2-3j Broken ribs
Y	**N**	A2-3k Any chest injuries or surgeries
Y	**N**	A2-3l. Any other lung problem that you've been told about

EXPLAIN ANY *YES* ANSWERS to questions A2-1 to A2-3 below.

PART A - SECTION 2 (mandatory)

Questions A2-4 to A2-9 must be answered by every employee who has been selected to use **ANY TYPE** of respirator.

		A2-4 Do you *currently* have any of the following symptoms of pulmonary or lung illness?
Y	**N**	A2-4a Shortness of breath
Y	**N**	A2-4b Shortness of breath when walking fast on level ground or walking up a slight hill or incline
Y	**N**	A2-4c Shortness of breath when walking with other people at an ordinary pace on level ground
Y	**N**	A2-4d Have to stop for breath when walking at your own pace on level ground
Y	**N**	A2-4e Shortness of breath when washing or dressing yourself
Y	**N**	A2-4f Shortness of breath that interferes with your job
Y	**N**	A2-4g Coughing that produces phlegm (thick sputum)
Y	**N**	A2-4h Coughing that wakes you early in the morning
Y	**N**	A2-4i Coughing that occurs mostly when you are lying down
Y	**N**	A2-4j Coughing up blood in the last month

Y	**N**	A2-4k Wheezing
Y	**N**	A2-4l Wheezing that interferes with your job
Y	**N**	A2-4m Chest pain when you breathe deeply
Y	**N**	A2-4n Any other symptoms that you think may be related to lung problems
		A2-5 Have you *ever had* any of the following cardiovascular or heart problems?
Y	**N**	A2-5a Heart attack
Y	**N**	A2-5b Stroke
Y	**N**	A2-5c Angina
Y	**N**	A2-5d Heart failure
Y	**N**	A2-5e Swelling in your legs or feet (not caused by walking)
Y	**N**	A2-5f Heart arrhythmia (heart beating irregularly)
Y	**N**	A2-5g High blood pressure
Y	**N**	A2-5h Any other heart problem that you've been told about
		A2-6 Have you *ever had* any of the following cardiovascular or heart symptoms?
Y	**N**	A2-6a Frequent pain or tightness in your chest
Y	**N**	A2-6b Pain or tightness in your chest during physical activity
Y	**N**	A2-6c Pain or tightness in your chest that interferes with your job
Y	**N**	A2-6d In the past 2 years, have you noticed your heart skipping or missing a beat
Y	**N**	A2-6e Heartburn or indigestion that is not related to eating
Y	**N**	A2-6f Any other symptoms that you think may be related to heart or circulation problems
		A2-7 Do you *currently* take medication for any of the following problems?
Y	**N**	A2-7a Breathing or lung problems

Y	**N**	A2-7b Heart trouble
Y	**N**	A2-7c Blood pressure
Y	**N**	A2-7d Seizures (fits)
		A2-8 If you've used a respirator, have you *ever had* any of the following problems? □ Check this box if you've **never used** a respirator, and go to question A2-9
Y	**N**	A2-8a Eye irritation
Y	**N**	A2-8b Skin allergies or rashes
Y	**N**	A2-8c Anxiety
Y	**N**	A2-8d General weakness or fatigue
Y	**N**	A2-8e Any other problem that interferes with your use of a respirator
Y	**N**	**A2-9 Would you like to talk to the health-care professional who will review this questionnaire about your answers to this questionnaire?**

EXPLAIN ANY *YES* ANSWERS to Questions A2-4 to A2-8 below. Questions continue on the next page.

PART A - SECTION 3: For full-facepiece respirator or self-contained breathing apparatus

Questions A3-10 to A3-15 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.**

Y	**N**	**A3-10 Have you *ever* lost vision in either eye (temporarily or permanently)?**
		A3-11 Do you *currently have* any of the following vision problems?
Y	**N**	A3-11a Wear contact lenses
Y	**N**	A3-11b Wear glasses
Y	**N**	A3-11c Color blind
Y	**N**	A3-11d Any other eye or vision problem
Y	**N**	**A3-12 Have you *ever had* an injury to your ears, including a broken ear drum?**
		A3-13 Do you *currently have* any of the following hearing problems?
Y	**N**	A3-13a Difficulty hearing
Y	**N**	A3-13b Wear a hearing aid
Y	**N**	A3-13c Any other hearing or ear problem
Y	**N**	**A3-14 Have you *ever had* a back injury?**
		A3-15 Do you *currently* have any of the following musculoskeletal problems?
Y	**N**	A3-15a Weakness in any of your arms, hands, legs, or feet
Y	**N**	A3-15b Back pain
Y	**N**	A3-15c Difficulty fully moving your arms and legs
Y	**N**	A3-15d Pain or stiffness when you lean forward or backward at the waist
Y	**N**	A3-15e Difficulty fully moving your head up or down

Y	**N**	A3-15f Difficulty fully moving your head side to side
Y	**N**	A3-15g Difficulty bending at your knees
Y	**N**	A3-15h Difficulty squatting to the ground
Y	**N**	A3-15i Climbing a flight of stairs or a ladder carrying more than 25 lbs
Y	**N**	A3-15j Any other muscle or skeletal problem that interferes with using a respirator

EXPLAIN ANY *YES* ANSWERS to Questions A3-10 to A3-15 below

EMPLOYEE CERTIFICATION FOR PART A QUESTIONS – PLEASE SIGN BELOW:

The answers that I have provided to the questions above are correct to the best of my knowledge.

_____ _____/_____/ 20____

Employee's signature Today's date (mm/dd/yr)

HEALTH-CARE PROVIDER RECOMMENDATION:

I have reviewed this respirator user health questionnaire and my recommendation is: (check one box):

No further medical evaluation needed. Fit testing may proceed. Respirator Program Coordinator notified.

Further medical evaluation is needed before fit test can proceed. Respirator Program Coordinator notified.

COMMENTS:

Office telephone: ( ) _____-_____ Today's date _____/_____/_____

_____ _____

Printed name of health-care provider reviewer	Signature of health-care provider reviewer

PART B – OPTIONAL RESPIRATOR USER QUESTIONS

Any of the following questions may be added at the discretion of the health-care professional reviewing your questionnaire.

Y	**N**	**B1 In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen?**
Y	**N**	B1a If YES, do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions?
Y	**N**	**B2 At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals?** If YES, name the chemicals if you know them:
		B3 Have you ever worked with any of the materials or under conditions listed below?
Y	**N**	B3a Asbestos
Y	**N**	B3b Silica (for example, in sandblasting)
Y	**N**	B3c Tungsten or cobalt (for example, grinding or welding these metals)
Y	**N**	B3d Beryllium
Y	**N**	B3e Aluminum
Y	**N**	B3f Coal (for example, mining)
Y	**N**	B3g Iron
Y	**N**	B3h Tin
Y	**N**	B3i Dusty environments
Y	**N**	B3j Any other hazardous exposures. If “yes” describe these exposures:

		B4 List any second jobs or side businesses you have:
		B5 List your previous occupations:
		B6 List your current and previous hobbies:
Y	**N**	**B7 Have you been in the military services?**
Y	**N**	B7a If YES, were you exposed to biological or chemical agents (either in training or combat)?
Y	**N**	**B8. Have you ever worked on a HAZMAT team?**
Y	**N**	B8a. If YES, were you exposed to biological or chemical agents (either in training or combat)?
Y	**N**	**B9 Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications)?** If YES, name the medications if you know the name:
		B10 Will you be using any of the following items with your respirator(s)?
Y	**N**	B10a HEPA Filters
Y	**N**	B10b Canisters (for example, gas masks)
Y	**N**	B10c Cartridges
		B11 How often are you expected to use the respirator(s)? Circle **Y**es or **N**o for answers that apply.
Y	**N**	B11a Escape only (no rescue use)

Y	**N**	B11b Emergency rescue only
Y	**N**	B11c Less than 5 hours **per week**
Y	**N**	B11d Less than 2 hours **per day**
Y	**N**	B11e 2-4 hours per day
Y	**N**	B11c Over 4 hours per day
		B12 During the period you are using the respirator(s), is your work effort?
Y	**N**	B12a **LIGHT** (*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*.) If YES, how long does this period last during the average shift? _____hrs._____mins.
Y	**N**	B12b **MODERATE** (*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.)* If YES, how long does this period last during the average shift? _____hrs._____mins.
Y	**N**	B12c **HEAVY** *(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.).* If YES, how long does this period last during the average shift? _____hrs._____mins.
Y	**N**	**B13 Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator?** If YES, describe this protective clothing and/or equipment:
Y	**N**	**B14 Will you be working under hot conditions (temperature exceeding 77°F)?**
Y	**N**	**B15 Will you be working under humid conditions?**

	B16 Describe the work you'll be doing while you're using your respirator(s):
	B17 Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases):
	B18 Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):

Name of the toxic substance	Estimated maximum exposure level per shift	Duration of exposure per shift
1.		hrs
2.		Hrs
3.		Hrs
4.		Hrs

	B19 Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security):
	B20 Respirator fit test (if performed, insert appropriate form).

EMPLOYEE CERTIFICATION FOR PART B QUESTIONS – PLEASE SIGN BELOW:

The answers that I have provided to the questions above are correct to the best of my knowledge.

_____ _____/_____/ 20____

Employee's signature Today's date (mm/dd/yr)

HEALTH-CARE PROVIDER'S COMMENTS ON PART B RESPONSES:

_____ _____

Printed name of health-care provider reviewer Signature of health-care provider reviewer

Today's Date: _____

Appendix E Audiometric History

Baseline ☐
Annual ☐
Retest ☐

AUDIOMETRIC HISTORY

Last Name	First Name	Employee ID
Division	Department	Job Title

PLEASE ANSWER THE FOLLOWING QUESTIONS (CIRCLE YOUR RESPONSE)

Can you hear better in one ear?	Yes	No
If "yes", which ear is best?	Right	Left
Been a change in hearing since your last test?	Yes	No
Seen a doctor/audiologist about your hearing?	Yes	No
Anybody in your family have a hearing loss?	Yes	No
Does your hearing change noticeably?	Yes	No
Have trouble hearing on the phone or TV?	Yes	No
Have trouble understanding conversations?	Yes	No
Do you hunt or use farm equipment?	Yes	No
Hours since you last exposure to loud noise?	Hrs	

If loud noise exposure has been less than 14 hours, did you use hearing protection?	Yes	No
Do you routinely work in loud noise?	Yes	No
Received training about noise in the past year?	Yes	No
Warning signs posted in your work area?	Yes	No
Ever restricted from working in noise?	Yes	No
Counseled about not wearing ear protection?	Yes	No
Do you routinely wear hearing protection?	Yes	No

If "YES", which type do you wear? Circle all that apply.

Push-ins	Max	EZ fit	Sparkplug
Decidamp	Tri Flanged	Ultrafit	Skull Screw
Optime95	Other (please describe):		

OTOSCOPIC EXAMINATION

	Normal in Appearance	Partially Occluded	Excessive Cerumen	Totally Occluded	Appeared Inflamed	Suspect Perforation	Foreign Body	Could Not Visualize	Did Not Examine
Right									
Left									

Comments: _____

Employee's Signature _____ Date _____

Examiner's Name: _____ Examiner's Signature: _____ CAOHC Number: _____

Appendix F Silica Questionnaire

Silica Questionnaire

PRINT your name: _____ **Employee ID#** _____

This questionnaire must be answered by any employee enrolled in the Freeport occupational health program for silica. Freeport will allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain medical confidentiality, Freeport or your supervisor must not look at or review your answers. Freeport must tell you how to deliver or send this questionnaire to the health-care professional who will review it.

Prior to answering these questions, you must complete the "Respirator user health questionnaire" Part A.

____/_____/20____	Today's date (mm/dd/20yy)

PART C – SECTION 1: OCCUPATIONAL HISTORY

*Please **PRINT** your responses in the space provided or **CIRCLE Y**-es or **N**-o*

Y	**N**	**C1-1 Have you ever worked full time (30 hours per week or more) for 6 months or more?** **If YES**, answer questions C1-1a to C-1-1d. If NO, skip to Section 2.
Y	**N**	**C1-2 Have you ever worked for a year or more in any dusty job**?
		C1-2a In what job/industry did you work in a dusty job?
		C1-2b What are the total number of years worked in a dusty job? _____years
		C1-2c Was the dust exposure? (*check one*) □ mild □ moderate □ severe
Y	**N**	**C1-3 Have you ever been exposed to chemical gases, fumes or vapors in your work?**
		C1-2a In what job/industry did you work during exposure?
		C1-2b What are the total number of years exposed? _____years
		C1-2c Was the exposure? (*check one*) □ mild □ moderate □ severe

		C1-4 What has been your usual occupation or job – the one you have worked at the longest?
		C1-4a Number of years employed in this occupation? _____ yrs
		C1-4b What was the position or job title for your usual occupation?
		C1-4c What is the business, field, or industry for your usual occupation?
		C1-5 For the following industries, indicate whether you worked in the industry. **If YES**, list the **total number of years** in which you worked in that industry:
Y	**N**	C1-5a In any mine? Total number of years _____
Y	**N**	C1-5b In any quarry? Total number of years _____
Y	**N**	C1-5c In any foundry? Total number of years _____
Y	**N**	C1-5d In any smelter? Total number of years _____
Y	**N**	C1-5e In any pottery? Total number of years _____
Y	**N**	C1-5g In sand blasting? Total number of years _____
Y	**N**	C1-5f In any cotton/flax/hemp mill? Total number of years _____
Y	**N**	C1-5h In asbestos installation or removal? Total number of years _____
Y	**N**	C1-5i In fiberglass/glass wool industry? Total number of years _____
Y	**N**	C1-5j In construction involving demotion/breakup of concrete, grinding of stones, etc? _____ years

PART C - SECTION 2: INITIAL MEDICAL HISTORY

Before completing this section, you must complete SECTION A of the RESPIRATOR USER HEALTH QUESTIONNAIRE. *Please **PRINT** your responses in the space provided or **CIRCLE Y**-es or **N**-o*

Y	**N**	**C2-1 Do you consider yourself to be in good health?** If NO, please explain**:**
		C2-2 Do you have or have you ever had any of the following illnesses?
Y	**N**	C2-2a Rheumatic fever
Y	**N**	C2-2b Kidney disease
Y	**N**	C2-2c Bladder disease
Y	**N**	C2-2d Jaundice or liver disease
		CHEST COLDS AND CHEST ILLNESSES
Y	**N**	**C2-3 If you get a cold, does it "usually" go to your chest?** (Usually means more than 1/2 the time) **If NO**, go to question C2-4. **If YES**, answer questions C2-3b to C2-3d.
Y	**N**	C2-3a During the past 3 years, have you had any chest illnesses that have kept you off work, indoors at home, or in bed?
Y	**N**	C2-3b Did you produce sputum (phlegm) with any of these chest illnesses?
Y	**N**	C2-3c In the last 3 years, how many such illnesses with (increased) phlegm did you have which lasted a week or more? _____illnesses
Y	**N**	**C2-4 Did you have any lung trouble before the age of 16?**
		Have you ever been told that you had any of the following:
Y	**N**	C2-5 **Acute bronchitis?**
Y	**N**	C2-5a If YES, was the diagnosis of bronchitis made by a health-care provider, such as a doctor?
		C2-5b If YES, at what age was bronchitis first diagnosed? _____ years of age
Y	**N**	C2-6 **Pneumonia?**
Y	**N**	C2-6a If YES, was the diagnosis of pneumonia made by a health-care provider, such as a doctor?

		C2-6b If YES, at what age was pneumonia first diagnosed? _____ years of age
Y	**N**	C2-7 **Hay fever?**
Y	**N**	C2-7a If YES, was the diagnosis made by a health-care provider, such as a doctor?
		C2-7b If YES, at what age was it first diagnosed? _____ years of age
Y	**N**	C2-8 **Chronic bronchitis?**
Y	**N**	C2-8a If YES, do you still have chronic bronchitis?
Y	**N**	C2-8b If YES, was the diagnosis made by a health-care provider, such as a doctor?
		C2-8c If YES, at what age was it first diagnosed? _____ years of age
Y	**N**	C2-9 **Emphysema?**
Y	**N**	C2-9a If YES, do you still have emphysema?
Y	**N**	C2-9b If YES, was the diagnosis made by a health-care provider, such as a doctor?
		C2-9c If YES, at what age was it first diagnosed? _____ years of age
Y	**N**	C2-10 **Asthma?**
Y	**N**	C2-10a If YES, do you still have asthma?
Y	**N**	C2-10b If YES, was the diagnosis made by a health-care provider, such as a doctor?
		C2-10c If YES, at what age was it first diagnosed? _____ years of age
		C2-10d If you no longer have asthma, at what age did it stop? ____years of age
		C2-11 When did you have your last chest X-ray? Month:_____ Year:_____
		C2-11a At what doctor's office or hospital was it taken?
		C2-11b What were the results of the last chest X-ray (if known)?

		COUGH AND PHLEGM
Y	**N**	**C2-12 Do you usually have a cough?** (Count a cough with first smoke or on first going out of doors. Exclude clearing of throat.) **If NO**, go to question C2-13. **If YES**, answer questions C2-12a-12k.
Y	**N**	C2-12a. Do you usually cough as much as 4 to 6 times a day 4 or more days out of the week?
Y	**N**	C2-12b. Do you usually cough at all on getting up or first thing in the morning?
Y	**N**	C2-12c. Do you usually cough at all during the rest of the day or at night?
		If **YES** to C2-12a-c, continue with C2-12d. **If NO**, go to C2-13.
Y	**N**	C2-12d Do you usually cough like this on most days for 3 consecutive months or more during the year?
		C2-12e For how many years have you had the cough? _____years
Y	**N**	C2-12f 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.)
Y	**N**	C2-12g Do you usually bring up phlegm like this as much as twice a day, 4 or more days out of the week?
Y	**N**	C2-12h Do you usually bring up phlegm at all on getting up or first thing in the morning?
Y	**N**	C2-12i Do you usually bring up phlegm at all on during the rest of the day or at night?
Y	**N**	C2-12j Do you bring up phlegm like this on most days for 3 consecutive months or more during the year?
		C2-12k For how many years have you had trouble with phlegm? _____years
		WHEEZING
Y	**N**	**C2-13 Does your chest ever sound wheezy or whistling?**
Y	**N**	C2-13a Does your chest sound wheezy when you have a cold?
Y	**N**	C2-13b Does your chest sound wheezy occasionally when you do not have a cold?

Y	**N**	C2-13c Does your chest sound wheezy most days or nights?
		C2-13d If YES to C-13a-13c, for how many years has wheezing been present? _____years
Y	**N**	**C2-14 Have you ever had an attack of wheezing that has made you feel short of breath?**
		C2-14a How old were you when you had your first such attack? ___years of age
Y	**N**	C2-14b Have you had 2 or more such episodes of shortness of breath during a wheezing attack?
Y	**N**	C2-14c Have you ever required medicine or medical treatments for wheezing attacks?
		TOBACCO USE (cigarette, pipe, or cigar smoking)
Y	**N**	**C2-15 Have you ever smoked cigarettes?** YES means 20 packs or more in your lifetime or 1 or more cigarettes per day for 1 year. If NO skip to question C-16.
Y	**N**	C2-15a Have you smoked cigarettes within the past month?
		C2-15b How old were you when you started regular cigarette smoking? _____years old
		C2-15c If you stopped smoking cigarettes completely, how old were you when you stopped? ___years old
		C2-15d How many cigarettes do you smoke per day? _____
		C2-15e On average, for the time you have smoked, how many cigarettes have you smoked per day? _____
		C2-15f Do/did you inhale cigarette smoke? (check one) □ do/did not inhale □inhale slightly □inhale moderately □inhale deeply
Y	**N**	**C2-16 Have you ever smoked a pipe?** A standard tobacco pouch holds approximately 1 ½ ounces. YES means more 12 ounces of tobacco in your lifetime. If NO, skip to question C-17.
Y	**N**	C2-16a Have you smoked a pipe within the past month?
		C2-16b How old were you when you started to smoke a pipe regularly? _____years old

		C2-16c If you stopped smoking a pipe completely, how old were you when you stopped? _____years old
		C2-16d How much pipe tobacco are you currently smoking PER WEEK? _____ounces (oz)
		C2-16e On average, for the time you have smoked, how much tobacco did you use PER WEEK? _____oz
		C2-16f Do/did you inhale pipe smoke? (check one) □do/did not inhale □inhale slightly □inhale moderately □inhale deeply
Y	**N**	**C2-17 Have you ever smoked cigars regularly?** YES means more than 1 cigar a week for a year If NO skip to EMPLOYEE CERTIFICATION.
		C2-17a How old were you when you started to smoke cigars regularly? _____years old
		C2-17b If you have stopped smoking cigars completely, how old were you when you stopped? ____ yrs old
		C2-17c On average, for the time you smoked cigars, how many cigars did you smoke per week? _____
		C2-17d How many cigars are you now smoking PER WEEK? _____
		C2-17e Do/did you inhale cigar smoke? (check one) □do/did not inhale □inhale slightly □inhale moderately □inhale deeply

EMPLOYEE CERTIFICATION FOR PART C QUESTIONS – PLEASE SIGN BELOW:

The answers that I have provided to the questions above are correct to the best of my knowledge.

_____ _____/_____/ 20____

Employee's signature Today's date (mm/dd/yr)

Appendix G Asbestos Health Questionnaire

Asbestos Health Questionnaire

Please CIRCLE or PRINT your answers. If you need help with a question, please ask for clarification.

YOUR NAME _____Today's date ____/____/20_____

Job title_____ Employee ID#: _____

Division_____Department_____

HOME street address_____

City_____ State_____ Zip_____

Telephone: Day ( ) _____-_____ Evening ( ) _____-_____

Your date of birth: ____/____/_____

Birthplace City_____ State_____ Social Security Number_____

13 What is your gender? (check one) □ Male □ Female
14 What is your marital status? (check one) □ Single □ Married □ Widowed □ Separated/Divorced
15 What is your race? (check one) □ Caucasian □ Hispanic □ Asian □ African American □ Native American □ Other_____
16 What is the highest grade completed in school (for example 12 years is completion of high school)? Number in years_____

Occupational History

Y	N	N/A	
			17A Have you ever worked full time (30 hours per week or more) for 6 months or more?
If "yes" to 17A answer 17B to 17E, if "no" skip to past medical history			

Y	**N**	**N/A**	17B Have you ever worked for a year or more in any dust job?
			Specify job/industry_____ Total years worked_____
			Was the dust exposure? (*check one*) □ mild □ moderate □ severe
Y	**N**	**N/A**	17C Have you ever been exposed to chemical gases, fumes or vapors in your work?
			Specify job/industry_____ Total years worked_____
			Was the exposure? (*check one*) □ mild □ moderate □ severe
17D What has been your usual occupation or job – the one you have worked at the longest?			
Number of years employed in this occupation? _____ yrs			
What was the position or job title for your usual occupation?			
What is the business, field, or industry for your usual occupation?			
17E For the following industries, indicate whether you worked in the industry. If YES, list the total number of years in which you worked in that industry:			
Y	**N**	**N/A**	In any mine? Total number of years _____
Y	**N**	**N/A**	In any quarry? Total number of years _____
Y	**N**	**N/A**	In any foundry? Total number of years _____
Y	**N**	**N/A**	In any pottery? Total number of years _____
Y	**N**	**N/A**	In any cotton, flax or hemp mill? Total number of years _____
Y	**N**	**N/A**	With asbestos? Total number of years _____

Past Medical History

Y	**N**	18A Do you consider yourself to be in good health? If NO, please explain:

Y	**N**	18B Have you any defect of vision? If YES, please explain:
Y	**N**	18C Have you any hearing defect? If YES, please explain:
		18D Are you suffering from or have you ever suffered from:
Y	**N**	Epilepsy (or fits, seizures, convulsions)?
Y	**N**	Rheumatic fever?
Y	**N**	Kidney disease?
Y	**N**	Bladder disease?
Y	**N**	Diabetes?
Y	**N**	Jaundice?

Chest Colds and Chest Illnesses

Y	**N**	**N/A**	19A If you get a cold, does it "usually" go to your chest? (usually means more than 50% of the time)
Y	**N**		20A During the last 3 years, have you had any chest illnesses that have kept you off work, indoors at home, or in bed?
If "yes" to 20A answer 20B and 20C			
Y	**N**		20B Did you produce phlegm with any of these chest illnesses?
20C In the last 3 years, how many illnesses with (increased) phlegm did you have which lasted a week or more? Number of illnesses_____ No such illnesses_____			
Y	**N**		21 Did you have any lung trouble before the age of 16?
22 Have you ever had any of the following?			
Y	**N**		1A Attacks of bronchitis?

If "yes" to 1A answer 1B and 1C			
Y	**N**	**N/A**	1B Was it confirmed by a doctor?
1C At what age was your first attack? Age in years_____ Does not apply_____			
Y	**N**		2A Pneumonia (include bronchopneumonia)?
If "yes" to 2A answer 2B and 2C			
Y	**N**	**N/A**	2B Was it confirmed by a doctor?
2C At what age did you first have it? Age in years_____ Does not apply_____			
Y	**N**		3A Hay fever?
If "yes" to 3A answer 3B and 3C			
Y	**N**	**N/A**	3B Was it confirmed by a doctor?
3C At what age did it start? Age in years_____ Does not apply_____			
Y	**N**		23A Have you ever had chronic bronchitis?
If "yes" to 23A answer 23B, 23C and 23D			
Y	**N**	**N/A**	23B Do you still have it?
Y	**N**	**N/A**	23C Was it confirmed by a doctor?
23D At what age did it start? Age in years_____ Does not apply_____			
Y	**N**		24A Have you ever had emphysema?
If "yes" to 24A answer 24B, 24C and 24D			
Y	**N**	**N/A**	24B Do you still have it?
Y	**N**	**N/A**	24C Was it confirmed by a doctor?
24D At what age did it start? Age in years_____ Does not apply_____			
Y	**N**		25A Have you ever had asthma?

If "yes" to 25A answer 25B, 25C, 25D and 25E			
Y	**N**	**N/A**	25B Do you still have it?
Y	**N**	**N/A**	25C Was it confirmed by a doctor?
25D At what age did it start? Age in years_____ Does not apply_____			
25E If you no longer have it, at what age did it stop? Age in years_____ Does not apply_____			
26 Have you ever had:			
Y	**N**		26A Any other chest illnesses?
			If yes, please specify
Y	**N**		26B Any chest operations?
			If yes, please specify
Y	**N**		26A Any chest injuries?
			If yes, please specify
Y	**N**	**N/A**	27A Has a doctor ever told you that you had heart trouble?
Y	**N**	**N/A**	27B Have you ever had treatment for heart trouble in the past 10 years?
Y	**N**	**N/A**	28A Has a doctor ever told you that you had high blood pressure?
Y	**N**	**N/A**	28B Have you had any treatment for high blood pressure (hypertension) in the past 10 years?
29 When did you last have your chest X-rayed? What year?			
30 Where did you last have your chest X-rayed (if known)?			
30A 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 (circle):

	Father			Mother		
31A Chronic Bronchitis?	Yes	No	Don't Know	Yes	No	Don't Know
31B Emphysema?	Yes	No	Don't Know	Yes	No	Don't Know
31C Asthma?	Yes	No	Don't Know	Yes	No	Don't Know
31D Lung cancer?	Yes	No	Don't Know	Yes	No	Don't Know
31E Other chest conditions?	Yes	No	Don't Know	Yes	No	Don't Know
31F Is parent currently alive?	Yes	No	Don't Know	Yes	No	Don't Know
31G Please specify:	Age if living _____ Age at death_____ Don't know____			Age if living _____ Age at death_____ Don't know____		
31H Please specify cause of death:						

Cough

Y	**N**		32A Do you usually have a cough? (Count a cough with first smoke or on first going out of doors. Exclude clearing throat.)
Y	**N**		32B Do you usually cough as much as 4 to 6 times a day 4 or more days a week?
Y	**N**		32C Do you usually cough at all on getting up or first thing in the morning?
Y	**N**		32D D you usually cough at all during the rest of the day or at night?
Y	**N**	**N/A**	32E Do you usually cough like this on most days for 3 consecutive months or more during the year?
32F For how many years have you had the cough? Number in years_____ Does not apply_____			
Y	**N**		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.)
Y	**N**		33B Do you usually bring up phlegm like this as much as twice a day 4 or more days of the week?

Y	**N**		33C Do you usually bring up phlegm at all on getting up or first thing in the morning?
Y	**N**		33D Do you usually bring up phlegm at all during the rest of the day or at night?
Y	**N**	**N/A**	33E Do you bring up phlegm like this on most days for 3 consecutive months or more during the year?
33F For how many years have you had trouble with phlegm? Number of years_____			

Episodes of Cough and Phlegm

Y	**N**	**N/A**	34A Have you had periods or episodes of (increased) cough and phlegm lasting for 3 weeks or more each year?
34B for how long have you had at least 1 such episode per year? Number of years____			

Wheezing

Y	**N**		35A Does your chest ever sound wheezy or whistling?
Y	**N**		35B Does your chest sound wheezy when you have a cold?
Y	**N**		35C Does your chest sound wheezy occasionally when you do not have a cold?
Y	**N**		35D Does your chest sound wheezy most days or nights?
35E For how many years has wheezing been present? Number of years_____			
Y	**N**		36A Have you ever had an attack of wheezing that has made you feel short of breath?
36B How old were you when you had your first such attack? Age in years____			
Y	**N**	**N/A**	36C Have you had 2 or more such episodes of shortness of breath during a wheezing attack?
Y	**N**	**N/A**	36D Have you ever required medicine or medical treatments for wheezing attacks?

Breathlessness

37 If disabled from walking by any condition other than heart or lung disease, please describe condition: Nature of condition_____ _____		
Y	**N**	38A Are you troubled by shortness of breath when hurrying on a level surface or walking up a slight hill?
		If "yes" answer 38B, 38C, 38D and 38E, if "no" skip to 39A
Y	**N**	38B Do you have to walk slower than people of your age on a level surface because of breathlessness?
Y	**N**	38C Do you ever have to sop for breath when walking at your own pace on a level surface?
Y	**N**	38D Do you ever have to stop for breath after walking about 100 yards (or after a few minutes) on a level surface?
Y	**N**	38E Are you too breathless to leave the house or breathless on dressing or climbing one flight of stairs?

Tobacco Smoking

Y	**N**	39A Have you ever smoked cigarettes? YES means 20 packs or more in your lifetime or 1 or more cigarettes per day for 1 year. If NO skip to question 40A.
Y	**N**	39B Do you now smoke cigarettes (as of one month ago)?
		39C How old were you when you started regular cigarette smoking? _____years old
		39D If you stopped smoking cigarettes completely, how old were you when you stopped? ___years old
		39E How many cigarettes do you smoke per day? _____
		39F On average, for the time you have smoked, how many cigarettes have you smoked per day? _____
		39 G Do/did you inhale cigarette smoke? (check one) □ do/did not inhale □inhale slightly □inhale moderately □inhale deeply

Y	**N**	40A Have you ever smoked a pipe? A standard tobacco pouch holds approximately 1 ½ ounces. YES means more 12 ounces of tobacco in your lifetime. If NO, skip to question 41A.
		40B How old were you when you started to smoke a pipe regularly? _____years old
		40C If you stopped smoking a pipe completely, how old were you when you stopped? _____years old
		40D How much pipe tobacco are you currently smoking PER WEEK? _____ounces (oz)
		40E On average, for the time you have smoked, how much tobacco did you use PER WEEK? _____oz
		40F Do/did you inhale pipe smoke? (check one) □do/did not inhale □inhale slightly □inhale moderately □inhale deeply
Y	**N**	41A Have you ever smoked cigars regularly? YES means more than 1 cigar a week for a year If NO skip to EMPLOYEE CERTIFICATION.
		41B How old were you when you started to smoke cigars regularly? _____years old
		41C If you have stopped smoking cigars completely, how old were you when you stopped? ____ yrs old
		41D On average, for the time you smoked cigars, how many cigars did you smoke per week? _____
		41E How many cigars are you now smoking PER WEEK? _____
		41F Do/did you inhale cigar smoke? (check one) □do/did not inhale □inhale slightly □inhale moderately □inhale deeply

Employee Certification

The answers that I have provided to the questions above are correct to the best of my knowledge.

_____ _____/_____/ 20____

Employee's signature Today's date (mm/dd/yr)

Appendix H Abreviated Asbestos Health Questionnaire

Abbreviated Asbestos Health Questionnaire

Please CIRCLE or PRINT your answers. If you need help with a question, please ask for clarification.

YOUR NAME _____Today's date ____/____/20_____

Job title _____ Employee ID#: _____

Division_____Department_____

HOME street address_____

City_____ State_____ Zip_____

Telephone: Day ( ) _____-_____ Evening ( ) _____-_____

Your date of birth: ____/____/_____ Social Security Number_____

Occupational History

Y	**N**		In the past year, did you work full time (30 hours per week or more) for 6 months or more?
If "yes" please continue, if "no" skip to Recent Medical History			
Y	**N**	**N/A**	In the past year, did you work in a dusty job?
			Was the dust exposure? (*check one*) □ mild □ moderate □ severe
Y	**N**	**N/A**	Have you ever been exposed to chemical gases, fumes or vapors in your work?
			Was the exposure? (*check one*) □ mild □ moderate □ severe

In the past year, what was your job /occupation?
In the past year, what was your job title/position?

Recent Medical History

Y	**N**	Do you consider yourself to be in good health? If NO, please explain:			
In the past year, have you developed:					
Y	**N**	Epilepsy (or fits, seizures, convulsions)?	**Y**	**N**	Rheumatic fever?
Y	**N**	Bladder disease?	**Y**	**N**	Kidney disease?
Y	**N**	Diabetes?	**Y**	**N**	Jaundice?
Y	**N**	Cancer?			

Chest Colds and Chest Illnesses

Y	**N**	**N/A**	If you get a cold, does it “usually” go to your chest? (usually means more than 50% of the time)
Y	**N**	**N/A**	During the past year, have you had any chest illnesses that have kept you off work, indoors at home, or in bed?
If “yes” please continue, if “no” skip to Respiratory System section			
Y	**N**	**N/A**	Did you produce phlegm with any of these chest illnesses?
In the past year, how many illnesses with (increased) phlegm did you have which lasted a week or more? Number of illnesses_____ No such illnesses_____			

Respiratory System

In the past year, have you developed:

Y	**N**	Asthma	**Y**	**N**	Other lung problems
Y	**N**	Bronchitis	**Y**	**N**	Heart disease
Y	**N**	Hay fever	**Y**	**N**	Frequent colds
Y	**N**	Other allergies	**Y**	**N**	Chronic cough
Y	**N**	Pneumonia	**Y**	**N**	Coughing
Y	**N**	Tuberculosis	**Y**	**N**	Wheezing
Y	**N**	Chest surgery	**Y**	**N**	Shortness of breath when walking or climbing a flight of stairs
Y	**N**	Do you smoke cigarettes? Packs per day_____ How many years?_____			

Employee Certification

The answers that I have provided to the questions above are correct to the best of my knowledge.

_____ _____/_____/ 20____

Employee's signature Today's date (mm/dd/yr)

Appendix I Report of Medical Evaluation

FREEPORT-MCMORAN COPPER & GOLD

Personal ☐ Company _____
Industrial ☐
Pre-Employment ☐

REPORT OF MEDICAL EVALUATION

Patient's Name (First, Middle, Last)	Date/Time of Injury/Illness	Date Injury Reported

Examined this patient on: _____ Time: _____ Job Title: _____

☐ Patient may return to work with no limitations on: ☐ To be determined by follow-up evaluation

Patient may return to work with the following limitations/restrictions on:

Patient is discharged from care: ☐ No ☐ Yes Date:

The following restrictions apply (Restrictions are cumulative unless otherwise noted):

Limitations (Please use space in item number 5 below, if additional space is required to explain limitations):

1. In an 8-12 hour work day patient may:

A. Stand/Walk:	B. Sit:	C. Drive:	D. Heights:	E. Environment:
☐ 0 hours	☐ 0 hours	☐ 0 hours	☐ No climbing ladders	☐ Clean
☐ 4 hours maximum	☐ 4 hours maximum	☐ 4 hours maximum	☐ No stair climbing	☐ No restrictions
☐ 8 hours maximum	☐ 8 hours maximum	☐ 8 hours maximum	☐ No repetitive stair climbing	F. Other
☐ 12 hours maximum	☐ 12 hours maximum	☐ 12 hours maximum	☐ No restrictions	☐ See Box #4
☐ No restrictions	☐ No restrictions	☐ No restrictions		

2. Patient is able to:

	Bend	Squat	Climb	Twist	Walk	Kneel	Lifting	
0 hours	☐	☐	☐	☐	☐	☐	☐	0 lbs.
2 hours maximum	☐	☐	☐	☐	☐	☐	☐	20 lbs. maximum
4 hours maximum	☐	☐	☐	☐	☐	☐	☐	30 lbs. maximum
6 hours maximum	☐	☐	☐	☐	☐	☐	☐	40 lbs. maximum
8 hour maximum	☐	☐	☐	☐	☐	☐	☐	50 lbs. maximum
10 hours maximum	☐	☐	☐	☐	☐	☐	☐	No restrictions
12 hours maximum	☐	☐	☐	☐	☐	☐		
No restrictions	☐	☐	☐	☐	☐	☐		

3. Other Restrictions or Instructions: ☐ No overhead work ☐ No repetitive overhead work
☐ No simple grasping ☐ No pushing or pulling ☐ No repetitive use of feet ☐ No use of power tools
☐ Sitting work only ☐ Keep Wound/Cast Clean & Dry ☐ No operating machinery ☐ Allow frequent position change

4. Other findings and/or limitations:

☐ Patient's next appointment is on: ☐ These restrictions are in effect until re-eval on :
☐ Is patient anticipated to return to duty within the next 90 days: ☐ Yes ☐ No
☐ Patient is not able to work at this time.
☐ Release to regular duty without restrictions is anticipated in or on: Days Weeks Date:

5. Medical diagnosis (Nature of injury/Illness for **Industrial Only**):

6 If medications prescribed today are taken during working hours the following is limited:
☐ Driving ☐ Operating Heavy Machinery ☐ Hazardous Tasks ☐ Other (explain):
☐ These medications should not be taken during work hours

Employee Disposition: (Used For Preplacement Exams Only, Not For ICA's)
☐ Employee is medically fit for assigned position or job in question.
☐ Employee is not medically fit for job in question or any other job in the mining sector.
☐ Employee is currently not fit for the job in question, but could be reevaluated at some future date.
☐ Employee is not medically fit for the job in question, but possibly could do another job in the mining sector.

Physician's or PA-C Name Printed:	Physician's or PA-C Signature:	Date:
I authorize release of information to:	Employee Signature:	Date:

HUMAN RESOURCES SERVICE CENTER PHONE #: 1-928-865-6496

LEAVE MANAGEMENT FAX #: 1-928-865-2427

Any release with restrictions must be signed and dated by Workers Compensation Coordinator. If it is not signed or dated send Employees to Employment Office to have release reviewed and employees evaluated to Work Hardening Program.

Appendix J Interval Testing Schedule

DIVISION	MONTH TO SCHEDULE EMPLOYEES FOR OCCUPATIONAL MONITORING											
2012	JAN	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
MINE MAINTENANCE												schedule missed employees
ADMINISTRATION												
LEACHING												
CRUSH AND CONVEY												
CONCENTRATOR												
MAINTENANCE SERVICES												
HYDROMET												
MINE OPERATIONS												
MINE DEVELOPMENT												

Appendix K Interval Testing Requirements by Similar Exposure Group

Division	Similar Exposure Group	Respiratory Protection	Hearing Conservation	Silica Management	Driver Examination	Crane Operator	Lead Management	Asbestos Management
Mine Operations	Truck Driver		1		2			
	Equipment Operator (Shovel, Dozer, Loader, Grader)		1		2			
	Drill Operator	1	1		2			
	Powder Employee		1		2			
	Supervisor							
	Administration and Management							
Mine Maintenance	Mechanic (Shovel, Drill, Diesel, Tire)		1			2		
	Electrician		1			2		
	Welder	1	1			2		
	Machinist		1			2		
	Supervisor		1					
	Administration and Management							
Concentrator	Mill Operator		1					
	Crusher Operator	1	1	1				
	Mill Mechanic		1			2		
	Crusher Mechanic	1	1	1		2		
	Tailings Operator	1	1		2			
	Electrician	1	1	1		2		
	Laborer	1	1	1				
	Metallurgist	1	1					
	Engineer	1	1					
	Management and Administration	1	1					
Crush/Convey	Operator	1	1	1				
	Mechanic	1	1	1		2		
	Electrician	1	1	1		2		
	Metallurgist	1	1					
	Engineer	1	1					
	Supervisor	1	1					
	Management and Administration	1	1					

Division	Similar Exposure Group	Respiratory Protection	Hearing Conservation	Silica Management	Driver Examination	Crane Operator	Lead Management	Asbestos Management
Hydrometallurgy	EW Operator	1	1			2	1	
	SX Operator	1	1					
	Mechanic	1	1			2	1	
	Electrician	1	1			2	1	
	Metallurgist							
	Engineer							
	Supervisor							
	Management and Administration							
Leaching	Operator		1			2		
	Mechanic		1			2		
	Supervisor							
	Management and Administration							
Maintenance Services	Mechanic	1	1			2		
	Electrician		1			2		
	Welder	1	1			2		
	Machinist		1			2		
	RCM Technician	1	1			2		
	Crane Operator		1		2	2		
	Equipment Operator		1		2	2		
	Laborer	1	1					
	Supervisor		1					
	Management and Administration							
Administration	Security Officer							
	Safety Specialist / Operations Technician							
	Sampler Technician		1					
	Supply Technician				2			
	Environmental Technician							
	Supervisor							
	Management and Administration							