INITIAL TEST ENTRY FORM

#

1 2 3 4

5 6 7 8

TO BE COMPLETED BY EMPLOYEE OR PERSONNEL OFFICE:

Company Name [ ]

Last, First Name [ ]

Sex **M / F** Birthdate ___ / ___ / ___ (MM DD YY)

Clock [ ] Shift [ ]

Dept. [ ] Job [ ]

Language **ENG / SPAN / PORTG / VIET**

Noise Level Exp. (if known) [ ]

TO BE COMPLETED BY EMPLOYEE:

	Yes	No
Have you had any hearing problems in the last 3 months?	❑	❑
Hearing Loss of Long Duration	❑	❑
Hearing Loss Recurrent	❑	❑
Ear Surgery	❑	❑
Ear Injury	❑	❑
Draining Ears or Ear Infections	❑	❑
Ear Malformation	❑	❑
Hearing Aid	❑	❑
Mumps	❑	❑
Measles	❑	❑
High Blood Pressure	❑	❑
Head Injuries	❑	❑
With Unconsciousness	❑	❑
Dizziness	❑	❑
Diabetes	❑	❑
Do You Work With Chemicals	❑	❑

Have you ever been exposed to any of the following non-occupational noise sources?

	Yes	No
Snowmobiles/Power Boats/ Motorcycles?	❑	❑
Power Tools/Chain Saws?	❑	❑
Farm Machinery?	❑	❑
Hunting, Trap or Skeet Shooting?	❑	❑
Exposure to loud music?	❑	❑
Flying?	❑	❑
Military Service?	❑	❑
Have you ever seen a doctor about an ear or hearing problem?	❑	❑
Were you ever exposed to loud noise in previous jobs?	❑	❑
Have you worked in noise today?	❑	❑
Have you worn hearing protection today?	❑	❑
___ none ___ plugs ___ muffs ___ both		
Do you have a headcold today?	❑	❑
Ringing Ears	❑	❑

TO BE COMPLETED BY TECHNICIAN:

NONE / P / M / BOTH — Protection

Y / N — 14 hr. quiet

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

Signature of Employee ______________________ Date _______ / _______ / _______

June 2010

INITIAL TEST ENTRY FORM

#

1 2 3 4

5 6 7 8

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Company Name [ ]

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Sex **M / F** Birthdate ___ / ___ / ___ (MM DD YY)

Clock [ ] Shift [ ]

Dept. [ ] Job [ ]

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Noise Level Exp. (if known) [ ]

TO BE COMPLETED BY EMPLOYEE:

	Yes	No
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Hearing Loss Recurrent	❑	❑
Ear Surgery	❑	❑
Ear Injury	❑	❑
Draining Ears or Ear Infections	❑	❑
Ear Malformation	❑	❑
Hearing Aid	❑	❑
Mumps	❑	❑
Measles	❑	❑
High Blood Pressure	❑	❑
Head Injuries	❑	❑
With Unconsciousness	❑	❑
Dizziness	❑	❑
Diabetes	❑	❑
Do You Work With Chemicals	❑	❑

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___ none ___ plugs ___ muffs ___ both		
Do you have a headcold today?	❑	❑
Ringing Ears	❑	❑

TO BE COMPLETED BY TECHNICIAN:

NONE / P / M / BOTH — Protection

Y / N — 14 hr. quiet

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

Signature of Employee ______________________ Date _______ / _______ / _______

June 2010