

ADVERTISEMENT FOR REQUEST FOR PROPOSAL  
COBB COUNTY PURCHASING DEPARTMENT

**BID OPENING DATE: OCTOBER 22, 2009**

Cobb County will receive Sealed Bids before 12:00 NOON, October 22, 2009 in the Cobb County Purchasing Department, 1772 County Services Parkway, Marietta, GA 30008 for:

**SEALED BID # 10 – 5449  
REQUEST FOR PROPOSAL  
PRE-EMPLOYMENT MEDICAL – PSYCHOLOGICAL SERVICES  
COBB COUNTY HUMAN RESOURCES DEPARTMENT**

**No bids will be accepted after the 12:00 noon deadline.**

Proposals are opened at 2:00 p.m. at Cobb County Purchasing Department, 1772 County Services Parkway, 2nd Floor, Bid/Meeting Room, Marietta, GA 30008. Proposals received after the date and time indicated will not be considered.

No proposal may be withdrawn for a period of ninety (90) days after date of bid opening, unless otherwise specified in the bid documents. Cobb County will consider the competency and responsibility of bidders in making the award. Cobb County reserves the right to reject any and all proposals, to waive informalities and technicalities, to reject portions of the proposals, and to award contracts in a manner consistent with the County and the laws governing the State of Georgia.

This solicitation and any addenda are available for download in PDF format on the Cobb County purchasing website. [www.purchasing.cobbcountyga.gov](http://www.purchasing.cobbcountyga.gov)

To request a copy of the proposal documents, **FAX** the following information to the Purchasing Department @ 770-528-1154 or **e-mail** requests to [purchasing@cobbcounty.org](mailto:purchasing@cobbcounty.org):

Company name, contact name, company address, phone number and fax number.

Please reference the proposal number and the title of the proposal in the request

Advertise: OCTOBER 9, 16, 2009



SUBMIT BID/PROPOSAL TO:  
COBB COUNTY PURCHASING DEPARTMENT  
1772 COUNTY SERVICES PARKWAY  
MARIETTA, GA 30008-4012

BID/PROJECT NUMBER: 10-5449

REQUEST FOR PROPOSAL  
PRE-EMPLOYMENT MEDICAL / PSYCHOLOGICAL SERVICES  
COBB COUNTY HUMAN RESOURCES DEPARTMENT

DELIVERY DEADLINE: OCTOBER 22, 2009 BEFORE 12:00 (NOON) EST  
**(NO BIDS/PROPOSALS WILL BE ACCEPTED AFTER THIS DEADLINE).**

OPENING DATE: OCTOBER 22, 2009 @ 2:00 P.M. IN THE PURCHASING DEPARTMENT BID ROOM.

BUSINESS NAME AND ADDRESS INFORMATION:

COMPANY NAME: \_\_\_\_\_

CONTACT NAME: \_\_\_\_\_

COMPANY ADDRESS: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

FAX NUMBER: \_\_\_\_\_

NAME AND OFFICIAL TITLE OF OFFICER GUARANTEEING THIS QUOTATION:

\_\_\_\_\_  
(PLEASE PRINT/TYPE)NAME

\_\_\_\_\_  
TITLE

SIGNATURE OF OFFICER ABOVE: \_\_\_\_\_  
(SIGNATURE)

TELEPHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

BIDDER WILL INDICATE TIME PAYMENT DISCOUNT: \_\_\_\_\_

BIDDER SHALL INDICATE MAXIMUM DELIVERY DATE: \_\_\_\_\_

BIDS RECEIVED AFTER THE DATE AND TIME INDICATED WILL NOT BE CONSIDERED. COBB COUNTY RESERVES THE RIGHT TO REJECT ANY AND ALL BIDS, TO WAIVE INFORMALITIES, TO REJECT PORTIONS OF THE BID, TO WAIVE TECHNICALITIES AND TO AWARD CONTRACTS IN A MANNER CONSISTENT WITH THE COUNTY AND THE LAWS GOVERNING THE STATE OF GEORGIA.

THE ENCLOSED (OR ATTACHED) BID IS IN RESPONSE TO INVITATION NUMBER 10-5449; IS A FIRM OFFER, AS DEFINED BY SECTION O.C.G.A. (S) 11-2-205 OF THE CODE OF GEORGIA (GEORGIA LAWS 1962 PAGES 156-178), BY THE UNDERSIGNED BIDDER. THIS OFFER SHALL REMAIN OPEN FOR ACCEPTANCE FOR A PERIOD OF 90 CALENDAR DAYS FROM THE BID OPENING DATE, AS SET FORTH IN THIS INVITATION TO BID UNLESS OTHERWISE SPECIFIED IN THE BID DOCUMENTS.

NOTICE TO BIDDERS - - BID QUOTES MUST INCLUDE INSIDE DELIVERY CHARGES

ADVERTISE DATES: OCTOBER 9, 16, 2009

## BIDDING INSTRUCTIONS – TERMS AND CONDITIONS

### 1. PREPARATION OF BID:

- (A) Bidders are expected to examine the drawings, specifications, schedules, and all instructions. Failure to do so will be at the bidder's risk.
- (B) Each bidder shall furnish the information required by the bid form. The bidder shall sign and print or type his/her name where designated. The person signing the bid must initial erasures or other changes.
- (C) Unit price for each quotation shall be shown and such price shall include packing unless otherwise specified, along with a total and grand total where applicable. In case of discrepancy between a unit price and extended price, the unit price will be presumed correct.
- (D) Where not otherwise specified, bidders must definitely state DATE OF DELIVERY.

### 2. EXPLANATION TO BIDDERS:

Any explanation desired by a bidder regarding the meaning or interpretation of Invitation to Bids, Request for Proposals or Qualifications, drawings, specifications, etc., must be in writing. All questions must be received within seven (7) business days prior to the bid opening date for a response to be generated by the County to all bidders in the form of an addendum. If any statement in the bidding documents, specifications, etc., appears ambiguous to the bidder, the bidder is specifically instructed to make a written request to the Purchasing Department, unless otherwise outlined in the specifications. Any information given to a prospective bidder concerning an Invitation for Bid will be furnished to all prospective bidders, as an addendum to the invitation, if such information is necessary to bidders in submitting bids on the invitation or if the lack of such information would be prejudicial to uninformed bidders. Receipt of the addendum by a bidder must be acknowledged on the bid or by letter received before the date and time specified for the bid opening. **ORAL EXPLANATION OR INSTRUCTIONS GIVEN BEFORE THE AWARD OF THE CONTRACT WILL NOT BE BINDING.**

### 3. SUBMISSION OF BIDS: FACSIMILE BIDS WILL NOT BE CONSIDERED.

- (A) Any Bid Package and modifications thereof shall be enclosed in a sealed envelope, addressed to the office specified in the Invitation to Bid, with the name and address of the bidder, the date and hour of bid opening, and name of bid. A bid reply label will be included in most bid packages stating the above referenced information. Any bid package NOT having bid information on outside of package could be opened as regular mail, and bid could be disqualified.
- (B) Samples of items, when required, must be submitted within the time specified, unless otherwise specified by the County, and at no expense to the County
- (C) An item offered must at least meet specifications called for and must be of quality which will adequately service the purpose and use for which it was intended.
- (D) Full identification of each item bid upon, including brand name, make, model, and catalog number, must be furnished according to the bid specifications if requested to identify exactly what the bidder is proposing. Supporting literature may be furnished to further substantiate the proposal.
- (E) The bidder represents that the article(s) to be furnished under this Invitation to Bid is (are) new and that the quality has not deteriorated so as to impair its usefulness.
- (F) Bids cannot be withdrawn or corrected after the bid opening (except reductions or changes by the successful bidder which would be beneficial or advantageous to the County). The County as deemed necessary may reject changes.
- (G) Cobb County is exempt from Federal Excise Tax and Georgia Sales Tax.
- (H) Cobb County does not accept conditional bids.

### 4. DEFAULT:

The Award as a result of bids received under this invitation may be in part based on the delivery factor. Accordingly, should delivery fail to be performed within the time specified by the bidder, the bid may then be declared in default of the contract. In such event, the County may then proceed to purchase in the open market the items from another source.

### 5. F.O.B. POINT:

Unless otherwise stated in the Invitation to Bid and any resulting contract, all articles will be F.O.B. Destination. This means delivered, unloaded, and placed in the designated place.

### 6. AWARD OF CONTRACT:

The Contract will be awarded to the responsible bidder whose bid will be the most advantageous to the County, price, and other factors considered. The County will make the determination. The County reserves the right at any time to reject any and all bids, to waive informalities and technicalities, to award portions of the bid, and to award contracts consistent with the County and the laws governing the State of Georgia. Normal payment terms are net thirty (30) days after receipt of invoice by the Finance Department.



**COBB COUNTY**  
PURCHASING DEPARTMENT  
1772 County Services Parkway  
Marietta, Georgia 30008-4012  
(770) 528-8400/FAX (770) 528-1154  
www.cobbcounty.org

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## **IMPORTANT NOTICE – PLEASE READ CAREFULLY!!**

All vendors are required to submit the ORIGINAL AND AT LEAST one (1) duplicated copy of any bid submitted to Cobb County. Please refer to your bid specifications to determine if more than one (1) copy is required. Non-submission of a duplicate copy may disqualify your bid/proposal.

A “**SEALED BID LABEL**” has been enclosed to affix to your bid. This label ***MUST*** be affixed to the outside of the envelope or package, **even if it is a “NO BID” response**. Failure to attach the label may result in your bid being opened in error or not being routed to the proper location for consideration. No bid will be accepted after the date and time specified. **IT IS THE VENDOR’S RESPONSIBILITY TO ENSURE THAT EACH BID HAS BEEN RECEIVED IN A TIMELY MANNER.**

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### **BIDS MUST BE RECEIVED BEFORE 12:00 (NOON) ON BID OPENING DAY**

Bids must be received at the Cobb County Purchasing Department. **Any bids received later than 12:00 (noon) will not be accepted.** The County accepts no responsibility for delays in the mail. Bids are to be mailed or hand delivered to:

COBB COUNTY PURCHASING DEPARTMENT  
1772 COUNTY SERVICES PARKWAY  
MARIETTA, GA 30008-4012

*Bids will be opened at 2:00 P.M. in the Cobb County Purchasing Department, 1772 County Services Parkway, 2<sup>nd</sup> Floor, Conference/Bid Room, Marietta, GA 30008.*

Thank you in advance for your cooperation.

## SEALED BID LABEL

### **SEALED BID ENCLOSED**

DELIVER TO:  
COBB COUNTY PURCHASING  
1772 County Services Parkway  
Marietta, GA 30008-4012

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**SEALED BID # 10-5449 DATE: October 22, 2009**

**BIDS MUST BE RECEIVED BEFORE 12:00 NOON**

**DESCRIPTION: Request for Proposal  
Pre-Employment Medical / Psychological Services**

**PLEASE ATTACH LABEL TO OUTSIDE OF BID PACKAGE**



*Cobb County...Expect the Best!*

**REQUEST FOR PROPOSAL**

**SEALED BID # 10 – 5449  
PRE-EMPLOYMENT MEDICAL / PSYCHOLOGICAL SERVICES  
COBB COUNTY HUMAN RESOURCES DEPARTMENT**

**BID OPENING DATE: OCTOBER 22, 2009**

BIDS ARE RECEIVED IN THE  
COBB COUNTY PURCHASING DEPARTMENT  
1772 COUNTY SERVICES PARKWAY  
MARIETTA, GEORGIA 30008  
**BEFORE 12:00 (NOON) BY THE BID OPENING DATE**

BIDS WILL BE OPENED IN THE COBB COUNTY PURCHASING DEPARTMENT  
**BID/MEETING ROOM AT 2:00 P.M.**

**VENDORS ARE REQUIRED TO SUBMIT THE ORIGINAL AND 5 COPIES OF BID  
(UNLESS OTHERWISE SPECIFIED IN BID SPECIFICATIONS)**

**N.I.G.P. COMMODITY CODE: 94874**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

REPRESENTATIVE: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

E-MAIL \_\_\_\_\_

**NOTE: The Cobb County Purchasing Department will not be responsible for the accuracy or completeness of the content of any Cobb County Invitation to Bid or Request for Proposal or subsequent addenda thereto received from a source other than the Cobb County Purchasing Department.**



*Cobb County...Expect the Best!*

**"STATEMENT OF NO BID"**

COBB COUNTY PURCHASING DEPARTMENT  
1772 COUNTY SERVICES PARKWAY  
MARIETTA, GA 30008

TO ALL PROSPECTIVE BIDDERS:

Because of the many requests to be placed on our vendors' list, we are continuously updating the list. While we want to include all bona fide vendors, we do not want to mail bids to those vendors who may no longer be interested in participating in our bidding process.

If you do not choose to respond to the attached Invitation to Bid/Request for Proposal, please fill out the form below indicating whether or not you want to be retained on our current vendor list.

Vendors who do not respond in any way (by either submitting a bid or by returning this form) over a period of one year may be removed from the current vendor list.

**Vendors who do not wish to bid often return the entire bid package, sometimes at considerable postage expense. Returning the entire bid package is not necessary. Simply return this form.**

Thank you for your cooperation.  
Cobb County Purchasing Department

**"STATEMENT OF NO BID"  
SEALED BID NUMBER 10-5449  
REQUEST FOR PROPOSAL  
PRE-EMPLOYMENT MEDICAL / PSYCHOLOGICAL SERVICES**

If you do not wish to respond to the attached Invitation to Bid/Request for Proposal, please complete this form and mail/fax to: **Cobb County Purchasing Department, Attention: Sealed Bid Department, 1772 County Services Parkway, Marietta, GA. Fax # 770-528-1154**

I do not wish to submit a bid/proposal on this solicitation.

**I wish to be retained on the vendor list for this commodity or service: Yes \_\_\_\_\_ No \_\_\_\_\_**

Please PRINT the following:

\_\_\_\_\_ Company

\_\_\_\_\_ Representative

You are invited to list reasons for your decision not to bid: \_\_\_\_\_

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

**COBB COUNTY REQUEST FOR PROPOSALS  
MEDICAL/PSYCHOLOGICAL SERVICES  
SEALED BID #10-5449**

**COBB COUNTY REQUEST FOR PROPOSALS**

**PRE-EMPLOYMENT  
MEDICAL/ PSYCHOLOGICAL SERVICES**

**SEALED BID #10-5449**

**COBB COUNTY REQUEST FOR PROPOSALS  
MEDICAL/PSYCHOLOGICAL SERVICES  
SEALED BID #10-5449**

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Attachments

- A: Law Enforcement Medical Standards
- B: Various Public Safety Special Units Forms
- C: Cobb County Drug Free Workplace Policy
- D: Blood Borne Pathogens Exposure Form
- E: POST Physician's Affidavit
- F: GA. Firefighters Standards & Training Council Medical Affidavit

Note: NFPA Medical Standard is available upon request (due to the length of the document, it is not included in this RFP).

**COBB COUNTY REQUEST FOR PROPOSALS  
MEDICAL/PSYCHOLOGICAL SERVICES  
SEALED BID #10-5449**

**Cobb County General Instructions For Proposers, Terms and Conditions**

***I. Preparation of Proposals***

Each proposer shall examine the drawings, specifications, schedule, and all instructions. Failure to do so will be at the proposer's risk.

Each proposer shall furnish all information required by the proposal form or document. Each proposer shall sign the proposal and print or type his or her name on the schedule. The person signing the proposal must initial erasures or other changes. An agent authorized to bind the company must sign proposals.

***II. Delivery***

Each proposer should state time of proposed delivery of goods or services. Words such as "immediate", "as soon as possible", etc. shall not be used. The known earliest date or the minimum number of calendar days required after receipt of order (delivery A.R.O.) shall be stated (if calendar days are used, include Saturday, Sunday and holidays in the number).

***III. Explanation To Proposers***

Any explanation desired by a proposer regarding the meaning or interpretation of the request for proposal, drawings, specifications, etc. must be received by **5:00 pm on Tuesday, October 13, 2009** in order for a reply to reach all proposers before the close of the proposal. Requests received after this deadline will not receive a reply. Any information given to a prospective proposer concerning a request for proposal will be furnished to all prospective proposers as an addendum to the invitation if such information is necessary or if the lack of such information would be prejudicial to uninformed proposers.

The written proposal document supersedes any verbal or written communication between parties. Receipt of addenda must be acknowledged in the proposal. Although the Purchasing Division will take effort to send any addendum to known proposers, it is the proposer's ultimate responsibility to ensure that they have all applicable addenda prior to proposal submittal. This may be accomplished via contact with the Purchasing Division prior to proposal submittal.

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**IV. *Submission of Proposals***

Proposals shall be enclosed in a sealed package, addressed to the Cobb County Purchasing Department with the name and address of the proposer, the date and hour of opening, and the request for proposal number on the face of the package. Telegraphic/faxed proposals will not be considered. Any addenda should be enclosed in the sealed envelopes as well.

Samples of items, when required, must be submitted within the time specified and, unless otherwise specified by the County, at no expense to the County. Unless otherwise specified, samples will be returned at the proposer's request and expense if testing does not destroy items. Items offered must meet required specifications and must be of a quality that will adequately serve the use and purpose for which intended.

Full identification of each item proposed, including brand name, catalog number, etc. must be furnished to identify exactly what the proposer is offering. Manufacturer's literature may be furnished. The proposer must certify that the items to be furnished are new and that the quality has not deteriorated so as to impair its usefulness.

Unsigned proposals will not be considered.

Cobb County is exempt from federal excise tax and Georgia sales tax with regards to goods and services purchased directly by Cobb County. Suppliers and contractors are responsible for federal excise tax and sales tax, including taxes for materials incorporated in county construction projects. Suppliers and contractors should contact the State of Georgia Sales Tax Division for additional information.

Except as otherwise provided by law, information submitted by a proposer in the proposal process shall be subject to disclosure after proposal award in accordance with the Georgia Open Records Act. Proprietary information must be identified. Entire proposals may not be deemed proprietary.

**V. *Withdraw Proposal Due To Error***

To withdraw a proposal after proposal opening, the supplier has up to forty-eight (48) hours to notify the Cobb County Purchasing Department of an obvious clerical error made in calculation of proposal. Withdrawal of bid bond for this reason must be done in writing. Suppliers who fail to request withdrawal of proposal by the required forty-eight (48) hours shall automatically forfeit bid bond. Bid bond may not be withdrawn otherwise.

No proposer who is permitted to withdraw a proposal shall, for compensation, supply any material or labor or perform any subcontract or other work agreement

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for the person or firm to whom the contract is awarded or otherwise benefit, directly or indirectly, from the performance of the project from which the withdrawn proposal was submitted.

Proposal withdrawal is not automatically granted and will be allowed solely at the discretion of Cobb County.

**VI. *Testing and Inspection***

Since tests may require several days for completion, the County reserves the right to use a portion of any supplies before the results of a test are determined. Cost of inspections and tests of any item that fails to meet specifications shall be borne by the proposer.

**VII. *F.O.B. Point***

Unless otherwise stated in the request for proposal and any resulting contract, or unless qualified by the proposer, items shall be shipped F.O.B. Destination. The seller shall retain title for the risk of transportation, including the filing for loss or damages. The invoice covering the items is not payable until the items are delivered and the contract of carriage has been completed. Unless the F.O.B. clause states otherwise, the seller assumes transportation and related charges either by payment or allowance.

**VIII. *Patent Indemnity***

The contractor guarantees to hold the County, its agents, officers or employees harmless from liability of any nature or kind for use of any copyrighted or uncopyrighted composition, secret process, patented or unpatented invention, articles or appliances furnished or used in the performance of the contract, for which the contractor is not the patentee, assignee or licensee.

**IX. *Bid, Payment & Performance Bonds***

NOT USED

**X. *Discounts***

Time payment discounts will be considered in arriving at net prices and in award of proposal. Offers of discounts for payment within ten (10) days following the end of the month are preferred.

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In connection with any discount offered, time will be computed from the date of delivery and acceptance at destination, or from the date correct invoice or voucher is received, whichever is the later date. Payment is deemed to be made for the purpose of earning the discount, on the date of the County check.

**XI. Insurance**

**See page 41 for Insurance Requirements**

**XII. Award**

Award will be made to the highest scoring responsive and responsible proposer according to the criteria stated in the proposal documents. The County may make such investigations as it deems necessary to determine the ability of the proposer to perform, and the proposer shall furnish to the County all such information and data for this purpose as the County may request. The County reserves the right to reject any proposal if the evidence submitted by, or investigations of such proposer fails to satisfy the County that such proposer is properly qualified to carry out the obligations of the contract.

The County reserves the right to reject or accept any or all proposals and to waive technicalities, informalities and minor irregularities in the proposals received. The County reserves the right to make an award as deemed in its best interest which may include awarding a proposal to a single proposer or multiple proposers; or to award the whole proposal, only part of the proposal, or none of the proposal to single or multiple proposers, based on its sole discretion of its best interest.

**XIII. County Furnished Property**

The County will furnish no material, labor or facilities unless so provided in the RFP.

**XIV. Rejection of Proposals**

Failure to observe any of the instructions or conditions in this request for proposal may constitute grounds for rejection of proposal.

**XV. Contract**

Each proposal is received with the understanding that the acceptance in writing by the County of the offer to furnish any or all of the commodities or services described therein shall constitute a contract between the proposer and the County

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SEALED BID #10-5449**

which shall bind the proposer on his part to furnish and deliver the articles quoted at the prices stated in accordance with the conditions of said accepted proposal. The County, on its part, may order from such contractor, except for cause beyond reasonable control, and to pay for, at the agreed prices, all articles specified and delivered.

Upon receipt of a proposal containing a Cobb County "Sample Contract" as part of the requirements, it is understood that the proposer has reviewed the documents with the understanding that Cobb County requires that all agreements between the parties must be entered into via these documents. If any exceptions are taken to any part, each exception must be stated in detail and submitted as part of the proposal document. If no exceptions are stated, it is assumed that the proposer fully agrees to the "Sample Contract" in its entirety. The County reserves the right to make changes to the "Sample Contract".

When the contractor has performed in accordance with the provisions of this agreement, Cobb County shall pay the contractor within a reasonable time any payment requested based upon work completed or service provided pursuant to the contract, the sum so requested, less the retainage stated in this agreement, if any. The County's normal payment terms are net thirty (30) days after receipt of invoice.

***XVI. Delivery Failures***

Failure of a contractor to deliver within the time specified or within reasonable time as interpreted by the Purchasing Director, or failure to make replacements of rejected articles/services when so requested, immediately or as directed by the Purchasing Director, shall constitute authority for the Purchasing Director to purchase in the open market or rebid for articles/services of comparable grade to replace the articles/services rejected or not delivered. On all such purchases, the contractor shall reimburse the County within a reasonable time specified by the Purchasing Director for any expense incurred in excess of contract prices, or the County shall have the right to deduct such an amount from monies owed the defaulting contractor. Alternatively, the County may penalize the contractor one percent (1%) per day for a period of up to ten (10) days for each day that delivery or replacement is late. Should public necessity demand it, the County reserves the right to use or consume articles/services delivered which are substandard in quality, subject to an adjustment in price to be determined by the Purchasing Director.

***XVII. Non-Collusion***

By submission of a proposal, the proposer certifies, under penalty of perjury, that to the best of its knowledge and belief:

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- (a) The prices in the proposal have been arrived at independently without collusion, consultation, communications, or agreement, for the purpose of restricting competition, as to any matter relating to such prices with any other vendor or with any competitor.
- (b) Unless otherwise required by law, the prices which have been quoted in the proposal have not been knowingly disclosed by the proposer prior to opening, directly or indirectly, to any other proposer or to any competitor
- (c) No attempt has been made, or will be made, by the proposer to induce any other person, partnership or corporation to submit or not to submit a proposal for the purpose of restricting competition.

Collusion and fraud in bid preparation shall be reported to the State of Georgia Attorney General and the United States Justice Department.

**XVIII. Conflict Of Interest, Etc.**

By submission of a proposal, the proposer certifies, under penalty of perjury, that to the best of its knowledge and belief:

- 1. No circumstances exist which cause a Conflict of Interest in performing the services required by this RFP, and
- 2. That no employee of the County, nor any member thereof, not any public agency or official affected by this RFP, has any pecuniary interest in the business of the responding firm or his sub-consultant(s) has any interest that would conflict in any manner or degree with the performance related to this RFP.

The responding firm also warrants that he and his sub-consultant(s) have not employed or retained any company or person other than a bona fide employee working solely for the responding firm or sub-consultant(s) to solicit or secure a contract agreement with Cobb County, as related to this RFP, and that he and his sub-consultant(s) have not paid or agreed to pay any person, company, corporation, individual, or firm other than a bona fide employee working solely for the responding firm or his sub-consultant(s) any fee, commission, percentage, gift, or other consideration contingent upon or resulting from the award of this Agreement.

For any breach or violation of this provision, the County shall have the right to terminate any related contract or agreement without liability and at its discretion to deduct from the price, or otherwise recover, the full amount of such fee, commission, percentage, gift, payment or consideration.

The successful responding firm shall require each of its sub-consultant(s) to sign a statement certifying to and agreeing to comply with the terms of the subsections above.

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***XIX. Default***

The contract may be cancelled or annulled by the Purchasing Director in whole or in part by written notice of default to the contractor upon non-performance or violation of any contract term. An award may be made to the next highest rated responsive and responsible proposer, or articles specified may be purchased on the open market similar to those terminated or the County may issue a new Request for Proposal. In any event, the defaulting contractor (or his surety) shall be liable to the County for costs to the County in excess of the defaulted contract prices; provided, however, that the contractor shall continue the performance of this contract to the extent not terminated under the provisions of this clause. Failure of the contractor to deliver materials or services within the time stipulated on its proposal, unless extended in writing by the Purchasing Director, shall constitute contract default.

***XX. Disputes***

Except as otherwise provided in the contract documents, any dispute concerning a question of fact arising under the contract which is not disposed of shall be decided after a hearing by the Purchasing Director who shall reduce his/her decision to writing and mail or otherwise furnish a copy thereof to the contractor. The decision of the Purchasing Director shall be final and binding, however, the contractor shall have the right to appeal said decision to a court of competent jurisdiction.

***XXI. Substitutions***

Proposers offering and quoting on substitutions or who are deviating from the attached specifications shall list such deviations on a separate sheet to be submitted with their proposal. The absence of such a substitution list shall indicate that the proposer has taken no exception to the specifications contained therein.

***XXII. Ineligible Proposers***

The County may choose not to accept the proposal of one who is in default on the payment of taxes, licenses or other monies owed to the County. Failure to respond three (3) consecutive times for any given commodity may result in removal from the list under that commodity.

***XXIII. General Information***

**COBB COUNTY REQUEST FOR PROPOSALS  
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Sealed proposals, with original signatures, will be accepted by the County Purchasing Department at the time, place, and date specified. One (1) original and five (5) copies of the proposal must be submitted, complete with a cover letter signed by an official within the organization who has authority over project negotiation.

These proposals must be in accordance with the purposes, conditions, and instructions provided in this RFP. The Cobb County Board of Commissioners assumes no responsibility for proposals received after the submission time, whether due to mail delays or any other reason. Proposals received after the submission time will be filed unopened and considered non-responsive.

Cobb County reserves the right to retain all proposals submitted, and to use any idea in any proposal regardless of whether that proposal is selected. All work performed by the successful respondent shall be performed in compliance with the Americans With Disabilities Act.

***XXIV. Uniformity Of Proposal***

To facilitate comparative analysis and evaluation of proposals it is desired that a uniform format be employed in structuring each proposal. The respondent's degree of compliance with the requirements of the RFP will be a factor in the subsequent point-based evaluation of the proposal. Proposals with major deviations or omissions may not be considered for detailed study. Proposals will become part of the contract with Cobb County should they be selected under the RFP.

***XXV. Request Additional Information***

Inquiries that must be answered in regards to the Proposal procedures or technical matters shall be submitted in writing via U.S. Mail or facsimile to:

Mr. Rick Brun, Purchasing Director  
Cobb County Purchasing Division  
1772 County Services Parkway  
Marietta, Georgia 30008-4021  
Fax: (770) 528-1154  
Email: [purchasing@cobbcounty.org](mailto:purchasing@cobbcounty.org)

Correspondence should be submitted only to the designated individual. All inquiries must be in writing. Copies of all inquiries and responses shall be shared with all known recipients of the RFP by addendum. **All inquiries must be received by Tuesday, October 13, 2009 by 5:00 pm.** Cobb County will not orally or telephonically address any question or clarification regarding specifications or procedures. Cobb County is not bound by any oral

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representations, clarifications, or changes made to the written specification by County employees, unless such clarification or change is provided to the respondent in written addendum form from Cobb County.

***XXVI. Firm Prices***

Prices quoted by proposal shall be firm and best prices. Prices quoted must be valid for a minimum of ninety days (90) days from the date of bid opening.

***XXVII. Proposal/Presentation Costs***

The cost for developing a proposal will be borne by the respondent. Cobb County is not liable for any costs incurred by the respondent in preparation and/or presentation of proposals in response to this RFP or for travel and other costs related to this RFP.

***XXVIII. Proposal Format***

Presentation of the relevant information is at the discretion of the respondent; however, the proposal must address all items identified in Section Titled, Proposal Requirements. To assist in the evaluation of proposals resulting from the RFP, it is recommended that each proposal be written in a concise and forthright manner and that unnecessary marketing statements and materials be avoided.

***XXIX. Indemnification/Hold Harmless***

By submission of a proposal, the selected responding firm agrees to indemnify Cobb County to the fullest extent permitted by law, protect, defend, indemnify and hold harmless Cobb County, its officers, officials, employees and volunteers from and against all claims, actions, liabilities, losses (including economic losses), or costs arising out of any actual or alleged a) bodily injury, sickness, disease, or death; or injury to or destruction of tangible property including the loss of use resulting there from; or any other damage or loss arising out of or resulting claims resulting in whole or part from any actual or alleged act or omission of the responding firm, sub-consultant, anyone directly or indirectly employed by any of them; or anyone for whose acts any of them may be liable in the performance of work; b) violation of any law, statute, ordinance, governmental administrative order, rule, regulation, or infringements of patent rights or other intellectual property rights by the responding firm in the performance of work; or c) liens, claims or actions made by the responding firm or other party performing the work, as approved by Cobb County.

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The indemnification obligations herein shall not be limited to any limitation on the amount, type of damages, compensation, or benefits payable by or for the responding firm or its sub-consultant(s), as approved by the County, under workers' compensation acts, disability benefit acts, other employee benefit acts, or any statutory bar or insurance.

**XXX. Proposal Evaluation**

The Evaluation process will address current requirements and consider possible future operation and maintenance needs. Both objective and subjective rationale will be involved in the decision process.

1. Evaluation Responsibility  
A selection committee will coordinate the review of all proposals and will submit a recommendation to the County Manager and Board of Commissioners.
2. Presentations  
During the evaluation process, the members of the selection committee may require that responding firms conduct a presentation. If required, these presentations will be scheduled in advance and limited in time. Location of the presentations will be pre-arranged.
3. Evaluation Criteria  
The County will use a specific set of criteria for the qualitative evaluation of competitive proposals. The structure of the evaluation will be to assign points to each response in a number of categories. A non-response to a specific category will result in no points being awarded for that category. Final rankings will be based on a combination of price and qualitative factors.

The specific qualitative categories may include, but not be limited to, the following:

1. Staff qualifications
2. Performance/Experience of the firm on projects of similar nature, magnitude and complexity
3. Approach to providing services, including training and support, and scope of work
4. Financial Stability
5. Availability of the firm to conduct the work
6. Cost

**All proposal requirements must be met, or capable of being met by the responding firm or the proposal will be disqualified as non-responsive. It is extremely important that project schedules are met. Only those firms or teams with the necessary resources and a commitment to complete all project work on schedule should submit a Proposal.**

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***XXXI. Multi-Year Contract Provisions***

The successful respondent will be required to enter into a contract containing the provisions as required by Georgia law pertaining to multi-year contracts. The following is a sample of the provision and will be adjusted as to the term or as to the length of the contract.

This contract shall terminate absolutely and without further obligation on the part of Cobb County at the close of the calendar year in which it was executed, and at the close of each succeeding calendar year for which it may be renewed as provided in O.C.G.A. Section 36-60-13. The contract shall automatically renew for each of the remaining calendar years provided for in the contract, unless positive action is taken by Cobb County to terminate such contract, and the nature of such action shall be written notice provided to the consulting firm within sixty (60) days before the end of the initial year of the contract or each succeeding remaining calendar year.

This contract shall terminate immediately and absolutely at such time as appropriated and otherwise unobligated funds are no longer available to satisfy the obligations of Cobb County under this contract.

***XXXII. Proposal Requirements***

The respondents must demonstrate competence and experience in the area of expertise outlined in this Request for Proposal.

Respondents must demonstrate competence and experience in public speaking and graphic presentations for the purpose of conveying project information to large and diverse community groups. Respondents should also demonstrate the ability to build consensus among public and private interest groups related to this project.

***XXXIII. Cover Letter/Executive Summary***

Respondents shall provide a cover letter or letter of transmittal to briefly summarize the company's interest and relevant qualifications for the project. This letter shall not exceed two (2) pages, and shall be signed by an agent of the responding firm who is authorized to negotiate the details of the proposed services.

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**XXXIV. Project Team**

Respondents shall provide an organizational chart for the proposed project team, as well as the relevant background and experience for every proposed team member.

**XXXV. Special Terms And Conditions**

Should these General Terms and Conditions be in conflict with any attached Special Terms and Conditions, the Special Terms and Conditions will control.

**XXXVI. Disadvantaged Business Enterprises (DBE): The following provisions should be carefully read to determine applicability to your business.**

Cobb County Government encourages the participation of all businesses in offering their services and/or products. The Cobb County Government has the goal to fairly and competitively procure the best product at the most reasonable cost.

A Disadvantaged Business Enterprise (DBE) is generally defined as a Female, Black American, Hispanic American and any other minority owned business. The Federal Government has long had program in place to ensure participation of DBE vendors and suppliers. The State of Georgia has established a similar program whereby DBE firms are defined, certified and made known. This effort is managed by the Georgia Department of Transportation (GDOT). More information can be obtained from GDOT web site:

1. <http://www.dot.state.ga.us/eo-div/index.shtml>

The Cobb County Government addresses DBE business participation (frequency and dollar value) in the following ways:

1. Cobb County wishes to identify all DBE participation; both at the contractor and sub-contractor levels in the following ways.
  - a. DBE businesses are requested to identify such status at the time they register as a vendor.
  - b. DBE businesses are requested to identify themselves at the time they propose to do business. Please complete **EXHIBIT B** if applicable and return with bid submittal.
  - c. All businesses will receive with each Purchase Order an instruction sheet for use of the furnished *Cobb County Government DBE*

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*Participation Report, EXHIBIT C.* Businesses are requested to complete this report and submit it with each invoice for the time period billed.

2. Cobb County has established a Disadvantaged Business Enterprise Plan in accordance with the regulations of the U.S. Department of Transportation (U. S. Department of Transportation (USDOT), 49 CFR Part 26.) The Cobb County Department of Transportation is the lead agency for implementing the USDOT DBE Program for the County.

*The Plan applies only to projects which are clearly indicated by the County.*

***XXXVII. Americans With Disabilities Act***

Cobb County requires all contractors to comply with applicable sections of the Americans With Disabilities Act (ADA) as an equal opportunity employer. In compliance with the Americans With Disabilities Act (ADA), Cobb County provides reasonable accommodations to permit a qualified applicant with a disability to enjoy the privileges of employment equal to those employees without disabilities. Disabled individuals must satisfy job requirements for education background, employment experience, and must be able to perform those tasks that are essential to the job with or without reasonable accommodations.

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**XXXVIII. Evidence of Compliance with Georgia Security & Immigration  
Compliance Act**

The County and Contractor agree that compliance with the requirements of O.C.G.A. Sec. 13-10-91 and Rule 300-10-1-.02 of the Rules of the Georgia Department of Labor are conditions of this Agreement for the physical performance of services.

\_\_\_\_\_  
Contractor Name

The Contractor further agrees that its compliance with the requirements of O.C.G.A. Sec. 13-10-91 and DOL Rule 300-10-1-.02 is attested to on the executed Contractor Affidavit and Agreement attached hereto as EXHIBIT A.

If employing or contracting with any subcontractor(s) in connection with this Agreement, Contractor further agrees:

- (1) To secure from the subcontractor(s) such subcontractor(s)' indication of the employee-number category applicable to the subcontractor(s); and
- (2) To secure from the subcontractor(s) an affidavit attesting to the subcontractor's compliance with O.C.G.A. Sec. 13-10-91 and DOL Rule 300-10-1-.02; such affidavit being in the form attached hereto and referenced as EXHIBIT A-1; and
- (3) To submit such subcontractor affidavit(s) to the County when the subcontractor(s) is retained, but in any event, prior to the commencement of work by the subcontractor(s).

The failure of Contractor to supply the affidavit of compliance at the time of execution of this Agreement and/or the failure of Contractor to continue to satisfy the obligations of O.C.G.A. Sec. 13-10-91 and DOL Rule 300-10-1-.02 as set forth in this Agreement during the term of the Agreement shall constitute a material breach of the contract. Upon notice of such breach, Contractor shall be entitled to cure the breach within ten (10) days, upon providing satisfactory evidence of compliance with the terms of this Agreement and State law. Should the breach not be cured, the County shall be entitled to all available remedies, including termination of the contract and damages.

**THIS PAGE MUST BE SUBMITTED WITH BID PACKAGE**

*SEE AFFIDAVITS ON FOLLOWING PAGES*

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**CONTRACTOR AFFIDAVIT & AGREEMENT  
EXHIBIT A**

By executing this affidavit, the undersigned contractor verifies its compliance with O.C.G.A. § 13-10-91, stating affirmatively that the individual, firm or corporation which is contracting with Cobb County, Georgia, has registered and is participating in a federal work authorization program\* [an electronic verification of work authorization program operated by the U.S. Department of Homeland Security or any equivalent federal work authorization program operated by the U.S. Department of Homeland Security to verify information of newly hired employees, pursuant to the Immigration Reform and Control Act of 1986 (IRCA), P.L. 99-603], in accordance with the applicability provisions and deadlines established in O.C.G.A. § 13-10-91.

The undersigned further agrees that should it employ or contract with any subcontractor(s) for the physical performance of services pursuant to the contract with Cobb County, Georgia, the contractor will secure from the subcontractor(s) verification of compliance with O.C.G.A. § 13-10-91 on the attached Subcontractor Affidavit. (EXHIBIT A-1) The contractor further agrees to maintain records of such compliance and shall provide a copy of each such verification to Cobb County, Georgia, at the time the subcontractor(s) is retained to perform such services.

BY: \_\_\_\_\_  
Authorized Officer or Agent  
[Contractor Name]

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

\_\_\_\_\_  
Title

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Company Name

SUBSCRIBED AND SWORN  
BEFORE ME ON THIS THE  
\_\_\_ DAY OF \_\_\_\_\_, 200\_

\_\_\_\_\_  
Notary Public  
My Commission Expires:

\_\_\_\_\_  
*\*The applicable federal work authorization program as of the effective date of the statute is the Basic Pilot program of the Systematic Alien Verification for Entitlements (SAVE) Program Office of U.S. Citizenship and Immigration Service (USCIS).*

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**SUBCONTRACTOR AFFIDAVIT  
EXHIBIT A-1**

By executing this affidavit, the undersigned subcontractor verifies its compliance with O.C.G.A. § 13-10-91, stating affirmatively that the individual, firm or corporation which is engaged in the physical performance of services on behalf of Cobb County, Georgia, has registered and is participating in a federal work authorization program\* [an electronic verification of work authorization program operated by the U.S. Department of Homeland Security or any equivalent federal work authorization program operated by the U.S. Department of Homeland Security to verify information of newly hired employees, pursuant to the Immigration Reform and Control Act of 1986 (IRCA)], in accordance with the applicability provisions and deadlines established in O.C.G.A. § 13-10-91.

BY: \_\_\_\_\_  
Authorized Officer or Agent  
[Contractor Name]

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

\_\_\_\_\_  
Title

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Company Name

SUBSCRIBED AND SWORN  
BEFORE ME ON THIS THE  
\_\_\_\_ DAY OF \_\_\_\_\_, 200\_

\_\_\_\_\_  
Notary Public  
My Commission Expires:

\_\_\_\_\_

*\*The applicable federal work authorization program as of the effective date of the statute is the Basic Pilot program of the Systematic Alien Verification for Entitlements (SAVE) Program Office of U.S. Citizenship and Immigration Service (USCIS).*

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**COBB COUNTY REQUEST FOR PROPOSALS  
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**EXHIBIT B**

**DISADVANTAGED BUSINESS ENTERPRISE (DBE) IDENTIFICATION  
FORM**

A Disadvantaged Business Enterprise (DBE) is generally defined as a Female, Black American, Hispanic American and any other minority owned business. If your firm is classified as a Disadvantaged Business Enterprise (DBE), please complete this form and submit with bid response or send to:

Cobb County Purchasing Department  
Attn: Mr. Rick Brun, Purchasing Director  
1772 County Services Parkway  
Marietta, GA 30008  
Fax: 770-528-1154  
Email: [purchasing@cobbcounty.org](mailto:purchasing@cobbcounty.org)

Name of Firm: \_\_\_\_\_

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

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

MBE Certification Number: \_\_\_\_\_

Name of Organization Certification \_\_\_\_\_

**This information is acquired for informational purposes only and will  
have no bearing on the award unless otherwise stated**

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**Instructions for Completing Exhibit C**  
**Disadvantaged Business Enterprise (DBE)**  
**Participation Report**

All Cobb County Government contractors or vendors are requested to complete a report descriptive of any DBE subcontractor involvement in work for which the government is making payment. If otherwise specified in an RFP or contract, additional reporting forms may be required as well.

The objective of this request is to assist in the identification of Disadvantaged Business Enterprise (DBE) business participation with the Cobb County Government and to quantify that participation.

The Cobb County Government does not administer a DBE Certification Program. The principle certification agency for the State of Georgia is the Georgia Department of Transportation. As a Contractor/Vendor you are not responsible for verification of any DBE Certification information of your subcontractor.

**\*\*\* Instructions \*\*\***

1. Contractor/Vendor is furnished the one-page *DBE Participation Report* form with each Cobb County Government-issued Purchase Order.
2. Contractor/Vendor completes this form for each billing period and attaches it to the invoice to then be sent to the Cobb County Government.
3. Upon receipt of a Contractor/Vendor invoice, County staff should simply separate the completed DBE form and transmit to:

Cobb County Purchasing Department,  
Attn.: DBE Report

A Disadvantaged Business Enterprise (DBE) is a firm that is under the control of someone in an ownership position (at least 51%) that:

1. Has membership in one or more of the following groups: Female, Black American, Hispanic American, Native American, Subcontinent Asian American and Asian-Pacific America. There may be other groups that may be eligible to be certified as DBE;
2. Is a U.S. citizen or lawfully admitted permanent resident of the U.S.;
3. Has a personal net worth which does not exceed \$750,000; and,
4. The business meets the Small Business Administration's size standard for a small business and does not exceed \$17.42 million in gross annual receipts;
5. The business is organized as a for-profit business.
6. The business may also be DBE eligible as a certified U.S. Small Business Administration 8(a) program.

**EXHIBIT C**  
**Cobb County Government Disadvantaged**  
**Business Enterprise Participation Report**

→ *PLEASE keep this blank form to make copies for actual use as needed. Also, please print or type in the form.* ←

Submitted by: \_\_\_\_\_ Period Invoiced: \_\_\_\_\_  
**Name of Prime Contractor/Vendor** **From/To:**  
Cobb County Project Name: \_\_\_\_\_ Bid or P.O. Number: \_\_\_\_\_  
Cobb County Department or Agency receiving service or product: \_\_\_\_\_  
Description of Purchased Service/Product: \_\_\_\_\_  
Full Contracted Amount: \$\_\_\_\_\_ Payment amount requested at this time: \$\_\_\_\_\_

1. Are YOU, the Prime Contractor or Vendor a DBE business? YES \_\_\_\_\_ NO \_\_\_\_\_
2. Please provide the following information for each subcontractor participating during this reporting period:

Subcontractor Business Name	Type Service or Product Supplied	Subcontractor Business/Contact Tel. Number	Actual Dollar Value of Subcontractor Participation this Reporting Period
			\$
			\$
			\$
			\$
			\$
			\$
			\$

Submitted by: \_\_\_\_\_  
Printed Name

Title or position: \_\_\_\_\_

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

Signature of Authorized Representative

**County Departments: Please send this completed form to the Cobb County Purchasing Department, ATTN: DBE Report**

## **INTRODUCTION**

### BACKGROUND

COBB COUNTY, GEORGIA, a political subdivision of the State of Georgia, provides services for the safety and general welfare of an unincorporated population of approximately 673,000 residents. Such services are provided under the authority of the Board of Commissioners and the Constitutional Officers of the County.

Cobb County has approximately 4,400 full time positions and about 1,000 part-time positions, with an operating budget of \$756,400,000 for fiscal year 2009.

### PHYSICAL AND PSYCHOLOGICAL EXAMINATIONS

#### *Employment Post-Offer - Medical*

The County requires physical exams only for applicants with moderate and heavy demand physical requirements, safety sensitive and for public safety applicants. The medical standards for law enforcement are provided in Attachment A. The firefighter medical standards are the same as those recommended by the National Fire Protection Association (NFPA). These standards are available upon request, but not attached to this RFP due to the length of the documentation. (**Please note:** These standards may be revised.)

#### *Employment Post-Offer - Psychological*

Applicants that are being considered for law enforcement, firefighter or juvenile courts probation officer's positions are required to submit to a clinical psychological examination which requires that a licensed psychiatrist or psychologist administer and grade a battery of psychological tests and conduct an oral interview. Based on the results of the tests and interview, the psychiatrist/psychologist must make a written recommendation whether the candidate is suitable for hire.

#### *Return to Work/Fitness for Duty - Medical*

When an employee has been physically injured, incapacitated, or otherwise unable to perform the duties of the job or where the supervisor identifies issues with an individual's physical abilities to perform the duties of the position, the County may require that a "fitness for duty" physical be administered to determine if the employee is able to return to work. When conducting these physicals, the physician compares the job requirements/demands with the employee's physical condition and determines whether the employee can perform the essential functions of the position. If the physician recommends that the employee is able to return to work with restrictions or accommodations, these should be stated in writing.

#### *Return to Work/Fitness for Duty – Psychological*

When an employee has been psychologically incapacitated, or otherwise mentally unable to perform the duties of the job or where the supervisor identifies issues with an individual's abilities to perform the duties of the position due to possible psychological reasons the County may require that a "fitness for duty" psychological evaluation be administered to determine if the employee is able to return to work. When conducting these evaluations, the psychiatrist or psychologist compares the job requirements/demands with the employee's psychological condition and determines whether the employee can perform the essential functions of the position. If the psychiatrist or psychologist recommends that the employee is able to return to work with restrictions or accommodations, these should be stated in writing.

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*Annual Physicals for Public Safety Special Unit Team Members*

The County requires physical exams for Haz Mat, Bomb Squad and Dive Team to ensure that only physically healthy employees are working in these demanding positions. Each Special Units Team has different forms that must be completed by the physician. Each Unit may have different tests required. See Attachment B for examples of the various forms.

*WORKERS' COMPENSATION CASES*

Services required that are related to workers' compensation issues include: providing initial and follow-up treatment for on-the-job injuries; providing medical opinions regarding the ability of employees to return to work with or without restrictions; and providing employees' disability ratings if applicable.

*DRUG SCREENS*

*Random*

The day for this type of drug test is chosen randomly; the County will attempt to give the provider a 24 hour advanced notice of this day. Additionally, the provider must be willing to provide after hours testing for employees that work night shift. It is expected that the tests will be completed early and as quickly as possible on the specified day so the employees are able to return to work in a timely manner.

*Reasonable Suspicion and Post-Accident*

The Cobb County Drug Free Workplace Policy (see Attachment C) also requires a drug test for any employee

- (1) for whom there exists reasonable suspicion that the employee has come to work under the influence of a drug, including alcohol; and
- (2) is mandatory when the accident involves a fatality, other injury and/or if the employee received a citation for a moving violation.

For all drug screens (random, reasonable suspicion, and post-accident), a medical review officer (MRO) must be available to review the results of the drug test.

*HEPATITIS VACCINATION PROGRAM*

Newly-hired sworn and certified employees in the County's public safety departments (Fire, Police, and Sheriff's Office) are required to have a series of three (3) hepatitis vaccinations, using a synthetically produced vaccine (Engerix B or equivalent) administered according to the manufacturer's guidelines.

*TESTING FOR BLOOD-BORNE PATHOGENS AND INFECTIOUS DISEASES*

Testing of blood-borne pathogens and infectious diseases for employees will be handled through the County's medical provider. The Blood Borne Exposure Follow-Up form is given as Attachment D.

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**NUMBER OF SERVICES PERFORMED PER AREA TYPE IN 2008**

TYPE OF EXAMINATION	NUMBER CONDUCTED
Post Offer Physical Exam – Public Safety	321
Post Offer Physical Exam – Mod/Heavy Demands	173
Post Offer Psychological Evaluations	321
Return to work/fitness for duty- Medical Exams	70
Return to work/fitness for duty- Psychological Evals	15
Public Safety Special Unit Physicals	50
Worker’s Compensation Cases Referred	40 per month
Random Drug Screens	200
Hepatitis Vaccinations	100 sets
Testing for blood borne pathogens	5

\* These figures are not guaranteed numbers per year and are for informational purposes only.

**PURPOSE**

This Request for Proposals (RFP) is being issued to secure services in the following areas for three (3) years with an option to extend for two (2) additional one (1) year periods:

- I. Physical examination
  - A. Employment post-offer
  - B. Return to work/fitness for duty
  - C. Annual examinations for Special Unit team members
  
- II. Psychological examination
  - A. Employment post-offer
  - B. Return to work/fitness for duty
  - C. Threat Assessment
  
- III. Evaluation and treatment of workers’ compensation cases
  
- IV. Drug screens
  
- V. Hepatitis vaccinations
  
- VI. Testing for blood-borne pathogens and infectious diseases

**Respondents may propose to provide services in any or all areas (I-A, I-B, I-C, II, III, IV, V and/or VI)**

Proposals must follow the RFP format.

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**SCOPE OF SERVICES**

I. *Physical exams*

A. Employment post-offer (5 groups)

**Group 1: Public Safety-Law Enforcement**

**This group includes:**

**Deputy Sheriff**

**Police Officer**

These employees are expected to encounter the most physically demanding job duties. They may not only be called upon to perform at maximum physical capacity at any time, but they must do so under circumstances where physical breakdown could be life-threatening to themselves or others because of the hazardous nature of their work assignments.

It is proposed that applicants for law enforcement public safety positions receive an examination that includes the following:

1. Review of Medical Questionnaire
2. Complete physical examination by physician
3. Vision test:                      Near and distant vision  
  Visual field  
  Depth perception  
  Color perception
4. Hearing test:                      Audiogram
5. Back assessment
6. Laboratory tests:
  - (a) Urinalysis
  - (b) Drug screen: per Cobb County Drug Free Workplace Policy (see Attachment C) using a non-regulated 10-panel
7. Written report of examination results that clearly states if the applicant passed or failed the exam including the completion of a POST Physician's Affidavit (see Attachment E).

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**Group 2: Public Safety-Firefighter**

These employees are expected to encounter the most physically demanding job duties. They may not only be called upon to perform at maximum physical capacity at any time, but they must do so under circumstances where physical breakdown could be life-threatening to themselves or others because of the hazardous nature of their work assignments. It is proposed that applicants for firefighter positions receive an examination that conforms to the NFPA medical standards and includes the following:

1. Review of Medical Questionnaire
2. Complete physical examination by physician
3. Vision test:      Near and distant vision  
                          Depth perception  
                          Color perception
4. Hearing test:     Audiogram
5. Pulmonary function
6. Laboratory tests:
  - (a) Urinalysis
  - (b) Drug screen: per Cobb County Drug Free Workplace Policy (see Attachment C) using a non-regulated 10-panel
7. Back assessment
8. Written report of examination results that clearly states if the applicant passed or failed the exam including completion of Georgia Firefighter Standards and Training Council Medical Affidavit (see Attachment F).

**Group 3: Public Safety-Emergency 911 Operators**

1. Review of Medical Questionnaire
2. Complete physical examination by physician
3. Vision test:      Near and distant vision  
                          Depth perception  
                          Color perception
4. Hearing test:     Audiogram
5. Laboratory tests:
  - (a) Urinalysis
  - (b) Drug screen: per Cobb County Free Workplace Policy (see Attachment C) non-regulated 10 panel
6. Written report of examination results that clearly states if the applicant passed or failed the exam including completion of a POST physician's affidavit.

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**Group 4: Heavy and Moderate Demands**

Heavy Demands

This group consists of jobs which regularly require one or more of the following:

- exerting up to **100 pounds** of force **occasionally**
- exerting up to **50 pounds** of force **frequently**
- exerting up to **20 pounds** of force **constantly**
- repetitive awkward motions of the trunk or back
- frequent bending, squatting, stooping, crouching, twisting, or climbing
- prolonged standing
- exposure to poor environmental conditions (loud noise, cold, heat, noxious inhalants, wet weather, skin irritants, etc.)
- exposure to hazardous equipment
- exposure to hazardous work sites (such as irregular surfaces)

Moderate Demands

Includes those job classifications which place moderate physical demands upon employees. This group consists of jobs which regularly require one or more of the following:

- exerting up to **50 pounds** of force **occasionally**
- exerting up to **20 pounds** of force **frequently**
- exerting up to **10 pounds** of force **constantly**
- standing, twisting, squatting, bending, or reaching repeatedly, frequently, or for prolonged periods
- exposure to poor environmental conditions (loud noise, noxious inhalants, skin irritants, cold/hot temperatures, wet weather, etc.)

The post-offer physical examination would include the following:

1. Review of Medical Questionnaire
2. Review of physical requirements of the position provided by Human Resources.
3. Complete physical examination by physician, to include all appropriate tests as determined by the physician including the DOT physical if applicable.
4. Vision test:                      Near and distant vision  
  Color perception
5. Hearing test:                      Audiogram
6. Back assessment
7. Laboratory tests:
  - (a) Urinalysis

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- (b) Drug screen: Per Cobb County Drug Free Workplace Policy non-regulated 10 panel screen. The 5 panel regulated screen is required for DOT employees.
- 8. Written report of examination findings that clearly states if the applicant passed or failed the exam.

**Group 5: Other Safety Sensitive Employees**

- 1. Laboratory tests:  
Drug screen: per Cobb County Drug Free Workplace Policy (see Attachment C) non-regulated 10 panel
  - 2. Report of drug test results
- B. Return to work/fitness for duty

An employee would be required to submit to a return-to-work/fitness for duty physical exam for non-workers' comp injuries or illnesses to determine the ability of the employee to continue to work or to return to work with or without restrictions.

The fitness-for-duty physical exam would include at a minimum the following:

- 1. Review of physical requirements/demands and duties of employee's position.
  - 2. Review of any medical information provided by attending physician.
  - 3. Appropriate medical exam to evaluate employee's physical ability to return to work.
  - 4. Order from specialist any exams needed to make an informed, independent decision on the employee's ability to return to work.
  - 5. Compare job requirements with employee's health status and other relevant factors to make a decision regarding return to work.
  - 6. Prepare written statement regarding employee's ability to continue to work or to return to work with or without restrictions.
- C. Annual physical exams for Public Safety Special Unit team members

Each special unit team have different types of exams, the most comprehensive is the Haz Mat physical that includes:

- (1) Physical examination per physician – annually
- (2) Medical work history – initially and updated annually
- (3) Lab studies annually – CBC, chemical profile, and urinalysis including:  
Glucose, LDH, Red blood count, Uric acid, SGOT, Hemoglobin, BUN, SGPT, Hematocrit, Creatinine, Iron, MCV, Sodium, Cholesterol, MCH, Potassium, Triglyceride, MCHC, Chloride, HDL, Platelets, Calcium, VLDL, Polys, Phosphorus,

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- LDL, Lymphs, Protein, TSH, Monocytes, Albumin-SRM, T4Thyroxine, EOS, Billrubin, T3, Alkaline phosphatase, White blood count
- (4) Pulmonary function tests (FVC and FEV1) – annually
- (5) Stool Hemocult testing – annually for haz mat
- (6) Chest X-ray – every five years up to age 40, then every three years
- (7) EKG – annually
- (8) Vision Test
- (9) Audiogram

D. Specific criteria for providing medical services

1. At a minimum, the contractor's medical facility and staff must be available to provide services between the hours of 8:00 a.m. and 5:00 p.m. Monday through Friday and provide for after hours drug testing. The contractor must give the County at least one week's notice of closing for holidays or other special events, and two weeks notice if there is to be a change in regular office hours.
2. Post-offer physical exams must sometimes be scheduled and conducted on short notice (for example, the contractor would be called in the morning to schedule an exam for that morning or afternoon). Average waiting time between arrival at the clinic and the time the service is provided should be less than 15 minutes. Total time in the center on average should be less than 1 hour and 30 minutes. The provider will allow non-injury physicals to be scheduled.
3. The actual physical examination must be conducted by a licensed physician. However, routine measurements and laboratory samples may be taken by nurses or appropriately licensed or qualified technicians. All results must be reviewed by a licensed physician.
4. Test results will be verified for accuracy to eliminate the need for retesting.
5. Examination results (i.e.; an indication of "pass" "fail" or "conditional pass with reasonable accommodation") will be sent to the Human Resources Department within 24 hours of the examination. A hard copy of the exam results will be provided within five (5) working days.
6. The contractor must ensure the availability of a principal physician during normal working hours (8:00 a.m. – 5:00 p.m., Monday through Friday) as a contact source to respond to questions from the Human Resources Department staff relating to medical examinations and services.
7. The contractor will maintain complete records on each individual examined. Such records will be confidential and will be available only to the contractor, and those County employees (i.e., managers, supervisors, etc) with a specific job-related need for such information.
8. The contractor must have equipment and personnel for back-up and/or emergencies to assure prompt scheduling of medical examinations.
9. The County may require expert medical advice and consultation (including research results and recommendations) on occasion for determining new or

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revising existing medical guidelines or changes in medical procedures and examinations for future specific needs.

10. The County will accept charges only for those services first requested by the County. All Cobb County Government invoices will be reviewed by the appropriate employees and sent to the appropriate Cobb County Representative monthly.
11. The contractor must be capable of acting as the County's medical review officer (MRO) to review results of drug test.
12. The contractor must have in place an accurate billing system that allows bills to be itemized per the County's specifications and sent to the County Human Resources Department on a monthly basis or the County's Third Party Administrators as required by Worker's Compensation.
13. Turn around time of drug screens should be 1-2 days on negative and up to 5 days on potential positive results. All chain of custody paperwork should be properly labeled to correctly identify the individual that was tested and list Cobb County Government as the employer.
14. All post offer physical, fitness for duty or return to work paperwork will be reviewed daily to ensure that it is complete and accurate. This will be performed by the appropriate personnel and the originals will be delivered to a Cobb County Representative. All results of physicals will be faxed or scanned within 24 hours.
15. An Injury Utilization Report will be provided quarterly for reviews.
16. Part-time physicians are not to see Cobb County Government employees.

II. *Psychological Evaluations*

A. Employment post-offer

A test battery including objective, job-related and validated psychological instruments should be administered to the applicants to include at a minimum a personality inventory, substance abuse screen and a security risk assessment. A semi-structured, face-to-face, job-related interview format should be conducted before a final psychological report is submitted. Finally, a written report of examination results should be sent that clearly states if the applicant passed or failed the exam.

B. Return to work/fitness for duty

The fitness-for-duty psychological evaluation would include at a minimum the following: a review of psychological requirements/demands and duties of employee's position, a review of any psychological/medical information provided by physician, psychiatrist or psychologist, an appropriate psychological exam to evaluate employee's ability to return to work, an order from specialist any exams needed to make an informed, independent decision on the employee's ability to return to work, a comparison of job requirements with employee's mental health status and other relevant factors to make a decision regarding return to work, a prepared written

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statement regarding employee's ability to return to work, with or without accommodation.

C. Threat assessment

From time to time, allegations or concerns about employee threats of workplace violence will necessitate an assessment to determine if an employee poses an unacceptable threat of injury or violence to himself or others. Upon request, the Provider should be capable of immediate consultations with employer's representative(s) and of reviewing situations and interviewing individuals under time constraints to determine the level of threat posed, if any, and to recommend any therapeutic or preventive workplace measures relative to the safety of employee and the general public

D. Specific criteria for providing psychological services

1. At a minimum, the contractor's medical facility and staff must be available to provide services between the hours of 8:00 a.m. and 5:00 p.m. Monday through Friday. Provisions should be made for emergency after hour calls for employees that may be suffering from severe trauma or suicidal thoughts. The contractor must give the County at least one week's notice of closing for holidays or other special events, and two weeks notice if there is to be a change in regular office hours.
2. Post-offer psychological exams must sometimes be scheduled quickly. For example, the contractor would be called in the morning to schedule an exam within the next 48 hours.
3. Only licensed or certified psychiatrists or psychologists trained and experienced in psychological test interpretation including experience with law enforcement psychological assessment will be considered. Practitioners should be familiar with the research literature available on psychological testing, as well as, state and federal laws relevant to this area of practice including the Americans with Disabilities Act.
4. Data on attributes considered most important for effective performance in a particular position should be obtained from job analysis, interview, survey or other appropriate sources. Test results will be verified for accuracy to eliminate the need for retesting. The testing instruments should be legally defensible in court and legal contentions and sensitive to any cultural biases.
5. Examination results (i.e.; an indication of "pass" "fail" or "conditional pass with reasonable accommodation") will be sent to the hiring department with 24 hours of the examination. A hard copy of the exam results will be provided within seven (7) working days.
6. The contractor must ensure the availability of a principal psychiatrist/psychologist during normal working hours (8:00 a.m. – 5:00 p.m., Monday through Friday) as a contact source to respond to questions from the Human Resources Department staff relating to evaluations and services.
7. The contractor will maintain complete records on each individual examined. Such records will be confidential and will be available only to the contractor,

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and those County employees (i.e., managers, supervisors, etc) with a specific job-related need for such information.

8. The contractor must have personnel for back-up and/or emergencies to assure prompt scheduling of evaluations.
9. The County may require expert advice and consultation (including research results and recommendations) on occasion for determining new or revising existing guidelines or changes in procedures and evaluations for future specific needs.
10. The County will accept charges only for those services first requested by the County.
11. The contractor must have in place an accurate billing system that allows bills to be itemized per the County's specifications and sent to the County Human Resources Department on a monthly basis.

III. *Evaluation and treatment of workers' compensation cases*

There are typically six (6) situations where an employee would require the services of the county physician as related to a workers' compensation case:

1. To obtain an evaluation of an injury that is sustained on the job and to receive treatment if necessary.
2. To receive follow-up treatment resulting from an on-the-job injury.
3. To rate an employee's disability as it relates to a work related injury.
4. To provide medical opinions and/or releases regarding the ability of an employee to return to work with or without restrictions.
5. To assist the County with Worker's Compensation claims by providing opinions and testimony as needed.
6. To provide releases for limited fitness for duty/return-to-work with restrictions when appropriate.

The contractor must exhibit knowledge of requirements for qualifying the County for workers' compensation and Subsequent Injury Trust Fund recovery. The County maintains a panel of physicians; the successful vendor would be added to this list.

IV. *Drug screens*

Per the County's Drug Free Workplace Policy, examples of other types of drug tests that will be required are for reasonable suspicion and post-accident tests.

When drug tests are administered, the procedure outlined in the County's policy shall be followed explicitly, ensuring that the chain of custody can be established from the time the sample is given to the time it is prepared for shipment to the lab. The successful bidder must also agree to amend its specimen collection practices should the federal law be amended to allow different methods of detecting controlled substances in the body. Any

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changes to the County's policy, based on changes in the law or otherwise, will be provided to the successful bidder and will be binding upon the successful bidder.

A NIDA-certified lab must be used to analyze the specimen results. For tests of employees holding CDLs, the split specimen procedure must be followed, as given in the County's Drug Free Workplace Policy. It is preferable that the lab be located within the metro Atlanta area, as well as the second lab used to test the split specimen, in the event of court appearances by lab staff members.

A medical review officer (MRO) must be available on-site to review the results of the tests. The MRO must also be available to testify when subpoenaed, along with any other necessary staff members.

Results of drug tests are to be reported to the Human Resources Department within 48 hours of the administration of the test, for tests with negative results. For tests with positive results, results should be reported **only after** the confirmatory test has been completed and the MRO has contacted or attempted to contact the employee pursuant to the County policy, but within five (5) working days of the administration of the test.

V. Hepatitis vaccinations

A series of three (3) vaccinations, using a synthetically produced vaccine (enginerix B or equivalent), will be administered to new firefighters in the Fire Department according to the manufacturers guidelines. The location of vaccination administration will be in Cobb County at a central location to be specified in the RFP response.

All employees will be post-tested to identify those employees who have not developed the necessary immunity after the normal three-shot sequence.

Booster shots will be administered for those employees identified in the above paragraph, in the same manner as given in the first paragraph.

Records as necessary will be maintained, to show each employee's immunization history (individual records that can be filed in each employees personnel file). Also to be maintained is an overall record that will allow Cobb County to see the status of each employee from start to finish of the program.

VI. Testing for blood-borne pathogens and infectious diseases

Under the County's Worker's Compensation Program, the practice is to test for exposure to blood-borne pathogens or infectious diseases when exposure is the result of a traumatic event (stabbing, fluid thrown in the employee's face/eyes, puncture by a needle).

See Attachment D for the Exposure Follow-Up form.

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**SPECIAL TERMS AND CONDITIONS**

1. All RFP responses will be evaluated for completeness and clarity according to the criteria established in the RFP to determine the most qualified firms. ( Please refer to page 13 for evaluation criteria)
2. Responses will be rank-ordered and interviews (either by phone or in person) of the highest ranked firms will be held by November 23, 2009 to ensure and clarify a full understanding of services to be provided and/or to further examine firm qualifications. It is anticipated that the successful firm will be recommended to the Purchasing Department for approval by November 10, 2009.
3. Rick Braun of the Cobb County Purchasing Department will act as the contact person regarding this RFP; his telephone number is 770-528-8416.
4. **An original and five (5) copies of the completed RFP response must be submitted to the Cobb County Purchasing Department, 1772 County Services Parkway, Marietta, Georgia 30008, before 12:00 noon on October 22, 2009. No bids will be accepted after the 12:00 noon deadline.**
5. Each respondent is to prepare the response according to the RFP format.
6. Cobb County reserves the right to reject any or all RFP responses submitted or any portion of a response, contact client references, required clarification or additional information, or require interviews with respondents. All costs related to the preparation, submittal, or presentation related to this RFP are the responsibility of the respondent and will not be assumed in full or in part by Cobb County.
7. All materials submitted in response to the RFP become the property of Cobb County and will be returned only at the option of the County. The County has the right to use any or all ideas presented in any response to the RFP whether amended or not, and selection or rejection of the proposal does not affect this right.
8. Bids will be opened at 2:00 p.m. on October 22, 2009 at the Cobb County Purchasing Department, 1772 County Services Parkway, Marietta, Georgia 30008.

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PROPOSED RFP SCHEDULE

RFP Advertised	October 9, 2009 October 16, 2009
RFP Due Date/Bid Opening (at Purchasing Bldg.)	Before 12:00 noon, October 22, 2009 (RFP's received after 12:00 noon will not be accepted)
Finalists Notified of Interview Times	By October 27, 2009
Visit Facilities of Finalists	By October 29, 2009
Finalist Interviews and Negotiations	By November 3, 2009
Obtain approval of County Manager	By November 5, 2009
Recommendation of Selected Firm to Board of Commissioners	November 10, 2009
Effective Date of Services	January 1, 2010

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FIRM INFORMATION

1. Firm Name:  
  
Address:  
  
Telephone #:
  
2. Name of Firm Contact:  
  
Telephone #:
  
3. Who will serve as the firm's authorized representative and negotiator? The person cited will be empowered to make a binding commitment for the respondent. This person must be available for an interview by November 3, 2009, if the firm is selected as a finalist.  
  
Name:  
  
Title:  
  
Address:  
  
Telephone #:
  
4. Please include firm's most recent annual financial statement.

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CLIENT REFERENCE INFORMATION

Following the format below, provide complete client reference information for three (3) firms/agencies for whom you currently provide services. Use additional pages as necessary.

Client:

Client Contact

Name:

Title:

Telephone #:

Date service first provided for this client:

Number of client's full-time employees:

Narrative of services performed:

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KEY PHYSICIAN'S / PSYCHOLOGIST'S QUALIFICATIONS AND AVAILABILITY

Provide the name, telephone number, narrative of qualifications, and a narrative statement of availability of the key physician/psychologist your firm designates to work with and assist the County in implementing services and performing follow-up/liaison work.

This person must be available for an interview on by November 3, 2009, if the firm is selected as a finalist.

Name:

Title:

Telephone #:

Qualifications (education, years experience, area of specialty, board certified? etc.)

Statement of availability/commitment:

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STAFF PHYSICIANS' AND PSYCHOLOGISTS' QUALIFICATIONS AND AVAILABILITY

Provide the name, telephone number, narrative of qualifications, and a narrative statement of availability of all staff physicians/psychologist your firm designates to work with the County in providing medical services as outlined in this RFP. Use additional pages as necessary (one physician per page).

Name:

Title:

Telephone #:

Qualifications (education, years of experience, area of specialty, number of similar assignments, board certified? etc.)

At what hospitals does this physician have admitting privileges?

Statement of availability/commitment:

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CONFLICT OF INTEREST STATEMENT

As a duly authorized representative of \_\_\_\_\_  
(Firm)

I, \_\_\_\_\_  
(Name) (Title)

Certify to the best of my knowledge that no circumstances exist which will cause a conflict of interest in performing services for Cobb County Government; that no employee of Cobb County, nor any public agency officials or employee affected by this Request for Proposals, has a pecuniary interest in the business of this firm, associates, or consultants of this firm, or the firm's parent firm, subsidiary, or other legal entity of which this firm is a part; and that no person associated with or employed by this firm has any interest that would conflict in any manner or degree with the performance of services for Cobb County Government. (The successful bidder will be required to execute this form no later than the time of contract negotiation.)

DATE: \_\_\_\_\_

COMPANY NAME: \_\_\_\_\_

AUTHORIZED REPRESENTATIVE NAME:

\_\_\_\_\_

TITLE: \_\_\_\_\_

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

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INSURANCE REQUIREMENTS

The firm certifies that if it is selected to provide services according to the conditions of this RFP, it will provide the County with proof of professional liability insurance for malpractice of at least \$1,000,000 per occurrence. The insurance policy will be written through an insurance company authorized to conduct business in the state of Georgia. Should insurance coverage be cancelled or changed, the firm will submit to the County a 60-day notice of cancellation.

The firm agrees to indemnify and save harmless the County, its officials, and employees from and against any loss or expense by reason of any liability arising from or out of the performance of services provided due to negligence of the firm and its staff, its agents, or employees.

A certified copy of proof of insurance must be delivered to and received by the Cobb County Finance Department, Risk Management Division, 100 Cherokee Street, Marietta, Georgia 30090, no later than **November 5, 2009**. Final contract award is contingent upon Cobb County's acceptance of insurance documentation.

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Signed

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Officer Title

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Date

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Witness

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GENERAL INFORMATION: PROPOSED SERVICES- MEDICAL

Please provide responses to the following questions:

1. What are your office hours?
2. If you change your regular office hours, will you give the County at least two weeks notice of this change?
3. Will you give the County at least one week's notice of the closing of your office for holidays?
4. Lead time required for an appointment
5. Is there X-ray equipment on site?
6. Will a radiologist review X-rays?
7. Do you operate your own laboratory ("lab")?
8. If so, is the lab licensed by the state?
9. Is the lab certified by the Substance Abuse and Mental Health Services Administration (SAMHSA)?
10. Where is the lab located?
11. Will you use an outside lab for any services?
12. If so, what is the name of the lab you use?
13. Is this lab licensed by the state?
14. Is this lab certified by SAMHSA?
15. Where is this lab located?
16. What lab will perform testing on split specimens? (Must be different from lab testing initial specimen).
17. Is this lab licensed by the state?
18. Is this lab certified by SAMHSA?
19. Where is this lab located?
20. How long does it take your firm to obtain the results of drug tests?
21. How long does it take to obtain confirmation of positive drug test results?
22. Is the key physician of your firm board-certified?
23. What is the key physician's specialty or field of practice?
24. Are all physicians on your staff board-certified?
25. Do you have a facility in Cobb County?

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26. If so, what is the address?
27. If your firm is not currently located in Cobb County, would you be willing to establish a facility here by January 1, 2010?
28. Is the key physician qualified to act as a Medical Review Officer (MRO) for drug test results?
29. Is the MRO on-site Monday-Friday, 8-5?
30. Is the MRO willing to perform all functions required to be performed by a MRO pursuant to the County policy?
31. Will accurate bills be sent to the County, in a format that is mutually acceptable to the contractor and the County?
32. How do you ensure that your staff follows proper protocols?
33. What is the staff turnover rate of your firm?
34. What is the average wait time at the facility to see a doctor?
35. On average, how long does a physical take—from the time the individual gets there until he/she leaves?
36. Would afterhours drug testing be available?
37. Will examination results be sent to HR Dept. within 24 hours of the examination?
38. Do you have personnel available for backup and emergencies so that post offer physicals would continue to be conducted in your absence?

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GENERAL INFORMATION: PROPOSED SERVICES- PSYCHOLOGICAL

Please provide responses to the following questions:

1. What are your office hours?
2. If you change your regular office hours, will you give the County at least two weeks notice of this change?
3. Will you give the County at least one week's notice of the closing of your office for holidays?
4. Will you be using a board-certified psychiatrist or a licensed psychologist to conduct psychological examinations?
5. What is the key psychiatrist's or psychologist's specialty or field of practice?
6. Do you have a facility in Cobb County?
7. If so, what is the address?
8. If your firm is not currently located in Cobb County, would you be willing to establish a facility here by October 1, 2009?
9. Will accurate bills be sent to the County, in a format that is mutually acceptable to the contractor and the County?
10. How do you ensure that your staff follows proper protocols?
11. What is the staff turnover rate of your firm?
12. What is the average wait time at the facility to see a psychiatrist/psychologist?
13. How long does an average evaluation take—from the time the individual gets there until he/she leaves?
14. Will provisions be made for emergency after hour calls for employees that may be suffering from severe trauma or suicidal thoughts?
15. Will evaluation results be sent to the HR Dept. within 24 hours of the examination?
16. Do you have personnel available for backup and emergencies so that psychological exams would continue to be conducted in your absence?

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GENERAL INFORMATION: PROPOSED SERVICES- WORKER'S COMPENSATION

Please provide responses to the following questions:

1. Do you have an emergency facility (walk-in without appointment)?
2. Physical therapy on site?
3. List the types of treatment provided.
4. After evaluation or treatment, please describe the method used to report status of employees and when they can return to work.
5. List of physicians you would use on referral basis and their areas of specialty.
6. What hospital you would use on referral?
7. Do you have timely billing and reporting systems?

GENERAL INFORMATION: PROPOSED SERVICES- DRUG TESTING

Please provide responses to the following questions:

1. Would you adhere to the procedures **exactly** as described in the Cobb County Drug Free Workplace Policy (see Attachment C)?
2. Would you have a qualified MRO on-site at all times during normal working hours to review results of test, to contact employees prior to verify positive test results, and to inform the Human Resources Director (or designee) of verified positive test results?
3. Would you report results of negative tests to the Human Resources Department within 48 hours of test administration?
4. Would you report results of positive tests (to include results of confirmatory tests) to the Human Resources Department within five (5) working days of test administration?
5. Would you have a specimen collection site that conforms to the requirements of the County's Drug Free Workplace Policy?
6. Did you have the ability to accommodate at least six (6) employees at once for random tests?

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IA. PROPOSED SERVICES AND FEES: POST-OFFER EMPLOYMENT PHYSICALS  
 (explanation of services required is located on page 7-10 of this document)

**TYPE SERVICE**

**PROPOSED FEE FOR SERVICE**  
 (Quote for 3 years only or 3 years  
 with two 1-year extensions)

**Give fees per applicant.**

<b>Group 1: Public Safety-Law Enforcement (Deputy Sheriff, Police Officer)</b>		<b>10/09- 10/10</b>	<b>10/10- 10/11</b>	<b>10/11- 10/12</b>	<b>10/12- 10/13</b>	<b>10/13- 10/14</b>
1.	Physical exam (to include review of Medical Questionnaire and submission of written report).	\$ _____	_____	_____	_____	_____
2.	Vision test Near and distant vision Depth perception Color perception	\$ _____	_____	_____	_____	_____
3.	Hearing test - Audiogram	\$ _____	_____	_____	_____	_____
4.	Lab tests					
	(a) Urinalysis	\$ _____	_____	_____	_____	_____
	(b) Drug screen	\$ _____	_____	_____	_____	_____
5.	Back Assessment	\$ _____	_____	_____	_____	_____
	<b>TOTAL FEE PER LAW ENFORCEMENT APPLICANT</b>	<b>\$ _____</b>	<b>_____</b>	<b>_____</b>	<b>_____</b>	<b>_____</b>

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**Group 2: Public Safety-Firefighter**

	10/09- 10/10	10/10- 10/11	10/11- 10/12	10/12- 10/13	10/13- 10/14
1. Physical exam (to include review of Medical Questionnaire and submission of written report).	\$ _____	_____	_____	_____	_____
2. Vision test Near and distant vision Depth perception Color perception	\$ _____	_____	_____	_____	_____
3. Hearing test – Audiogram	\$ _____	_____	_____	_____	_____
4. Back assessment	\$ _____	_____	_____	_____	_____
5. Lab tests					
(a) Urinalysis	\$ _____	_____	_____	_____	_____
(b) Drug screen	\$ _____	_____	_____	_____	_____
6. Pulmonary function test	\$ _____	_____	_____	_____	_____
<b>TOTAL FEE PER APPLICANT</b>	<b>\$ _____</b>	<b>_____</b>	<b>_____</b>	<b>_____</b>	<b>_____</b>

**Group 3: Public Safety-911 Operators**

(NOTE: This procedure may be modified, based on recommendations of a successful bidder)

	10/09- 10/10	10/10- 10/11	10/11- 10/12	10/12- 10/13	10/13- 10/14
1. Post-offer physical exam including review of Medical Questionnaire and submission of a written report.	\$ _____	_____	_____	_____	_____
2. Vision test Near and distant vision Color perception	\$ _____	_____	_____	_____	_____
3. Hearing test – Audiogram	\$ _____	_____	_____	_____	_____
4. Lab tests					
(a) Urinalysis	\$ _____	_____	_____	_____	_____
(b) Drug screen	\$ _____	_____	_____	_____	_____
<b>TOTAL FEE PER 911 OPERATOR APPLICANT</b>	<b>\$ _____</b>	<b>_____</b>	<b>_____</b>	<b>_____</b>	<b>_____</b>

**COBB COUNTY REQUEST FOR PROPOSALS  
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<u>Group 4: Heavy Demands &amp; Moderate Demands</u>		10/09- 10/10	10/10- 10/11	10/11- 10/12	10/12- 10/13	10/13- 10/14
1.	Post-offer physical exam (to include review of Medical Questionnaire and Physical Requirements form, and submission of written report)	\$ _____	_____	_____	_____	_____
2.	Vision test Near and distant vision Color perception (if relevant)	\$ _____	_____	_____	_____	_____
3.	Hearing test – Audiogram	\$ _____	_____	_____	_____	_____
4.	Back assessment	\$ _____	_____	_____	_____	_____
5.	Lab tests					
	(a) Urinalysis	\$ _____	_____	_____	_____	_____
	(b) Drug screen	\$ _____	_____	_____	_____	_____
	<b>TOTAL FEE PER APPLICANT</b>	\$ _____	_____	_____	_____	_____

<u>Group 5: Other safety sensitive positions</u>		10/09- 10/10	10/10- 10/11	10/11- 10/12	10/12- 10/13	10/13- 10/14
1.	Lab tests					
	(a) Drug screen	\$ _____	_____	_____	_____	_____
	<b>TOTAL FEE PER SAFETY SENSITIVE APPLICANT</b>	\$ _____	_____	_____	_____	_____

I-B PROPOSED SERVICES AND FEES: MEDICAL RETURN TO WORK/FITNESS-FOR-DUTY PHYSICAL EXAMS (explanation of services required are located on page 10 of this document)

**THE TOTAL FEE (PER EMPLOYEE) FOR SERVICES:**

10/09-10/10    \$ \_\_\_\_\_  
 10/10-10/11    \$ \_\_\_\_\_  
 10/11-10/12    \$ \_\_\_\_\_  
 10/12-10/13    \$ \_\_\_\_\_  
 10/13-10/14    \$ \_\_\_\_\_

**COBB COUNTY REQUEST FOR PROPOSALS  
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I-C PROPOSED SERVICES AND FEES: ANNUAL PHYSICALS FOR PUBLIC SAFETY SPECIAL UNITS TEAM MEMBERS (explanation of services required are located on page 10-11 of this document)

<b>TYPE SERVICE</b>		<b>PROPOSED FEE FOR SERVICE</b>				
<b>Give fees per employees</b>		<b>10/09- 10/10</b>	<b>10/10- 10/11</b>	<b>10/11- 10/12</b>	<b>10/12- 10/13</b>	<b>10/13- 10/14</b>
1.	Physical exam	\$ _____	_____	_____	_____	_____
2.	Pulmonary function test	\$ _____	_____	_____	_____	_____
3.	Vision test	\$ _____	_____	_____	_____	_____
4.	Hearing test – Audiogram	\$ _____	_____	_____	_____	_____
5.	Blood profile (as given on p. 11 of this RFP)	\$ _____	_____	_____	_____	_____
6.	Urine profile (as given on p. 11 of this RFP)	\$ _____	_____	_____	_____	_____
7.	Stool hemocult test	\$ _____	_____	_____	_____	_____
8.	Chest X-ray (when required)	\$ _____	_____	_____	_____	_____
9.	EKG	\$ _____	_____	_____	_____	_____
<b>TOTAL FEE PER SPECIAL UNIT EMPLOYEE</b>		\$ _____	_____	_____	_____	_____

II. PROPOSED SERVICES AND FEES: PSYCHOLOGICAL EVALUATIONS (explanation of services required are located on page 12 of this document)

A. Employment Post Offer

**THE TOTAL FEE (PER EMPLOYEE) FOR SERVICES:**

<b>10/09-10/10</b>	\$ _____
<b>10/10-10/11</b>	\$ _____
<b>10/11-10/12</b>	\$ _____
<b>10/12-10/13</b>	\$ _____
<b>10/13-10/14</b>	\$ _____

**COBB COUNTY REQUEST FOR PROPOSALS  
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B. Return to Work/Fitness for Duty

**THE TOTAL FEE (PER EMPLOYEE) FOR SERVICES:**

10/09-10/10     \$ \_\_\_\_\_

10/10-10/11     \$ \_\_\_\_\_

10/11-10/12     \$ \_\_\_\_\_

10/12-10/13     \$ \_\_\_\_\_

10/13-10/14     \$ \_\_\_\_\_

C. Threat Assessment

**THE TOTAL FEE (PER EMPLOYEE) FOR SERVICES:**

10/09-10/10     \$ \_\_\_\_\_

10/10-10/11     \$ \_\_\_\_\_

10/11-10/12     \$ \_\_\_\_\_

10/12-10/13     \$ \_\_\_\_\_

10/13-10/14     \$ \_\_\_\_\_

**III. PROPOSED SERVICES AND FEES: WORKERS' COMP CASES**

(explanation of services required is located on page 14 of this document)

**Please fill in the blanks:**

Contractor would offer \_\_\_\_\_% discount to Georgia Workers' Compensation Fee Schedule for Physicians and Surgeons as given in the latest adopted fee schedule for 10/09-10/10.

Contractor would offer \_\_\_\_\_% discount to Georgia Workers' Compensation Fee Schedule for Physicians and Surgeons as given in the latest adopted fee schedule for 10/10-10/11.

Contractor would offer \_\_\_\_\_% discount to Georgia Workers' Compensation Fee Schedule for Physicians and Surgeons as given in the latest adopted fee schedule for 10/11-10/12.

Contractor would offer \_\_\_\_\_% discount to Georgia Workers' Compensation Fee Schedule for Physicians and Surgeons as given in the latest adopted fee schedule for 10/12-10/13.

Contractor would off \_\_\_\_\_% discount to Georgia Workers' Compensation Fee Schedule for Physicians and Surgeons as given in the latest adopted fee schedule for 10/13-10/14.

**COBB COUNTY REQUEST FOR PROPOSALS  
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**IV. PROPOSED SERVICES AND FEES: DRUG SCREENS**

(explanation of services required is located on page 14 of this document)

<b>TYPE SERVICE</b>	<b>PROPOSED FEE FOR SERVICE</b>				
	<b>10/09- 10/10</b>	<b>10/10- 10/11</b>	<b>10/11- 10/12</b>	<b>10/12- 10/13</b>	<b>10/13- 10/14</b>
<b>Give fees per employee</b>					
Drug screen	\$ _____	_____	_____	_____	_____
Confirmatory test (for positive results)	\$ _____	_____	_____	_____	_____
Split specimen confirmatory test	\$ _____	_____	_____	_____	_____
Live testimony of MRO (per hour)	\$ _____	_____	_____	_____	_____
Live testimony of other staff (per hour)	\$ _____	_____	_____	_____	_____
Live testimony of lab personnel (per hour)	\$ _____	_____	_____	_____	_____

**V. PROPOSED SERVICES AND FEES: HEPATITIS VACCINATIONS**

(explanation of services required is located on page 15 of this document)

<b>TYPE SERVICE</b>	<b>PROPOSED FEE FOR SERVICE</b>				
	<b>10/09- 10/10</b>	<b>10/10- 10/11</b>	<b>10/11- 10/12</b>	<b>10/12- 10/13</b>	<b>10/13- 10/14</b>
<b>Give fees per employee</b>					
1. Series of 3 vaccinations as described on Page 15 of this RFP	\$ _____	_____	_____	_____	_____
2. Post-test to identify employees who have Not developed immunity	\$ _____	_____	_____	_____	_____
3. Booster shots	\$ _____	_____	_____	_____	_____
4. Will records on each employee be maintained? (Circle One)			YES		NO
5. Location of administration of vaccinations: (Give Address Below)	_____ _____ _____ _____				

**COBB COUNTY REQUEST FOR PROPOSALS  
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 SEALED BID #10-5449**

**VI. PROPOSED SERVICES AND FEES: BLOOD-BORNE PATHOGENS & INFECTIOUS DISEASES**  
 (explanation of services required is located on page 34 of this document)

<b>TYPE SERVICE</b>	<b>PROPOSED FEE FOR SERVICE</b>				
<b>Give fees per employee</b>	<b>10/09- 10/10</b>	<b>10/10- 10/11</b>	<b>10/11- 10/12</b>	<b>10/12- 10/13</b>	<b>10/13- 10/14</b>
1. Test for exposure to blood-borne pathogens	\$ _____	_____	_____	_____	_____
2. Test for exposure to infectious diseases	\$ _____	_____	_____	_____	_____
3. Will records on each employee be maintained? (Circle One)			YES		NO

**APPENDIX A**  
**LAW ENFORCEMENT**  
**MEDICAL STANDARDS**

**COBB COUNTY GOVERNMENT  
LAW ENFORCEMENT MEDICAL STANDARDS**

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**COBB COUNTY GOVERNMENT**

**LAW ENFORCEMENT MEDICAL**  
**STANDARDS**

*Revised by the Cobb County Human Resources Department  
in Consultation with the County Attorney's Office*

*Revised October 2003*

## PART I:

# INTRODUCTION TO LAW ENFORCEMENT MEDICAL STANDARDS

## CAPABILITIES OF THE COUNTY PHYSICIAN'S OFFICE

The determination of an applicant's eligibility for law enforcement officer positions entails many aspects and areas of fact-finding. Some of this information may be elicited only through, or best through, a medical examination. Other information may need to be gained by other methods and test.

With respect to the post-offer situation, the county physician's office currently can perform [or arrange to have performed] the following procedures:

- post-offer physical examination
- spirometry
- audiometry
- cardiac stress test (this should be scheduled by the Department prior to the post-offer physical examination)
- urinalysis
- various blood analyses
- visual acuity testing
- color vision testing
- visual depth perception testing

Arrangements for any other appropriate procedures may be made with the agreement of the parties involved.

Certain tests of agility and endurance, even though they may have direct bearing on medical eligibility, ought to be performed outside of the County Physician's office. The County Physician may, if reasonably required, render an opinion about an applicant, based on information gathered NOT under his direct supervision. In such a case, it is the responsibility of the applicant and the Department to render to the medical examiner, in a timely fashion, any pertinent information.

## BACKGROUND AND PURPOSE OF MEDICAL STANDARDS

Cobb County aims to assure the public that it intends to do its utmost to provide the public with law enforcement officers who meet high standards of ethical, psychological, and physical status.

All applicants must undergo several screens before they will be given a conditional offer of employment. The screens, henceforth termed "in-house screens", may include the following:

1

1. Background check

2. Polygraph test
3. Fitness and agility test
4. Any other screening procedure that the department feels is necessary

Any test required shall be administered in compliance with all applicable rules, regulations and laws.

It is only after the initial screens have been passed that the applicant will be asked to undergo the post-offer physical examination. The purpose of the post-offer physical examination is to ensure that applicants meet certain medical standards so that they can indeed perform their duties, with or without accommodation. Any medical condition noted by the examination will be assessed only as it may reasonably impact the ability of the applicant to perform the essential functions of the position.

Any potential or actual medical “abnormality” uncovered in the case of a law enforcement officer applicant must be evaluated as to its effect on the applicant.

The County realizes that what is “abnormal” for some may be the normal condition for others. Nevertheless, an opinion must be rendered whether applicants with such an “abnormal” condition are able, with or without reasonable accommodation, to discharge all the essential job functions of the position without posing a direct threat to themselves, co-workers, and the public.

In order to make the necessary decision, medical findings must be judged against a minimum standard of acceptability. The County has established the standards after careful scrutiny of applicable laws, and after consultation with various experts in the relevant fields.

Law enforcement officer applicants who do not meet a medical standard will be judged medically ineligible for the position for which they are applying. Candidates who are rejected on the basis that their medical condition poses a direct threat to the health or safety of themselves or others will be assessed on an individual basis. This individualized assessment shall include consideration of all relevant factors including the duration of the risk, the nature and severity of the potential harm, the likelihood that the potential harm will occur, and the imminence of the potential harm.

In evaluating those factors, the County will consider all relevant information, including but not limited to: input from the applicant, the experience of the applicant in previous similar positions, and the opinions of medical doctors and

other professionals or associates of the candidate who have expertise in the medical condition involved and/or direct knowledge of the candidate's qualifications for or ability to perform the job.

Before rejecting an applicant on the basis that the applicant poses a direct threat, the County shall advise the applicant of the reasons for the proposed rejection, including each essential function of the job which the County believes the applicant cannot safely perform and all of the reasons why the County believes the applicant cannot safely perform those functions, and invite the applicant to provide, within a reasonable time, additional information in regard to the applicant's ability to perform the job safely, with or without reasonable accommodation, including but not limited to information from other physicians and information about the applicant's current and recent physical capabilities. The County shall evaluate this information in good faith to determine whether the applicant can safely perform the essential functions of the position with or without reasonable accommodation and maintain records of all factors taken into consideration in reaching its final decision. Such documentation shall include the weight given to each element or factor.

The following sections give the rationale, or justification, for the standards given in Part II of this document.

## VISION

For a field duty law enforcement officer, adequate vision is a necessary prerequisite to function safely and effectively. In addition to performing tasks at intermediate and far ranges, the officer is required to read and write reports, check identification papers, rapidly scan automotive instruments and gear.

Moreover, law enforcement officers must be able to perceive and identify persons, objects, and signals at the fringes of their visual fields. The extent to which they can do this is termed the "peripheral vision". Although peripheral vision refers to both side-to-side extent as well as up-and-down range, in the context of this document, it is the former – the horizontal field of vision – that will be assessed. If, in the opinion of the medical examiner, it is necessary to test any other dimension of the applicant's visual field, the candidate will be informed of this requirement.

The rapid – and sometimes critical – discrimination of colors and shades will be evaluated under the function of color vision. Although there are several forms of color vision deficiencies, the most common one is red-green color blindness, and it is the one that will be routinely checked for at the County physician's office. If necessary, other tests of color discrimination may be required.

The clarity with which a person sees, at any particular distance, is a measure of an individual's visual acuity. "Normal" visual acuity is considered as 20/20. The

numerator indicates the distance in feet at which the individual correctly sees a symbol on an eye chart. The denominator states the distance in feet at which a statistically "normal" person would perceive the same symbol under similar circumstances. People may test better than, equal to, or worse than "normal". For example, a visual acuity of 20/100 (worse than normal) means that the patient can correctly see at 20 feet that which a "normal" subject would see at 100 feet.

### DISTANT VISION

It is reasonable to expect that law enforcement officers may find themselves in situations where they must discern and decide upon visual cues at a distance of 20 feet or more. Even if they use visual correction, such as eyeglasses or contact lenses, these may become dislodged, and the officer will have to rely on unassisted vision only.

To assure a minimum level of visual performance without the use of corrective lenses, applicants must demonstrate that they can see acceptably well with their "naked eyes".

### NEAR VISION

As explained above, the County considers it necessary that each applicant show a minimum visual proficiency at "near distance". This is defined as from 12 inches to 30 inches from the reader's eyes.

- Therefore, all law enforcement officer applicants must show a near visual acuity, with or without corrective lenses, of 20/40 or better in the worse of the two eyes.
- Any candidate failing to meet this standard will be judged medically ineligible for the position offered.

### VISUAL FIELD TESTING

Visual field testing is also called "peripheral visual field testing."

Individuals see an area in front of them. It is as if their eyes were at the center of a sphere and their visual area was a region on the inside of the same sphere. An observer can see only those objects that lie within the boundaries, or peripheries, of this "visual field". This area is roughly elliptical in shape, with the long axis lying horizontally. The shorter vertical axis is also called the "central meridian." The extent to which a person sees to either side of the central meridian is measured as an angle between the vertical axis and the farthest point to the left or right of that line.

A normal visual field extends to 85 degrees to each side of the central meridian.

Obviously, it is an advantage to a person to have as large a visual field as possible. And it is a considerable disadvantage, or even a danger, if that field is diminished. This danger is particularly acute in the case of law enforcement officers, who may not notice threats, signals for help, or potential assistance or assailants lying outside of their visual field. Certain medical conditions may cause a reduction in applicants' visual fields to the point that they cannot safely and efficiently perform their essential job functions.

### DEPTH PERCEPTION

Depth perception is a function of binocular vision, which enhances performance in various scenarios. Although studies are inconclusive and few, it is generally believed that good depth perception is of great benefit in functions such as rapid target acquisition and quick loading of weapons in stressful situations.

Depth perception is measured as an angle (part of an arc) at which proper depth discrimination is demonstrated. "Normal" depth perception is considered as 20 seconds of arc. The smaller the angle, the better the depth perception. There seems to be "...evidence for requiring candidates to have a minimum degree of binocular fusion and stereopsis (depth perception) of approximately 40 seconds of arc." However, some law enforcement agencies have adopted less stringent requirements than the 40 sec. of arc as noted above.

### COLOR VISION

Color vision is the function that enables a viewer to distinguish among the various frequencies (colors) of visible light. The integrity of this function is important to perceive and correctly assess many different standard and non-standard images. These may include traffic lights, color of uniform or dress. In stressful situations (such as friend or foe, or "shoot/don't shoot"), intact color vision may make the difference between tragedy and peaceful resolution.

For purposes of this medical standard, the term "visual correction" shall mean the only enhancement of visual acuity by means of removable devices such as eyeglasses or contact lenses (soft or hard).

Some minimal level of visual acuity is necessary for the law enforcement duties of officers in the field. It is anticipated that in some situations, an officer's eyeglasses or contact lenses may be rendered less than fully functional, or inoperative. In such cases, officers may be forced to rely on this remaining "unaided vision" while still attending to the tasks of protecting the safety of themselves, their partners, and the public. Therefore, some minimum level of unaided visual acuity is thought to be a necessary qualification.

Visual correction aids are subject to various mishaps including dislodgment, smearing, fogging up, or mechanical deformation. In addition, a contact lens may

trap particles between it and the wearer's eye. This would cause discomfort and tearing (even in the unaffected eye), distracting the officer from more urgent tasks.

"Normal" visual acuity is considered 20/20. The numerator indicates the distance in feet at which the patient correctly sees a symbol on an eye chart. The denominator states the distance in feet at which a statistically "normal" person would perceive the same symbol under similar circumstances. People may test better than, equal to, or worse than "normal". For example, a visual acuity of 20/100 (worse than normal) means that the patient can correctly see at 20 feet that which a "normal" subject would see at 100 feet.

The County recognizes that some persons, in the initial time period after having corrective lenses prescribed, will discontinue their prescribed use. The County strongly discourages such "drop-out" since the non-use of corrective lenses may prevent officers from performing their duties well.

### HEARING ACUITY

Hearing acuity is essential for the perception of sound stimuli and for speech discrimination. Required hearing functions for a field officer include the following:

1. Speech comprehension: face-to-face, telephone, and radio
2. Ability to discern non-speech sounds
3. Ability to distinguish between types of non-speech sounds (footsteps vs. leaves rustling)
4. Localization of sound

These hearing functions must remain operative when the officer is in a quiet or noisy background (e.g., sirens, crowds, and gunfire).

The usual frequency range of normal human speech is from 500 Hz to 3000 Hz. The officer may need to make quick decisions based on calls for help, threatening sounds, and radio communication. This need is heightened in stressful situations.

All applicants will be asked, as a necessary precondition of hire, to pass a pure tone audiometric screen at various frequencies.

Please note that prior noise exposure may adversely affect, or invalidate, the hearing test. Therefore, to save time and unnecessary expense, the applicant is strongly advised to avoid exposure to sustained (duration exceeding 5 minutes) noise or loudness in excess of 80 dB for the 14-hour period prior to the test. An 80-dB noise is approximately the sound level in a sports car traveling at 50 mph. The

use of appropriate hearing protection may make such exposure acceptable. If these exposure levels are exceeded, the candidate ought to reschedule the hearing test.

### EPILEPSY

Applicants who have a medical or psychological condition which entails a reasonable likelihood of loss of bodily control may pose a direct threat to themselves, their co-workers, and the public. Epilepsy can be such a condition.

Epileptic seizures, of any type, may have varying precipitating factors (such as emotional, physical, visual) and may have varying degrees of predictability, outcome, tractability, and control.

### DIABETES MELLITUS

Diabetes Mellitus (sugar diabetes) is a multi-system disease. It may involve the heart, blood vessels, eyes, nerves, kidneys and other organs. It carries the risk of sudden, extreme changes in blood sugar levels and other metabolic derangement. This may produce abrupt or rapidly evolving alteration of consciousness and deterioration of bodily function(s).

Patients who do not need insulin may be able to control their condition with diet, exercise, weight control, or oral medication. These patients have Non-Insulin Dependent Diabetes Mellitus (NIDDM).

Other patients require insulin for control. These patients have Insulin Dependent Diabetes Mellitus (IDDM).

## PART II:

### THE MEDICAL STANDARDS

#### THE MEDICAL EXAMINATION

The medical examination is composed of at least the following components:

1. Review of medical history
2. Review of family and social history
3. Functional inquiry
4. Physical examination
5. Evaluation of medical tests and laboratory data (if any)

The purpose of the above components is to obtain medical facts, which are relevant to the applicant's ability to perform the essential job functions of the job.

In some cases, the county physician may require additional information from the applicant's personal physician. In these instances, consent for further information will be obtained and evaluated prior to any transfer of medical data.

Based on all available facts, a medical opinion will be rendered by the County Physician as to the applicant's ability to perform those functions. His office will then pass his findings and opinions to the Human Resources Department.

Any candidate who, in the judgment of the medical examiner, fails to meet minimum standards, will be ineligible for the position applied for unless a specific administrative waiver is granted in the case. The waiver must include at least the following information: \_\_\_\_\_

#### DRUG USE

In the interest of the public safety and job performance, the County has formulated strict rules regarding the use of certain drugs by active duty law enforcement officers:

- The use of narcotics is prohibited unless specifically prescribed for the patient by a licensed medical practitioner. Such use is sanctioned only if the patient (law

enforcement officer) is using such medication in the manner prescribed and not in such a manner that, while on duty, his/her physical or psychological function may be adversely affected.

- The use of mind-altering (stimulants or sedatives) drugs is prohibited.
- Addiction to any substance in the above two classes of drugs is a disqualifier for employment in the position applied for.
- Passage of a drug screen is mandatory.

If deemed necessary by the department and the County physician, the medical review officer (County physician) will evaluate the specific case and render an opinion as to the use of licit or illicit drugs and substances.

### VISION

All law enforcement officer applicants must show an unaided, binocular (both eyes) visual acuity of 20/100 or better.

Therefore, every law enforcement officer applicant must show a horizontal visual field of at least 70 degrees to either side of the central meridian. Unless a potential problem is identified, the vertical field is usually not tested during post-offer physical examinations.

It is the policy of the County that each new-hire shall show a minimum stereoptic performance of 70 sec. of arc as measured by equipment currently in use. Candidates who do not meet this requirement will be referred to the appropriate specialist for diagnosis and possible correction.

### COLOR VISION

The County has established the following minimum standards, which will have to be met by all applicants:

1. All candidates will have to pass the Ishihara color test (consisting of fourteen or more color plates). A pass is considered the correct identification of at least 10 plates.
2. A candidate failing to meet this standard will be required to pass the Farnsworth D-15 test.
3. A candidate who fails the Farnsworth D-15 test will be advised to check with an appropriate professional for possible re-test and/or further evaluation.

That specialist will submit a note to the County physician stating the date of the evaluation and the method(s) used in any procedures.

4. Based on this professional's assessment, the candidate will be reevaluated as to eligibility status by the County physician.
5. Contact lens for color vision deficiencies cannot be used in taking the Ishihara color vision portion of the vision test, since use of the lenses violates the basic illumination requirements for the test and may hinder performance on the Farnsworth D-15.

The County physician may request other tests, procedures, or opinions – if he feels that any of these medically justifiable.

### APPLICANTS WITH VISUAL CORRECTION

For purposes of this medical standard, the term “visual correction” shall mean the enhancement of visual acuity only by means of removable devices such as eyeglasses or contact lenses (soft or hard).

The order of preference, with respect to visual correction, is as follows (optimum first, least optimal last):

Applicant meets visual acuity standard:

1. Without any need for visual correction
2. After correction by soft contact lenses
3. After correction by hard contact lenses
4. After correction by eyeglasses

In all four cases above, it is assumed that the applicant has met the mandatory minimum unaided visual acuity standard.

The County has adopted the following visual acuity standards for applicants using contact lenses or eyeglasses:

1. The candidate will demonstrate binocular unaided visual acuity of 20/100 or better.
2. If corrective lenses are used, then the applicant will be required to demonstrate a visual acuity in the weaker eye that is at least 20/40

3. Applicants using contact lenses or glasses will have to attest that they have worn these lenses (as directed by their optometrist or ophthalmologist) for a period of at least three calendar months prior to the date of the post-offer physical examination. (This is to reduce the likelihood that the applicant will “drop-out” of the routine prescribed corrective lens use.)
4. Any candidate failing to meet the standard will be judged medically ineligible for the position offered.

All these above requirements are in addition to any vision standard(s) outlined elsewhere in this document.

### HEARING ACUITY

Perception of sounds is measured as a “decibel (Db) loss” at a particular frequency. The greater the decibel loss, the worse the hearing.

Hearing acuity will be judged as passable if the hearing threshold is no worse than the following cutoffs at the following frequencies:

<i>Frequency (Hz)</i>	<i>Maximum Hearing Loss (dB)</i>
500	30
1000	30
2000	30
3000	35

Candidates with hearing impairments who do not meet these thresholds will be assessed on an individual, case-by-case basis at the County’s expense and may be required to see an appropriate specialist with expertise in the area of the candidate’s specific condition for assessment, diagnosis, and/or retesting and/or correction. A report by such a specialist will then be used in any re-evaluation of the candidate.

In case of re-testing, the specialist will submit a note on behalf of the candidate to the County physician performing the pre-employment physical examination, indicating the following:

1. Date of re-test.
2. A statement attesting whether a hearing aid was used during the procedure.

3. The frequencies tested (at minimum 500 Hz, 1000 Hz, 2000 Hz, and 3000 Hz) and the acuity recorded.
4. A statement that the individualized assessment included consideration of all relevant factors including the applicant's background, experience, education, skills, etc. and consideration of whether the applicant can perform the essential functions of the position with or without reasonable accommodation.

All hearing tests will be performed with ANSI-certified instruments which meet or exceed OSHA standards S3.6-1969.

### EPILEPSY

All cases involving epilepsy will be judged on an individual basis but will almost certainly need referral to an expert. All pertinent factors will have to be weighed before a medical opinion is rendered.

Applicants with a diagnosis of epilepsy (regardless of type) will be obliged to provide medical documentation and will be assessed on an individual basis to determine if they pose a direct threat to themselves, their co-workers, and the public.

### DIABETES MELLITUS

All candidates with Diabetes Mellitus will be judged individually; however, the requirements will include, but not be limited to, the following:

1. Medical evidence documenting medical care over the previous five years.
2. Verification from applicant's physician that the applicant has not had serious episodes of hypoglycemia (low blood sugar) over the past five years.
3. Evidence that the applicant is free from autonomic nervous system dysfunction.
4. Evidence that the applicant has no active proliferative retinopathy, vitreous hemorrhage, or macular edema.
5. Evidence of passing the Farnsworth D-15 color vision test in addition to the Ishihara color vision test.

All law enforcement officer applicants in whom a diagnosis of Insulin Dependent Diabetes Mellitus is established or is being considered, must meet at the least the above five requirements to be considered eligible for the job.

**APPENDIX B**

**VARIOUS PUBLIC SAFETY**

**SPECIAL UNITS FORMS**

## OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

Date: 08/17/2009

Chart #: \_\_\_\_\_

Age \_\_\_\_\_

Sex: \_\_\_\_\_

SSN: \_\_\_\_\_

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

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

Employer Name: \_\_\_\_\_

Department: \_\_\_\_\_

**TO THE EMPLOYER**

Answers to questions in Section 1, and to question 9 in section 2 of part A, do not require a medical examination. However, it does require that a Physician or Licensed Health Care Professional (PLHCP) review this questionnaire and answer any questions you may have concerning the questions asked in this questionnaire.

**TO THE EMPLOYEE**

Can you read? (Circle one) Yes No

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

**TO THE PHYSICIAN OF OTHER LICENSED HEALTH CARE PROFESSIONAL (PLHCP)**

Review Part A Sections 1 and 2. When an employee answers YES to any of the questions in Section 2 and the questionnaire is not administered in conjunction with a physical examination, the employee needs to be considered for a follow-up physical examination with particular emphasis on those areas in which the employee answered YES. When an employee answers YES to any of the questions in Section 2 and this questionnaire is completed in conjunction with a physical examination, the physician will place particular emphasis upon those areas to which the employee answered YES. In either situation the PLHCP will complete the "PLHCP's Written Statement" to both the employee and employer within 2 days.

**PART A SECTION 1 (MANDATORY)**

The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Your height: \_\_\_\_\_ ft. \_\_\_\_\_ in.
2. Your weight: \_\_\_\_\_ lbs.
3. Your job title: \_\_\_\_\_
4. A phone number where you can be reached by the health care professional who will review this questionnaire (include area code): \_\_\_\_\_
5. The best time to phone you at this number is: \_\_\_\_\_ am/ \_\_\_\_\_ pm.
6. Has your employer told you how to contact the health care professional who will review this questionnaire? (circle one): Yes No
7. Check the type of respirator you will use (you can check more than one category):
  - a. \_\_\_\_\_ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
  - b. \_\_\_\_\_ Other type (for example, half - or full-facepiece type, powered - air purifying, supplied - air, self-contained breathing apparatus).
8. Have you worn a respirator (circle one): Yes No  
If "Yes", what type(s): \_\_\_\_\_

TO BE FILED IN EMPLOYEE'S MEDICAL FILE

**OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE**

**PART A SECTION 2 (MANDATORY)**

**Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator. (please circle "Yes" or "No").**

1. Yes No      **Do you currently smoke tobacco, or have you smoked tobacco in the last month?**
2.                      **Have you ever had any of the following conditions?**  
 Yes No      a. Seizures (fits)  
 Yes No      b. Diabetes (sugar disease)  
 Yes No      c. Allergic reactions that interfere with your breathing  
 Yes No      d. Claustrophobia (fear of closed-in places)  
 Yes No      e. Trouble smelling odors
3.                      **Have you ever had any of the following pulmonary or lung problems?**  
 Yes No      a. Asbestosis  
 Yes No      b. Asthma  
 Yes No      c. Chronic bronchitis  
 Yes No      d. Emphysema  
 Yes No      e. Pneumonia  
 Yes No      f. Tuberculosis  
 Yes No      g. Silicosis  
 Yes No      h. Pneumothorax (collapsed lung)  
 Yes No      i. Lung cancer  
 Yes No      j. Broken ribs  
 Yes No      k. Any chest injuries or surgeries  
 Yes No      l. Any other lung problem that you've been told about
4.                      **Do you currently have any of the following symptoms of pulmonary or lung disease?**  
 Yes No      a. Shortness of breath  
 Yes No      b. Shortness of breath when walking on level ground or walking up a slight hill or incline  
 Yes No      c. Shortness of breath when walking with other people at an ordinary pace on level ground  
 Yes No      d. Have to stop for breath when walking at your own pace on level ground  
 Yes No      e. Shortness of breath when washing or dressing yourself  
 Yes No      f. Shortness of breath that interferes with your job  
 Yes No      g. Coughing that produces phlegm (thick sputum)  
 Yes No      h. Coughing that wakes you early in the morning  
 Yes No      i. Coughing that occurs mostly when you are lying down  
 Yes No      j. Coughing up blood in the last month  
 Yes No      k. Wheezing  
 Yes No      l. Wheezing that interferes with your job  
 Yes No      m. Chest pain when you breathe deeply  
 Yes No      n. Any other symptoms that you think may be related to lung problems

**TO BE FILED IN EMPLOYEE'S MEDICAL FILE**

**OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE**

5. **Have you ever had any of the following cardiovascular or heart problems?**  
 Yes No a. Heart attack  
 Yes No b. Stroke  
 Yes No c. Angina  
 Yes No d. Heart failure  
 Yes No e. Swelling in your legs or feet (not caused by walking)  
 Yes No f. Heart arrhythmia  
 Yes No g. High blood pressure  
 Yes No h. Any other heart problem that you've been told about
6. **Have you ever had any of the following cardiovascular or heart symptoms?**  
 Yes No a. Frequent pain or tightness in your chest  
 Yes No b. Pain or tightness in your chest during physical activity  
 Yes No c. Pain or tightness in your chest that interferes with your job  
 Yes No d. In the past two years, have you noticed your heart skipping or missing a beat  
 Yes No e. Heartburn or indigestion that is not related to eating  
 Yes No f. Any other symptoms that you think might be related to heart or circulation problems
7. **Do you currently take medication for any of the following problems?**  
 Yes No a. Breathing or lung problems  
 Yes No b. Heart trouble  
 Yes No c. Blood pressure  
 Yes No d. Seizures (fits)
8. **If you've used a respirator, have you ever had any of the following problems?**  
**(If you've never used a respirator, check the following space \_\_\_\_\_ and go to question 9)**  
 Yes No a. Eye irritation  
 Yes No b. Skin allergies or rashes  
 Yes No c. Anxiety  
 Yes No d. General weakness or fatigue  
 Yes No e. Any other problems that interfere with your use of a respirator
9. Yes No **Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?**

**Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.**

10. Yes No **Have you ever lost vision in either eye (temporarily or permanently)**
11. Yes No **Do you currently have any of the following vision problems?**  
 Yes No a. Wear contact lenses  
 Yes No b. Wear glasses  
 Yes No c. Color blindness  
 Yes No d. Any other eye or vision problems

**TO BE FILED IN EMPLOYEE'S MEDICAL FILE**

**OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE**

12. Yes No      **Have you ever had an injury to your ears, including a broken ear drum?**
13.              **Do you currently have any of the following hearing problems?**  
 Yes No      a. Difficulty hearing  
 Yes No      b. Wear a hearing aide  
 Yes No      c. Any other hearing or ear problems
14. Yes No      **Have you ever had a back injury?**
15.              **Do you currently have any of the following musculoskeletal problems?**  
 Yes No      a. Weakness in any of your arms, hands, legs, or feet  
 Yes No      b. Back pain  
 Yes No      c. Difficulty fully moving your arms and legs  
 Yes No      d. Pain or stiffness when you lean forward or backward at the waist  
 Yes No      e. Difficulty fully moving your head up or down  
 Yes No      f. Difficulty fully moving your head side to side  
 Yes No      g. Difficulty bending at your knees  
 Yes No      h. Difficulty squatting to the ground  
 Yes No      i. Climbing a flight of stairs or a ladder carrying more than 25 lbs.  
 Yes No      j. Any other muscle or skeletal problem that interferes with using a respirator.

**TO THE PLHCP**

Check ✓ the **ONE** that applies

- I have reviewed Part A Section 2 of this questionnaire with the employee and I do not recommend that a physical examination be performed.
- I have reviewed Part A Section 2 of this questionnaire with the employee and I am recommending that a physical examination be performed.
- I have reviewed Part A section 2 of this questionnaire without the employee and I do not recommend that a physical examination be performed.
- I have reviewed Part A Section 2 of this question without the employee and I am recommending that a physical examination be performed.

\_\_\_\_\_  
 PLHCP Signature

\_\_\_\_\_  
 Employee Signature  
 (When Available)

\_\_\_\_\_  
 Date

**TO BE FILED IN EMPLOYEE'S MEDICAL FILE**

**OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE**

**PART B of this OSHA Questionnaire is discretionary. The health care professional who will be reviewing this questionnaire will determine if this part needs to be completed by the employee.**

**Part B (DISCRETIONARY)**

Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. Yes No **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?**  
 Yes No If "Yes", do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you are working under these conditions?
2. Yes No **At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (for example: gases, fumes, or solvents)?**  
 If "Yes", name the chemicals if you know them: \_\_\_\_\_
3. **Have you ever worked with any of the materials, or under any of the conditions, listed below:**  
 Yes No Asbestos  
 Yes No Silica (for example: sandblasting)  
 Yes No Tungsten/Cobalt (for example: grinding or welding this material)  
 Yes No Beryllium  
 Yes No Aluminum  
 Yes No Coal (for example: mining)  
 Yes No Iron  
 Yes No Tin  
 Yes No Dusty Environments  
 Yes No Any other hazardous exposures  
 If "Yes", describe these exposures: \_\_\_\_\_
4. **List any second jobs or side businesses you have:** \_\_\_\_\_
5. **List your previous occupations:** \_\_\_\_\_
6. **List your current and previous hobbies:** \_\_\_\_\_
7. Yes No **Have you been in the military services?**  
 If "Yes", were you exposed to biological or chemical agents (either in training or combat)  
 Yes No
8. Yes No **Have you ever worked on a HAZMAT team?**
9. Yes No **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 them: \_\_\_\_\_

**TO BE FILED IN EMPLOYEE'S MEDICAL FILE**

OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

10. Will you be using any of the following items with your respirator:

- Yes No a. HEPA Filters
Yes No b. Canisters (for example; gas masks)
Yes No c. Cartridges

11. How often are you expected to use the respirator(s) (circle "yes" or "no" for all answers that apply to you)

- Yes No a. Escape only (no rescue)
Yes No b. Emergency Rescue only
Yes No c. Less than 5 hours per week
Yes No d. Less then 2 hours per day
Yes No e. 2 to 4 hours per day
Yes No f. Over 4 hours per day

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

- Yes No a. Light (less than 200 kcal per hour)
Examples of light work are sitting while writing, 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.
Yes No b. Moderate ( 200 to 350 kcal per hour)
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.
Yes No c. Heavy (above 350 kcal per hour)
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.

13. Yes No 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

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

15. Yes No Will you be working under humid conditions

16. Describe the work you'll be doing while you're using your respirator(s)

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

TO BE FILED IN EMPLOYEE'S MEDICAL FILE

**OSHA RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE**

**18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator:**

Name of first toxic substance: \_\_\_\_\_  
 Estimated maximum exposure per shift: \_\_\_\_\_  
 Duration of exposure per shift: \_\_\_\_\_  
 Name of second toxic substance: \_\_\_\_\_  
 Estimated maximum exposure per shift: \_\_\_\_\_  
 Duration of exposure per shift: \_\_\_\_\_  
 Name of third toxic substance: \_\_\_\_\_  
 Estimated maximum exposure per shift: \_\_\_\_\_  
 Duration of exposure per shift: \_\_\_\_\_  
 Name of any other toxic substances that you'll be exposed to while using your respirator(s):  
 \_\_\_\_\_  
 \_\_\_\_\_

**19. 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):**

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

**Appendix D to Section 1910.134 (Mandatory) Information for Employees Using Respirators  
When Not Required Under the Standard**

Respirators are an effective method of protection against designated hazards when properly selected and worn. Respirator use is encouraged, even when exposures are below the exposure limit, to provide additional level of comfort and protection for workers. However, if a respirator is used improperly or not kept clean, the respirator itself can become a hazard to the worker. Sometimes, workers may wear respirators to avoid exposures to hazards, even if the amount of hazardous substance does not exceed the limits set by OSHA standards. If your employer provides respirators for your voluntary use, or if you provide your own respirator, you need to take certain precautions to be sure that the respirator itself does not represent a hazard.

You should do the following:

1. Read and heed all instructions provided by the manufacturer on use, maintenance, cleaning and care, and warnings regarding the respirator limitations.
2. Choose respirators certified for use to protect against the contaminant of concern. NIOSH, the National Institute for Occupational Safety and Health of the U. S. Department of Health and Human Services, certifies respirators. A label or statement of certification should appear on the respirator or respirator packaging. It will tell you what the respirator is designed for and how much it will protect you.
3. Do not wear your respirator into atmospheres containing contaminants for which your respirator is not designed to protect against. For example, a respirator designed to filter dust particles will not protect you against gases, fumes, vapors, or very small solid particles of fumes or smoke.
4. Keep track of your respirator so that you do not mistakenly use someone else's respirator.

TO BE FILED IN EMPLOYEE'S MEDICAL FILE

**Employee Information**

Employee Name: \_\_\_\_\_

SSN: \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Contact Numbers: (\_\_\_\_) \_\_\_\_\_ Type: \_\_\_\_\_

(\_\_\_\_) \_\_\_\_\_ Type \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ Type \_\_\_\_\_

**Employee General Medical History**

Check all items that apply, *past or present*, to your health history. Explain any "Yes" answers.

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

Immunizations: Tetanus toxoid, date \_\_\_\_\_ Hepatitis B, date \_\_\_\_\_ Antibody Titer \_\_\_\_\_

Medical History: Is there any history, past or present, of:

	No	Yes	Year	Details/Medicines
Serious Illness	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Serious Injury	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Deformity	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Skin, glands	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Ears, Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Nose, Sinus	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Teeth, tonsils	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Dentures	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Bridge	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Chest, lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Stomach, bowels	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Kidneys or urine	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Albumin	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Infection	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Menstrual prob.	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hernia (rupture)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Back, limbs, joints	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other (explain)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

**Physical Exam (to be completed by a licensed physician)**

Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ Pulse \_\_\_\_\_ Respirations \_\_\_\_\_

Vision: Normal \_\_\_\_\_ Glasses \_\_\_\_\_ Contacts \_\_\_\_\_

Hearing: Normal \_\_\_\_\_ Abnormal \_\_\_\_\_ Explain: \_\_\_\_\_

Check Box:

	N	Abn		N	Abn		N	Abn
Head	<input type="checkbox"/>	<input type="checkbox"/>	Throat	<input type="checkbox"/>	<input type="checkbox"/>	Cardiopulmonary system	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Teeth	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>
Ears	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Nose	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>

Explain any abnormalities: \_\_\_\_\_

\_\_\_\_\_

**Diagnostic & Laboratory Test**

Diagnostic Test: (check box)

	N	Abn		N	Abn		N	Abn
12 Lead EKG	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary Function	<input type="checkbox"/>	<input type="checkbox"/>	Chest X-ray	<input type="checkbox"/>	<input type="checkbox"/>

Explain any abnormalities: \_\_\_\_\_

\_\_\_\_\_

Laboratory Test: (check box)

	N	Abn		N	Abn		N	Abn
U/A Micro	<input type="checkbox"/>	<input type="checkbox"/>	CBC c diff	<input type="checkbox"/>	<input type="checkbox"/>	Chem Panel 18	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Risk Profile	<input type="checkbox"/>	<input type="checkbox"/>	T4 Total	<input type="checkbox"/>	<input type="checkbox"/>			

Explain any abnormalities: \_\_\_\_\_

\_\_\_\_\_

**Physician Information**

Signature: \_\_\_\_\_  
Licensed Physician

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

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

City, State, Zip: \_\_\_\_\_



## Statement of Understanding

**Directions to Student:** This is a statement in which you are informed of potential hazards that may be encountered and of the conduct required of you during Dive Rescue International training programs. Your signature is required on this document in order for you to participate in this program. Read, and if necessary, discuss this Statement of Understanding with your instructor. As you carefully read this document, please initial each section to acknowledge your understanding. Please fill in all blanks and make sure to sign the form.

\_\_\_\_\_ You must be a member of a public safety agency or a department and be at least 18 years old to participate in the training program.

\_\_\_\_\_ The activities you will encounter during this program can be exciting and demanding. When done correctly, using tried and proven techniques and equipment, they can be done safely. However, when established safety procedures are not followed, there are dangers which may result in serious injury or even death. The potential hazards include but are not limited to: equipment failure, entanglement, loss of safety line, barotrauma, decompression sickness, drowning, hypothermia, hyperthermia, panic/stress, physical trauma, regulator/equipment freeze-up, communications failure, dry suit or ice rescue suit problems, misuse of equipment, falls, entrapment, strong currents, and equipment difficulties.

\_\_\_\_\_ Dive Rescue International and its staff are very much aware of these hazards and plan to help minimize them, but you must be aware that they cannot be totally eliminated. Ultimately, you are responsible for your safety and the safety of others in this program. You will be expected to obey commonly accepted commands and to attempt exercises when instructed to do so. At no time will you be required to participate when you are not comfortable with what you are doing. It is your responsibility to make the final decision to participate in each activity.

\_\_\_\_\_ This is not a sport or recreational course. It is a professional training program designed for personnel wishing to take a serious approach to rescue and recovery tactics and skills in dangerous environments. This program will be conducted utilizing both classroom lectures and hands-on exercises. Your total attention and participation in a professional manner are required. Horseplay, any type of harassment, practical jokes, consumption of alcohol or drugs, and smoking are not allowed while you are participating in the program.

\_\_\_\_\_ This program can involve very strenuous work, placing you in not only physically, but mentally stressful situations. It is important that your respiratory and circulatory systems be in good condition. A person with heart trouble, epilepsy, asthma, or other medical problems should not participate. If taking medication, consult your doctor and the instructor before starting the program.

\_\_\_\_\_ You have been advised of the type of equipment you are to supply for the program. Dive Rescue International has no control over this equipment and it is your responsibility to see that such equipment is in good operating condition and it is your responsibility to know the proper techniques in its use.

\_\_\_\_\_ I have read this Statement of Understanding and agree to the conditions and requirements as listed above.

**Participant's Name (please print)** \_\_\_\_\_

**Participant's Signature** \_\_\_\_\_

**Date** \_\_\_\_\_



19. a. Name of public safety agency where candidate employed :

b. Length of employment:	c. Full Time <input type="checkbox"/> Yes <input type="checkbox"/> No
20. Employment Address (Street, City, State, Zip Code)	21. Rank or Title

22. **Signature of Nominating Official** (from the applicant's agency)

\_\_\_\_\_  
Name and Title (Print or Type)

**Bomb Squad Information**

23. a. Name of Accredited Bomb Squad to which assigned	b. Bomb Squad Identifier Number
c. Name of Bomb Squad Commander (Defined as the certified bomb technician point of contact who will speak for the squad)	
d. Mailing Address of Bomb Squad (Street, City, State, Zip Code)	
e. Telephone Number of Bomb Squad	f. Fax Number of Bomb Squad
g. E-mail of Bomb Squad	
h. <b>Signature of Bomb Squad Commander</b> (Required if the Bomb Squad Commander is employed by a different agency)	

24. **Waiver:** I am about to take a course of instruction at the Hazardous Devices School and am aware that this course may necessitate my personal handling of live explosives, incendiary materials, hazardous chemicals, as well as the wearing of bomb suits, respiratory protective equipment and other personal protective equipment. I acknowledge that I am taking this course on my own initiative. I am fully aware of the dangers and risks involved in this course of instruction and realize that neither the United States Government nor the Federal Bureau of Investigation is agreeing to act as insurers of my safety. Therefore, in consideration of the permission extended to me by the United States, through its officers and Agents, to take this course of instruction, I do hereby, forever discharge the Government of the United States and all its officers, Agents, and employees, acting officially or otherwise, from any and all claims or causes of action on account of any injury to me or my property which results through no fault or wrongdoing on behalf of the Government or its employees during the course of instruction or the handling of any hazardous device. I further acknowledge and agree that any claims or causes of actions against the Federal Government I may have for injuries to myself or to my property during my instruction will be those provided for by the Federal Tort Claims Act or other applicable federal statutes.

25. **All Applicants:** Return this form and other designated forms, including medical forms, to the Training Coordinator in the FBI Field Office in your region.

26. \_\_\_\_\_  
**Signature of Applicant** \_\_\_\_\_  
**Date**

## Non-Personnel Consent to Release Information

To Whom It May Concern:

I hereby give consent to any authorized representative of the Federal Bureau of Investigation to obtain any information in your files pertaining to my academic, achievement, athletic, attendance, credit (including credit card and payment device numbers), disciplinary, employment, law enforcement (including, but not limited to, any record of charge, prosecution, or conviction for civil or criminal offenses), military, or professional license records (including any grievance records). I hereby direct each entity to which this form is presented to release such information upon request of the authorized recipient as described above, regardless of any other agreement or direction I may have made.

This consent is executed with full knowledge and understanding that the information is for the official use of the Federal Bureau of Investigation in connection with the determination of suitability for employment and/or eligibility for new or continued access to classified information of a current or prospective government employee with whom I am associated. Consent is granted for the Federal Bureau of Investigation to furnish such information as is described above to third parties in the course of fulfilling its official responsibilities.

Copies of this consent that show my signature are as valid as the original signed by me. This consent is valid for one (1) year from the date signed.

Signature (sign in ink)	Full Name (type or print clearly)	Date Signed
Other Names Used		Social Security Account No.
Signature of Parent or Guardian (if required)	Place of Birth	Date of Birth
Signature of Witness	Name & Title of Witness	

### PRIVACY ACT STATEMENT

**Authority:** The collection of information requested by this form is authorized under Executive Order 10450, Security Requirements for Government Employees; Executive Order 12968, Access to Classified Information; and the Fair Credit Reporting Act, 15 U.S.C. §§1681 et seq. Providing requested information is voluntary; however, failure to furnish the requested information and consent may affect our ability to complete the determination of suitability for employment and/or eligibility for new or continued access to classified information of a current or prospective government employee with whom you are associated.

**Principal Purpose:** The information will be used principally to obtain such academic, achievement, athletic, attendance, credit, disciplinary, educational, employment, law enforcement, military, and professional license records as may be necessary to determine the suitability for employment and/or eligibility for new or continued access to classified information of a current or prospective government employee with whom you are associated. Your Social Security Account Number (SSAN) identifies you in most of the above-listed transactions. We will use your SSAN to accurately identify your records and to process investigations, inquiries, and/or determinations related to this consent.

**Routine Uses:** In addition to disclosures within the Department of Justice on a need-to-know basis, information reported on this form may be disclosed in accordance with all applicable routine uses as may be published at any time in the Federal Register, including all routine uses for the FBI Central Records System. These routine uses include the following disclosures: to potential sources in order to locate, seek, and obtain information or records pertaining to you; to any appropriate governmental authorities responsible for civil or criminal law enforcement, counterintelligence, or security matters to which the information may be relevant; to non-FBI employees performing Federal assignments; to courts or adjudicative bodies when the FBI considers it has an interest in the proceedings; or as otherwise mandated by law, treaty, or Executive Order.





<b>MEDICAL RECORD</b>	<b>REPORT OF MEDICAL HISTORY</b>	DATE OF EXAM
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**NOTE: This information is for official and medically-confidential use only and will not be released to unauthorized persons**

1. NAME OF PATIENT (Last, first, middle)			2. IDENTIFICATION NUMBER	3. GRADE
4a. HOME ADDRESS (Street or RFD; City or Town; State; and ZIP Code)			5. EXAMINING FACILITY	
4b. CITY	4c. STATE	4d. ZIP CODE		
6. PURPOSE OF EXAMINATION				

**7. STATEMENT OF PATIENT'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Use additional pages if necessary)**

a. PRESENT HEALTH	b. CURRENT MEDICATION	REGULAR OR INTERIM
c. ALLERGIES (Include insect bites/stings and common foods)		
	d. HEIGHT	e. WEIGHT
8. PATIENT'S OCCUPATION	9. ARE YOU (Check one)	
	<input type="checkbox"/> RIGHT HANDED <input type="checkbox"/> LEFT HANDED	

**10. PAST/CURRENT MEDICAL HISTORY**

CHECK EACH ITEM	YES	NO	DONT KNOW	CHECK EACH ITEM	YES	NO	DONT KNOW	CHECK EACH ITEM	YES	NO	DONT KNOW
Household contact with anyone with tuberculosis				Shortness of breath				Bone, joint or other deformity			
Tuberculosis or positive TB test				Pain or pressure in chest				Loss of finger or toe			
Blood in sputum or when coughing				Chronic cough				Painful or "trick" shoulder or elbow			
Excessive bleeding after injury or dental work				Palpitation or pounding heart				Recurrent back pain or any back injury			
Suicide attempt or plans				Heart trouble				"Trick" or locked knee			
Sleepwalking				High or low blood pressure				Foot trouble			
Wear corrective lenses				Cramps in your legs				Nerve injury			
Eye surgery to correct vision				Frequent indigestion				Paralysis (include infantile)			
Lack vision in either eye				Stomach, liver, or intestinal trouble				Epilepsy or seizure			
Wear a hearing aid				Gall bladder trouble or gallstones				Car, train, sea or air sickness			
Stutter or stammer				Jaundice or hepatitis				Frequent trouble sleeping			
Wear a brace or back support				Broken bones				Depression or excessive worry			
Scarlet fever				Adverse reaction to medication				Loss of memory or amnesia			
Rheumatic fever				Skin diseases				Nervous trouble of any sort			
Swollen or painful joints				Tumor, growth, cyst, cancer				Periods of unconsciousness			
Frequent or severe headaches				Hernia				Parent/sibling with diabetes, cancer, stroke or heart disease			
Dizziness or fainting spells				Hemorrhoids or rectal disease				X-ray or other radiation therapy			
Eye trouble				Frequent or painful urination				Chemotherapy			
Hearing loss				Bed wetting since age 12				Asbestos or toxic chemical exposure			
Recurrent ear infections				Kidney stone or blood in urine				Plate, pin or rod in any bone			
Chronic or frequent colds				Sugar or albumin in urine				Easy fatigability			
Severe tooth or gum trouble				Sexually transmitted disease				Been told to cut down or criticized for alcohol use			
Sinusitis				Recent gain or loss of weight				Used illegal substances			
Hay Fever or allergic rhinitis				Eating disorder (anorexia, bulimia, etc.)				Used tobacco			
Head injury				Arthritis, Rheumatism or Bursitis							
Asthma				Thyroid trouble or goiter							

NSN 7540-00-181-8638  
Previous edition not usable

**STANDARD FORM 93 (REV. 6/96) (EG)**  
Prescribed by ICMR/GSA  
FIRMR (41 CFR) 201-9.202-1  
Designed using Perform Pro, WHS/DIOR, Apr 97

				11. FEMALES ONLY		
CHECK EACH ITEM	YES	NO	DON'T KNOW	DATE OF LAST MENSTRUAL PERIOD	DATE OF LAST PAP SMEAR	DATE OF LAST MAMMOGRAM
Treated for a female disorder						
Change in menstrual pattern						

CHECK EACH ITEM. IF "YES" EXPLAIN IN BLANK SPACE TO RIGHT. LIST EXPLANATION BY ITEM NUMBER

ITEM	YES	NO
12. Have you been refused employment or been unable to hold a job or stay in school because of:		
a. Sensitivity to chemicals, dust sunlight, etc.		
b. Inability to perform certain motions.		
c. Inability to assume certain positions.		
d. Other medical reasons (If yes, give reasons.)		
13. Have you ever been treated for a mental condition? (If yes, specify when, where, and give details.)		
14. Have you ever been denied life insurance? (If yes, state reason and give details.)		
15. Have you had, or have you been advised to have, any operation? (If yes, describe and give age at which occurred.)		
16. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)		
17. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)		
18. Have you ever been rejected for military service because of physical, mental, or other reasons? (If yes, give date and reason for rejection.)		
19. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)		
20. Have you ever received, is there pending, or have you ever applied for pension or compensation for existing disability? (If yes, specify what kind, granted by whom, and what amount, when, why.)		
21. Have you ever been arrested or convicted of a crime, other than minor traffic violations? (If yes, provide details.)		
22. Have you ever been diagnosed with a learning disability? (If yes, give type, where, and how diagnosed.)		

23. LIST ALL IMMUNIZATIONS RECEIVED

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service. I understand that falsification of information on Government forms is punishable by fine and/or imprisonment.

24a. TYPED OR PRINTED NAME OF EXAMINEE	24b. SIGNATURE	24c. DATE
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**NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY."**

25. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (Physician shall comment on all positive answers in items 7 through 11. Physician may develop by interview any additional medical history deemed important, and record any significant findings here.)

26a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINEE	26b. SIGNATURE	26c. DATE
---	----------------	-----------

**Hazardous Devices School  
Physical Capacities Form**

Applicant's Name: \_\_\_\_\_

Dear Doctor:

The above named individual is applying to attend a course at the Hazardous Devices School, which will certify him/her as a bomb technician. This training is physically demanding in that it requires students to wear protective suits while performing tasks. The bomb suit with helmet weighs up to 70 pounds and is quite restrictive. The combination chemical suit (level B) and WMD bomb suit (40-pound suit) also requires the wearing of a self-contained breathing apparatus (SCBA) with respirator. The microenvironment within this equipment can expose the wearer to temperatures in excess of 100 degrees Fahrenheit, and humidity of 100% for periods of up to 30 minutes. Tasks to be performed include carrying a portable x-ray (25 pounds) and disrupter (40 pounds) a distance of at least 600 feet. During these tasks the student must kneel, position the tools and get back up on their own. If they fall, they must be able to get back up without assistance. In order to be accepted to this HDS course, the applicant must not have any of the restrictions listed below.

Please check any of the following medical restrictions that may apply to the applicant:

- \_\_\_\_\_ Restricted from lifting more than 50 pounds.
- \_\_\_\_\_ Restricted from kneeling, bending or twisting.
- \_\_\_\_\_ Restricted from working in a respirator (including negative pressure or SCBA types) .
- \_\_\_\_\_ Overweight to the degree that wearing a 70-pound bomb suit while carrying equipment would present health risks.
- \_\_\_\_\_ Restricted from wearing protective chemical and/or bomb suits.

Comments: \_\_\_\_\_

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

I have discussed the OSHA Respirator Medical Evaluation Questionnaire with the patient. (Questionnaire may be maintained by health care provider and need not be returned to the patient or the FBI.)

\_\_\_\_\_  
**Physician's Printed Name**

\_\_\_\_\_  
**Physician's Signature**

\_\_\_\_\_  
**Date**

**Maximum Weight by Height**  
From the *National Guidelines for Bomb Technicians*

Height (inches)	Male				Female			
	Age Group				Age Group			
	21-29	30-39	40-49	50+	21-29	30-39	40-49	50+
58					100	103	106	109
59					105	108	111	114
60	166	169	172	175	110	113	116	119
61	170	173	176	179	115	118	121	124
62	173	176	179	182	120	123	126	129
63	176	179	182	185	125	128	131	134
64	180	183	186	189	130	133	136	139
65	183	186	189	192	135	138	141	144
66	186	189	192	195	140	143	146	149
67	190	193	196	199	145	148	151	154
68	193	196	199	202	150	153	156	159
69	196	199	202	205	155	158	161	164
70	200	203	206	209	160	163	166	169
71	203	206	209	212	165	168	171	174
72	206	209	212	215	170	173	176	179
73	210	213	216	219	175	178	181	184
74	213	216	219	222	180	183	186	189
75	216	219	222	225	185	188	191	194
76	220	223	226	229	190	193	196	199
77	223	226	229	232	195	198	201	204
78	226	229	232	235	200	203	206	209
79	230	233	236	239	205	208	211	214
80	233	236	239	242	210	213	216	219

Alternative Body Fat Test	Age Group			
	21-27	28-39	40-49	50+
Maximum Body Fat (Male)	22%	24%	26%	28%
Maximum Body Fat (Female)	30%	32%	34%	36%

**OSHA 29CFR, Appendix C to Sec. 1910.134:  
OSHA Respirator Medical Evaluation Questionnaire (Mandatory)**

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

To the employee:

Can you read (circle one): Yes/No

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers. Additionally, your employer must tell you how to deliver or send this questionnaire to the health care professional, who will review it.

**Part A. Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (please print).**

1. Today's date: \_\_\_\_\_
2. Your name: \_\_\_\_\_
3. Your age (to nearest year): \_\_\_\_\_
4. Sex (circle one): Male/Female
5. Your height: \_\_\_\_\_ ft. \_\_\_\_\_ in.
6. Your weight: \_\_\_\_\_ lbs.
7. Your job title: \_\_\_\_\_
8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): \_\_\_\_\_
9. The best time to phone you at this number: \_\_\_\_\_
10. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes/No
11. Check the type of respirator you will use (you can check more than one category):
  - a. \_\_\_\_\_ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
  - b. \_\_\_\_\_ Other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).
12. Have you worn a respirator (circle one): Yes/No  
If "yes," what type(s): \_\_\_\_\_

**Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please circle "yes" or "no").**

1. Do you *currently* smoke tobacco, or have you smoked tobacco in the last month: Yes/No
2. Have you ever had any of the following conditions?
  - a. Seizures (fits): Yes/No
  - b. Diabetes (sugar disease): Yes/No
  - c. Allergic reactions that interfere with your breathing: Yes/No
  - d. Claustrophobia (fear of closed-in places): Yes/No
  - e. Trouble smelling odors: Yes/No
3. Have you ever had any of the following pulmonary or lung problems?
  - a. Asbestosis: Yes/No
  - b. Asthma: Yes/No
  - c. Chronic bronchitis: Yes/No
  - d. Emphysema: Yes/No
  - e. Pneumonia: Yes/No
  - f. Tuberculosis: Yes/No
  - g. Silicosis: Yes/No
  - h. Pneumothorax (collapsed lung): Yes/No
  - i. Lung cancer: Yes/No
  - j. Broken ribs: Yes/No
  - k. Any chest injuries or surgeries: Yes/No
  - l. Any other lung problem that you've been told about: Yes/No
4. Do you *currently* have any of the following symptoms of pulmonary or lung illness?
  - a. Shortness of breath: Yes/No
  - b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: Yes/No
  - c. Shortness of breath when walking with other people at an ordinary pace on level ground: Yes/No
  - d. Have to stop for breath when walking at your own pace on level ground: Yes/No
  - e. Shortness of breath when washing or dressing yourself: Yes/No
  - f. Shortness of breath that interferes with your job: Yes/No
  - g. Coughing that produces phlegm (thick sputum): Yes/No
  - h. Coughing that wakes you early in the morning: Yes/No
  - i. Coughing that occurs mostly when you are lying down: Yes/No
  - j. Coughing up blood in the last month: Yes/No
  - k. Wheezing: Yes/No
  - l. Wheezing that interferes with your job: Yes/No
  - m. Chest pain when you breathe deeply: Yes/No
  - n. Any other symptoms that you think may be related to lung problems: Yes/No

5. Have you *ever had* any of the following cardiovascular or heart problems?
- a. Heart attack: Yes/No
  - b. Stroke: Yes/No
  - c. Angina: Yes/No
  - d. Heart failure: Yes/No
  - e. Swelling in your legs or feet (not caused by walking): Yes/No
  - f. Heart arrhythmia (heart beating irregularly): Yes/No
  - g. High blood pressure: Yes/No
  - h. Any other heart problem that you've been told about: Yes/No
6. Have you *ever had* any of the following cardiovascular or heart symptoms?
- a. Frequent pain or tightness in your chest: Yes/No
  - b. Pain or tightness in your chest during physical activity: Yes/No
  - c. Pain or tightness in your chest that interferes with your job: Yes/No
  - d. In the past two years, have you noticed your heart skipping or missing a beat: Yes/No
  - e. Heartburn or indigestion that is not related to eating: Yes/No
  - f. Any other symptoms that you think may be related to heart or circulation problems: Yes/No
7. Do you *currently* take medication for any of the following problems?
- a. Breathing or lung problems: Yes/No
  - b. Heart trouble: Yes/No
  - c. Blood pressure: Yes/No
  - d. Seizures (fits): Yes/No
8. If you've used a respirator, have you *ever had* any of the following problems? (If you've never used a respirator, check here • and go to question 9.)
- a. Eye irritation: Yes/No
  - b. Skin allergies or rashes: Yes/No
  - c. Anxiety: Yes/No
  - d. General weakness or fatigue: Yes/No
  - e. Any other problem that interferes with your use of a respirator: Yes/No
9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: Yes/No

**Questions 10 to 15 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.**

10. Have you *ever* lost vision in either eye (temporarily or permanently): Yes/No

11. Do you **currently** have any of the following vision problems?
  - a. Wear contact lenses: Yes/No
  - b. Wear glasses: Yes/No
  - c. Color blind: Yes/No
  - d. Any other eye or vision problem: Yes/No
  
12. Have you **ever had** an injury to your ears, including a broken ear drum: Yes/No
  
13. Do you **currently** have any of the following hearing problems?
  - a. Difficulty hearing: Yes/No
  - b. Wear a hearing aid: Yes/No
  - c. Any other hearing or ear problem: Yes/No
  
14. Have you **ever had** a back injury: Yes/No
  
15. Do you **currently** have any of the following musculoskeletal problems?
  - a. Weakness in any of your arms, hands, legs, or feet: Yes/No
  - b. Back pain: Yes/No
  - c. Difficulty fully moving your arms and legs: Yes/No
  - d. Pain or stiffness when you lean forward or backward at the waist: Yes/No
  - e. Difficulty fully moving your head up or down: Yes/No
  - f. Difficulty fully moving your head side to side: Yes/No
  - g. Difficulty bending at your knees: Yes/No
  - h. Difficulty squatting to the ground: Yes/No
  - i. Climbing a flight of stairs or a ladder carrying more than 25 lbs: Yes/No
  - j. Any other muscle or skeletal problem that interferes with using a respirator: Yes/No

**Part B. Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.**

1. 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: Yes/No  
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: Yes/No

2. 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: Yes/No  
If "yes," name the chemicals if you know them: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Have you *ever* worked with any of the materials, or under any of the conditions, listed below:

- a. Asbestos: Yes/No
- b. Silica (e.g., in sandblasting): Yes/No
- c. Tungsten/cobalt (e.g., grinding or welding this material): Yes/No
- d. Beryllium: Yes/No
- e. Aluminum: Yes/No
- f. Coal (for example, mining): Yes/No
- g. Iron: Yes/No
- h. Tin: Yes/No
- i. Dusty environments: Yes/No
- j. Any other hazardous exposures: Yes/No

If "yes," describe these exposures: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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

6. List your current and previous hobbies: \_\_\_\_\_  
\_\_\_\_\_

7. Have you been in the military services? Yes/No  
If "yes," were you exposed to biological or chemical agents (either in training or combat): Yes/No

8. Have you *ever* worked on a HAZMAT team? Yes/No
9. 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): Yes/No  
If "yes," name the medications if you know them: \_\_\_\_\_
10. Will you be using any of the following items with your respirator(s)?
- a. HEPA Filters: Yes/No
  - b. Canisters (for example, gas masks): Yes/No
  - c. Cartridges: Yes/No
11. How often are you expected to use the respirator(s) (circle "yes" or "no" for all answers that apply to you)?:
- a. Escape only (no rescue): Yes/No
  - b. Emergency rescue only: Yes/No
  - c. Less than 5 hours *per week*: Yes/No
  - d. Less than 2 hours *per day*: Yes/No
  - e. 2 to 4 hours *per day*: Yes/No
  - f. Over 4 hours *per day*: Yes/No
12. During the period you are using the respirator(s), is your work effort:
- a. **Light** (less than 200 kcal per hour): Yes/No  
If "yes," how long does this period last during the average shift: \_\_\_\_\_ hrs. \_\_\_\_\_ mins.  
Examples of a light work effort are *sitting* while writing, typing, drafting, or performing light assembly work; or *standing* while operating a drill press (1-3 lbs.) or controlling machines.
  - b. **Moderate** (200 to 350 kcal per hour): Yes/No  
If "yes," how long does this period last during the average shift : \_\_\_\_\_ hrs. \_\_\_\_\_ mins.  
Examples of moderate work effort are *sitting* while nailing or filing; *driving* a truck or bus in urban traffic; *standing* while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; *walking* on a level surface about 2 mph or down a 5-degree grade about 3 mph; or *pushing* a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.
  - c. **Heavy** (above 350 kcal per hour): Yes/No  
If "yes," how long does this period last during the average shift: \_\_\_\_\_ hrs. \_\_\_\_\_ mins.  
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.).

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator: Yes/No  
If "yes," describe this protective clothing and/or equipment: \_\_\_\_\_  
\_\_\_\_\_

14. Will you be working under hot conditions (temperature exceeding 77°F): Yes/No

15. Will you be working under humid conditions: Yes/No

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

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

18. 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 first toxic substance: \_\_\_\_\_

Estimated maximum exposure level per shift: \_\_\_\_\_

Duration of exposure per shift: \_\_\_\_\_

Name of the second toxic substance: \_\_\_\_\_

Estimated maximum exposure level per shift: \_\_\_\_\_

Duration of exposure per shift: \_\_\_\_\_

Name of the third toxic substance: \_\_\_\_\_

Estimated maximum exposure level per shift: \_\_\_\_\_

Duration of exposure per shift: \_\_\_\_\_

The name of any other toxic substances that you'll be exposed to while using your respirator:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

19. 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):



U.S. Department of Justice  
Federal Bureau of Investigation  
Critical Incident Response Group  
Bomb Data Center  
2501 Investigation Parkway  
Quantico, VA 22135

# FBI Hazardous Devices Recertification Course

Performance Standard Test Form (Optional for Recertification candidates who exceed height/weight guidelines)

*Bomb Squad Commanders are to personally complete and certify this form. Should a candidate fail to demonstrate an ability to complete similar tasks once at the Hazardous Devices School, the candidate will be dismissed from training.*

Candidate's Name	
Rank or Title	
Agency	
Agency Address (Street, City, State, ZIP)	
Business Telephone	

I, \_\_\_\_\_, certify that the above-captioned candidate can perform a series of task-oriented functions while wearing a Full Coverage Bomb Suit in normally encountered environmental conditions.

*A recommended series of task-oriented functions is: 1) Have candidate put on Full Coverage Bomb Suit; 2) While wearing Full Coverage Bomb Suit, walk 300 feet, carrying a portable X-ray/film cassette OR disrupter to a simulated IED; 3) Set-up X-ray OR disrupter; 4) Walk back to safe distance and simulate activation of portable X-ray OR disrupter; 5) Return to simulated IED and recover equipment.*

\_\_\_\_\_  
Signature of Bomb Squad Commander

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name and Title (Print of Type)

\_\_\_\_\_  
Agency

\_\_\_\_\_  
Address (Street, City, State, Zip)

\_\_\_\_\_  
Business Telephone

**APPENDIX C**

**DRUG FREE WORKPLACE POLICY**

# Drug-Free Workplace Policy

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*Applies only to Board of Commissioners Employees*

*Effective Date: Adopted 5/89; Revised 6/89, 6/92, 12/94, 9/98, 12/99, 06/04, 2/07*

## **§-I. GENERAL PROVISIONS**

### **A. PURPOSE**

To provide regulations concerning controlled substances use and alcohol misuse by County employees.

### **B. SCOPE**

Board of Commissioners' Employees.

### **C. POLICY**

Cobb County seeks to provide a safe and productive work environment for County employees, free from alcohol and controlled substances. The County is committed to complying with federal laws and regulations related to the Drug Free Work Place Act of 1988, as amended, and the Omnibus Transportation Employee Testing Act of 1991, as well as to ensuring safe operations where individuals are engaged in safety-sensitive job classifications. The policy seeks to maximize productivity without experiencing the costs, delays and tragedies associated with work-related accidents as a result of alcohol and substance abuse.

#### **1. Background**

The County recognizes drug abuse as a potential health, safety and security problem. The use of alcohol and/or controlled substances in the workplace and otherwise can seriously injure the health of employees, adversely impair the performance of their duties and endanger the safety and well-being of fellow employees, citizens and others. Health risks generally associated with alcohol and drug abuse can result in but are not limited to: a lowered immune system, damage to critical nerve cells, physical dependency, lung damage, heart problems, liver disease, physical and mental depression, increased infection, irreversible memory loss, personality changes, and thought disorders.

#### **2. Condition of Employment**

Employees must, as a condition of employment, abide by the terms of this Policy.

#### **3. General Prohibitions**

The unlawful manufacture, distribution, dispensing, possession, purchase, use, or sale of alcohol and controlled substances (including prescription drugs used illegally) is prohibited on County property, at any County activity, in County owned or leased vehicles, or while conducting County business even though not on County property.

This shall include the use or possession of controlled substances, the abuse of prescription medications, the possession/use of prescription medications by anyone other than the person for whom the medication was prescribed, and the use or abuse of alcohol.

#### **4. Controlled Substances**

Controlled substances as used in this policy refers to those covered in Schedules I-V of O.C.G.A. §§16-13-25 through 16-13-29 and Schedules I-V of 21 C.F.R. Part 1308, as either may be amended. Included are marijuana, cocaine, opiates, amphetamines and phencyclidine (PCP).

#### **5. Discipline**

Violations of this policy will result in disciplinary action, up to and including termination, and may have resulting criminal consequences. Disciplinary action may include a requirement for successful completion of an approved treatment plan. Employees must, as a condition of employment, abide by the terms of this policy.

#### **6. Addressing Concerns**

Any employee who has a concern about the unlawful manufacture, distribution, dispensing, possession, purchase, use, or sale of alcohol or controlled substances should immediately contact one of the following resources for assistance:

- a. The Employee Assistance Program regarding intervention and/or for referrals on treatment and related issues;
- b. The Human Resources, Public Safety, and/or Police Departments to report incidents of illegal activity; and/or
- c. The Human Resources Department or County Attorney's Office for assistance on the disciplinary process or policy-related issues.

#### **7. Duty to Report Criminal Conviction**

Employees must report any criminal conviction related to drug activity in the workplace (including any location where one has performed work) to the Human Resources Director within five (5) days after the conviction. Such notification may result in disciplinary action, up to and including termination, which should be taken within thirty (30) days after notification. Within ten (10) days after notice of such conviction, the County will notify the appropriate federal agency.

#### **8. Drug-Free Awareness Program**

The County has established a drug-free awareness program to educate employees about the dangers of alcohol and drug abuse in the workplace. As part of this program, the County provides all employees with a copy of this policy, which includes information concerning penalties that may be imposed for violations of the policy. Information regarding alcohol and drug abuse, drug counseling, treatment and rehabilitation, and employee assistance programs periodically will be supplied to employees. Furthermore, the County provides ongoing training for managers and supervisors responsible for the administration and enforcement of this policy, including training to determine whether reasonable suspicion exists to require testing and the availability of assistance for employees.

#### **9. Employee Assistance**

The County strongly encourages employees with drug or alcohol problems to seek professional advice and assistance before the problem leads to an incident requiring disciplinary action. Confidential assistance will be offered to employees who voluntarily identify themselves to an immediate supervisor, department head, the County Employee Relations Specialist, or the County Human Resources Director as needing assistance with an alcohol or drug problem. Help is available through referrals to the Employee Assistance Program (EAP) or through other appropriate resources.

The County will use its best efforts to work with individuals who timely identify themselves as needing assistance and will seek to accommodate such persons for a reasonable time to permit evaluation, treatment and rehabilitation. However, participation in a treatment or rehabilitation program does not preclude normal disciplinary action for violations of this policy or relieve an employee of responsibility for satisfactorily performing assigned duties.

The self-identification program may not be utilized to interfere with required testing. (For example, an employee may not identify him/herself as unfit to perform work after having been notified of a random or reasonable suspicion test and expect to avoid the consequences for a positive test or a refusal to test.)

#### **10. Records**

The County, testing laboratories, Medical Review Officer(s) and Substance Abuse Professional(s) shall maintain in strict confidence all records developed and/or acquired in pursuing this policy. Such records may be released only as provided for by law or in accordance with federal regulations.

#### **11. Inquiries**

Employee questions concerning this policy should be addressed to the Human Resources Director, who has been designated as the program coordinator to implement and maintain the alcohol and drug-testing program of the County within the guidelines of this policy and federal regulations.

#### **12. Confidentiality**

Employees should treat testing information and results as confidential and hold it in the strictest confidence. Unless the information needs to be conveyed for a business purpose, the information should not be discussed or shared with other employees.

### **D. PROHIBITIONS FOR ALL EMPLOYEES**

#### **1. Applicants**

No applicant for a job or position requiring a pre-employment screening test (including an employee seeking a transfer or promotion into that position) with a result showing an alcohol concentration of 0.02 or greater or a positive controlled substances test will be employed in that job or position. Applicants who are denied employment for this reason may re-apply after six (6) months from the date of the test.

#### **2. Employees**

Any employees in violation of alcohol or controlled substances will be subject to severe disciplinary action, up to and including termination.

For the purposes of this policy, "on duty" means all time from the time an employee begins to work or is required to be in readiness to work until the time he/she is relieved from work and of all responsibility for performing work. An employee is considered to be "on duty" during all time spent providing a breath sample or urine specimen, including travel time to and from the collection site, in order to comply with any required testing procedure under this policy.

Any supervisor with actual knowledge that an employee is in violation of any of the prohibitions of this section shall not permit the employee to perform or continue to perform job-related duties.

**a. Alcohol Prohibitions**

**(1) Alcohol Concentration.**

No employee shall report for duty or remain on duty while having an alcohol concentration of 0.02 or greater.

No employee tested pursuant to this policy with an alcohol concentration of 0.02 or greater shall remain on duty.

Regardless of disciplinary action, no employee tested pursuant to this policy with an alcohol concentration of 0.02 or greater may perform any duties until the start of the employee's next regularly scheduled work period, which shall be not less than 24 hours following administration of the test.

**(2) Alcohol Possession.**

No employee shall use, possess open alcohol or use alcohol while on duty.

**(3) Pre-Duty Use.**

No Cobb County employee, including those whose jobs are classified as safety sensitive, shall perform safety-sensitive functions or engage in the duties of a safety-sensitive job classification within four (4) hours after using alcohol.

**(4) On-Duty Use.**

No employee shall use alcohol while on duty or while performing duties of his/her position.

**(5) Use Following Accident.**

No employee required to take a post-accident alcohol test shall use alcohol for eight (8) hours following the accident or until he/she undergoes a post-accident alcohol test, whichever occurs first.

**(6) Positive Test Results.**

No employee shall report for duty, remain on duty or perform the functions of his/her position within 24 hours of the time the employee tested positive for alcohol in violation of this policy. Positive results will subject an employee to disciplinary action, up to and including termination.

**(7) Refusal to Submit to Required Test.**

No employee shall refuse to submit to a required alcohol test under this policy. A refusal to submit to testing will result in the same consequences as if the employee had submitted to the test and the result was positive.

**(8) Tampering.**

No employee shall tamper with the specimen. A determination as to whether the tampering has occurred will be made by the physician or responsible lab personnel.

**b. Controlled Substances Prohibitions**

**(1) General Prohibition.**

No employee shall manufacture, distribute, dispense, possess, purchase, use or sell controlled substances while on duty.

**(2) Pre-Duty Use.**

No employee shall report for duty when the employee has used any controlled substance, except when the use is in strict accordance with the instructions of a licensed medical practitioner who has advised the employee that the substance will not adversely affect his/her ability to safely perform the duties of his/her position.

**(3) On-Duty Use.**

No employee shall use any controlled substance while on duty, or remain on duty when he/she has used any controlled substance, except when the use is in strict accordance with the instructions of a licensed medical practitioner who has advised the employee that the substance will not adversely affect his/her ability to safely perform the duties of his or her position. The abuse and/or inappropriate use of legally prescribed drugs is prohibited while on duty.

**(4) Employee Duties When Using Prescription Medication.**

It is the employee's responsibility to notify his/her prescribing medical practitioner of his/her duties and to understand whether the physician approves the use of the prescription medication while the employee is performing his/her duties. An employee shall not perform duties when (a) he/she knows or should know that he or she is potentially impaired due to a prescription or other drug use or (b) has been advised by a physician that the substance will adversely affect his/her ability to safely perform his/her job functions.

When the use of a controlled substance is pursuant to the instruction of a physician who has advised the employee that the substance will not adversely affect his/her ability to safely perform the functions of his/her position, the employee must notify the County of such approved therapeutic drug use in advance of conducting safety-sensitive functions (for Category II employees) or engaging in the duties required under a safety-sensitive job classification (for Category III employees).

**(5) Positive Test Results.**

No employee shall report for duty, remain on duty or perform the functions of his/her position if the employee has tested positive for controlled substances. Positive results will subject an employee to disciplinary action, up to and including termination.

**(6) Refusal to Submit to Required Test.**

No employee shall refuse to submit to a required controlled substances test under this policy. A refusal to submit to testing will result in the same consequences as if the employee had submitted to the test and the result was positive.

**(7) Tampering.**

No employee shall tamper with the specimen. A determination as to whether the tampering has occurred will be made by the physician or responsible lab personnel.

**E. CATEGORIES OF EMPLOYEES (IDENTIFIED FOR TESTING)**

To maintain a safe and drug-free environment, the County has established procedures to perform screenings for alcohol and controlled substances. For the purposes of describing prescribed tests and their applicability to segments of the County's employment population, employees are divided into three categories.

**1. Category I** employees include all employees of Cobb County. Category I employees may be required to submit to alcohol and/or drug testing as provided by County policy.

**2. Category II** employees include only those employees who perform safety-sensitive functions. Category II employees may be required to submit to alcohol and/or drug testing in accordance with federally established guidelines.

**3. Category III** employees include only those employees employed in designated safety-sensitive job classifications (see Appendix A). Category III employees may be required to submit to controlled substances testing in accordance with County policy.

**F. MANDATORY SUBMISSION**

Submission to required screenings is a condition of employment. Any employee who fails to submit to the required testing under this policy is considered to have tested positive and is subject to the same discipline as if the employee had submitted to the test and the result was positive.

**G. TYPES OF TESTS**

Required alcohol and/or controlled substances screenings under this policy arise in six circumstances.

The types of tests to be administered are as follows:

**1. Pre-Employment Testing**

Because substance abuse is not easily detectable in an applicant without testing for controlled substances, and because the health and safety of employees and citizens depend on a workforce free of substance abuse, Category II and Category III employees must undergo pre-employment controlled substances testing. Applicants for these positions will be required to submit to urinalysis testing at the medical provider chosen by the County, and shall be required to sign an agreement releasing

the medical provider and the the County from liability. Prior to the employee being allowed to perform functions on behalf of the County, verification that the controlled substance screening was negative must be received. Any applicant with a confirmed positive test will be denied employment. Tampering with specimens is prohibited. A determination as to whether tampering has occurred will be made by the physician or responsible lab personnel. Where a determination of tampering is made, the applicant will not be considered for employment.

## **2. Random Testing**

Employees who perform safety-sensitive functions (Category II employees) and those in safety-sensitive job classifications (Category III employees) may be subjected to random screenings. (Category II employees are subject to screenings for alcohol and controlled substances. Category III employees are subject to screenings for controlled substances only.)

## **3. Post-Accident Testing**

Any employee may be required to submit to an alcohol and/or substance abuse test following a work-related accident. Such testing is mandatory for a Category II employee when the accident involves a fatality, other injury and/or the employee received a citation for a moving violation. Such testing shall be performed as soon after the accident as practicable. However, an employee who is subject to post-accident testing shall remain readily available for such testing, or may be deemed to have refused to submit to the testing. No employee required to take a post-accident alcohol test shall use alcohol for eight (8) hours following the accident, or until he/she undergoes a post-accident alcohol test, whichever occurs first.

In addition to disciplinary action, positive post-accident testing may result in criminal penalties and/or the denial of workers' compensation benefits.

## **4. Reasonable Suspicion Testing**

Any employee may be required to submit to an alcohol and/or controlled substances test procedure when there is a reasonable suspicion of drug or alcohol abuse. Reasonable suspicion testing will be used to determine fitness for duty, and may include appropriate urine and/or breath testing.

### **a. Reasonable Suspicion Defined**

Reasonable suspicion is based on the belief that an employee is using or has used alcohol in violation of the policy drawn from specific objective and articulable facts and reasonable inferences drawn from those facts in light of experience. Among other things, such facts and inferences may be based upon, but not limited to, the following:

- Observable phenomena while at work such as direct observation of substance abuse or of the physical symptoms or manifestations of being impaired due to substance abuse;
- Observations related to appearance, speech or body odors;
- Abnormal conduct or erratic behavior while at work or a significant deterioration in work performance;
- A report of substance abuse provided by a reliable and credible source;
- Evidence that an employee has used, possessed, sold, solicited, or transferred drugs while working or while on the County premises or while operating a vehicle, machinery or equipment;
- Evidence of visible impairment.

#### **b. Reasonable Suspicion Procedures**

Where there is reasonable suspicion of drug or alcohol abuse or impairment, an employee will be deemed unable to properly perform his or her required duties and will not be permitted to return to work. The following steps should be taken:

- Whenever possible, two supervisors should confirm and document the existence of reasonable suspicion.
- Senior management should determine whether the employee should be tested. In reaching the decision, management is encouraged when possible, to consult with Human Resources or the County Attorney's Office to the existence of reasonable suspicion.
- If a decision is reached that testing should occur, the employee should not be allowed to drive, but should be transported by a supervisor to and from the designated medical testing facility.
- Employees may be placed on administrative leave while awaiting results.
- Employees who have been determined to be impaired or whose test results are pending should not be permitted to drive home. Rather, such individuals should be released to a competent adult or driven home by a supervisor.
- Senior management should notify the Human Resources Director, or his representative at 770-528-2538 that the employee was taken to the facility.

#### **5. Return-to-Duty Testing**

Any employee found to have engaged in prohibited conduct under this policy (or who identifies him/herself as needing assistance) shall, if eligible to return to work, submit to testing. Prior to returning to his/her duties, the employee's test results should show a breath alcohol concentration of less than 0.02 and a verified negative controlled substance test.

Return-to-duty testing may arise under the following circumstances:

- a. Where the employee identified him/herself as needing assistance, was absent from the workplace for the purposes of evaluation and/or treatment, has been released to return to work, and is eligible to return to work.
- b. Where the employee was found to be in violation of this policy following a reasonable suspicion alcohol and/or drug screening, was not terminated, and is eligible to return to work.
- c. Where the employee was found to be in violation of this policy, was not terminated, participated in a rehabilitation program, and is eligible to return to work.

#### **6. Follow-Up Testing**

When an employee has been found to have violated this policy and a determination has been reached that the employee will be permitted to return to work, the employee will be subjected to unannounced follow-up testing. The number and frequency of such follow-up testing will consist of at least six tests in the first 12 months following the employee's return-to-duty. The actual requirements of the follow-up testing should be determined after consultations with a Substance Abuse

Professional (SAP), the Human Resources Department, and/or the County Attorney's Office.

#### **H. TESTING PROCEDURES**

Required testing procedures use an evidential breath testing (EBT) device for alcohol testing. For controlled substances testing, urine specimen collection and testing by a laboratory certified by the U.S. Department of Health and Human Services are required. At the discretion of the physician or employer, alternative types of testing (e.g. blood or hair) may be required. Random alcohol testing and controlled substances testing shall be limited to the time period surrounding the performance of safety-related functions which includes immediately prior to or following the employee's performance of a safety-related function. Controlled substances testing may be performed at any time the employee is at work.

#### **I. CONSEQUENCES OF POSITIVE TESTS**

When testing confirms prohibited alcohol concentration levels or the presence of a controlled substance, the employee will be removed immediately from work-related activity and may be subjected to severe disciplinary action, up to and including termination. (Employees who undergo assessments from a substance abuse professional following a positive test result are not protected from disciplinary action. The county is not required to provide rehabilitation, to pay for substance abuse treatment, or to reinstate an employee on the basis of an assessment occurring after a positive test result.)

#### **J. PROCEDURES MANUAL**

A complete set of drug and alcohol screening procedures for employees is contained in the *Drug Free Workplace Policy Procedures Manual* and is available from the Human Resources Department for affected employees and their supervisors. The procedures discuss in detail the types of screenings, when and how they are to be conducted, and the actions that will be taken should the employee receive a confirmed positive alcohol or drug test.

#### **K. COSTS & ADMINISTRATION**

The costs of all required screenings are to be borne by the County, which will contract with appropriately certified testing laboratories and/or other providers to conduct required testing, analysis, review, and reporting.

Contractors must provide, maintain and actively enforce a drug and alcohol testing program that meets the requirements of federal regulations and this policy.

#### **L. TESTING CATEGORIES**

##### **1. CATEGORY I: Alcohol & Controlled Substances Testing for All Employees**

###### **a. Who is Covered?**

Category I employees include all employees of Cobb County.

###### **b. Tests Required**

All County employees are required to submit to reasonable suspicion testing and post-accident testing. When appropriate, County employees must also submit to return-to-duty testing and follow-up testing and an evaluation by a SAP if a rehabilitation plan is permitted.

##### **2. CATEGORY II: Alcohol & Substance Abuse Testing For Employees Engaged in Safety-Sensitive Functions (CDL Drivers)**

**a. Who is Covered?**

Category II employees are deemed to be those performing safety-sensitive functions (e.g., employees required to hold a CDL as a condition of employment) as defined by federal law. The Act is intended to help prevent accidents and injuries resulting from the misuse of alcohol and controlled substances by employees performing safety-sensitive functions.

**b. Tests Required**

Category II employees are required to pass urine and/or breath testing prior to employment, to submit to random testing, to submit to reasonable suspicion testing, to submit to post-accident testing, to submit to return-to-duty testing, and to submit to follow-up testing if a rehabilitation plan is permitted.

**c. Random Testing Provisions**

The County shall randomly select and test ten percent (10%) of the average number of Category II positions for alcohol and fifty percent (50%) of the average number of Category II positions for controlled substances, as provided under federal regulations. Category II employees will be randomly selected on a monthly basis for testing. (The random selection of Category II employees will be separate from the selection of Category III employees.)

**3. CATEGORY III: Substance Abuse Testing for Employees In Designated Safety-Sensitive Job Classes**

**a. Purpose**

The County has a compelling and substantial interest in ensuring that employees who occupy safety-sensitive positions are unimpaired by controlled substances when performing their duties. This policy is instituted to deter the use of controlled substances by persons occupying or applying to occupy safety-sensitive job classifications.

**b. Who is Covered?**

Category III employees include all persons who hire into, are transferred into, or are promoted into safety-sensitive job classifications. The job classifications identified as safety-sensitive positions are approved by the Board of Commissioners. A current listing is included as Appendix A to this policy.

**c. Background**

In 1998, the County independently identified safety-sensitive job classifications to be subjected to pre-employment and random testing for substance abuse only. While recognizing a significant need to expand its drug-testing policies to include employees in safety-sensitive job classifications, the County limited the reach of the policy based on historical alcohol and substance abuse testing observations. In January 1995, the County implemented a federally-mandated drug and alcohol testing program for Category II employees, whose positions primarily required them to have Commercial Drivers' Licenses. The random testing portion of that program resulted in a number of positive tests and a number of refusals to test, specifically related to controlled substances.

**d. Tests Required**

Employees occupying safety-sensitive job classifications are required to pass controlled substances testing prior to employment and to submit to random testing for controlled substances. Requirements for reasonable suspicion testing, post-

accident testing, return-to-work testing, and follow-up testing (whether for drugs or alcohol) under Part I remain applicable to individuals employed in safety-sensitive job classifications.

**e. Random Testing Provisions**

The County shall randomly select and test ten percent (10%) of the workforce identified as being employed in safety-sensitive job classifications each year for controlled substances. Category III employees will be randomly selected on a monthly basis for testing. (The random selection of Category II employees will be separate from selection of Category III employees.)

**f. Safety-Sensitive Job Classifications Identified**

The County identified the following job classes as safety-sensitive, reasonably warranting pre-employment and random drug testing:

1. Positions involving public safety wherein employees possess police powers and/or are authorized to carry weapons: Employees who have authority to carry weapons pose a danger to themselves, their fellow employees and/or the citizenry when their performance or judgment is impaired by controlled substances. The use of controlled substances by employees with police powers can impair judgment and/or undermine the governmental interest in enforcing drug and other laws.
2. Positions in the Fire & Emergency Services: Positions in Fire and Emergency Services require employees to be prepared to react quickly and make decisions affecting the public health and safety. Employees so employed may endanger themselves, their fellow employees, and/or the public if controlled substances impair their performance.
3. Positions involving the supervision of correctional and/or detention center inmates: Positions where employees work with and/or have access to correctional/ detention centers and inmates require that personnel be of uncompromised integrity and judgment. Because of the inmate supervisory issues, allowing detention and/or correctional employees to use or possess controlled substances while in the workplace poses significant risks to security and good order.
4. Positions involving handling of hazardous chemicals and/or the operation of machinery of oversized vehicles: A concrete danger of substantial harm to the employee, co-employees, and the public exists if employees involved in operating heavy machinery or handling hazardous chemicals are impaired by controlled substances. Because such individuals are not subject to day-to-day scrutiny as in a traditional office environment, great harm may occur before supervisors notice signs of impairment.

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**APPENDIX A**

**COBB COUNTY SAFETY SENSITIVE JOB CLASSES  
CATEGORY III**

**CRITERIA:  
Job Classes that:**

1. Are involved with public safety and/or authorize employees to carry weapons
2. Require employees to be prepared to react and make decisions quickly
3. Involve the operation of machinery
4. Involve the driving of oversized vehicles
5. Involve the handling of chemicals and/or medications
6. Any position that supervises correctional and/or detention center inmates

<b>CLASS CODE</b>	<b>CLASS TITLE</b>
5012	Animal Care Specialist
5011	Animal Control Officer I
5020	Animal Control Officer II
5903	Animal Control Supervisor
5017	Animal Control Technician
6236	Assistant Police Chief
3070	Biologist
3105	Chemist
6243	Chief of Police
6234	Deputy Fire Chief
6244	Fire Battalion Chief
6230	Fire Captain
6235	Fire Chief
6345	Fire Division Chief
5016	Fire Driver/Engineer
5019	Fire Inspector Technician
5022	Fire Inspector I
5023	Fire Inspector II

5024	Fire Investigator Technician
5025	Fire Investigator I
5026	Fire Investigator II
5901	Fire Lieutenant
5014	Firefighter I
5015	Firefighter II
5030	Firefighter III
3067	Laboratory Technician
3905	Laboratory Superintendent
4020	Automotive Technician I
4021	Automotive Technician II
4022	Automotive Technician III
6238	Police Captain
6237	Police Major
6237	Police Lieutenant
5054	Police Officer
5055	Police Officer II
5053	Police Officer III
5904	Police Sergeant
6250	Public Safety Director
4030	Utility Worker I
4031	Utility Worker II
3085	Instrument Technician
3080	Wastewater Plant Operator I
3081	Waste Water Plant Operator II
3082	Waste Water Plant Operator III
3083	Waste Water Plant Operator IV
5131	Weapons and Equipment Tech

**APPENDIX D**

**EXPOSURE FORMS**

# BLOOD BORNE PATHOGEN TRANSCRIPTION GUIDELINES FOR INITIAL VISIT

- Subjective:** Information from Patient on Exposure:  
Description of Incident/Exposure
- While doing what?
  - When: Date/Time
  - How: Ex: Needle stick, Human bite, Blood splash to body surface (How Long?), Condition of body surface.
  - Where: Location of the incident
  - Is Source Known or Not Known
    - If known, is Source being tested?
    - When can results be expected?
  - Patient Personal History: Hepatitis B, A, C, HIV or STD's. Liver Disease?
- Vaccination Status:
- History of Hepatitis B vaccine (Full series? When completed? If not, most recent injection).
  - Date of Last Tetanus?

- Objective:** Description/Type of Wound/Exposure  
Vital Signs, S/S of illness.

**Assessment**  
**Data:**

- Level of Exposure/Risk (Ex.: EC1-Concentra Guideline Manual)  
Is Post Exposure Prophylaxis Appropriate?  
Work Status Indicated?

- Plan:** Blood Borne Pathogen Protocol Initiated:  
Immediate/Short-term and Long-term Measures – Labs, Follow-up Appointments, Counseling according to Exposure Level, Anti-virals, Barrier protection, Consents Signed, Patient Handouts on Exposure  
Does Patient Verbalize Understanding of Instructions/Exposure?

Tetanus vaccine booster administered today.

### BLOOD AND BODY FLUIDS RISK ASSESSMENT EXPOSURE FORM

Name \_\_\_\_\_  
Date and Time of exposure \_\_\_\_\_  
Location of Incident \_\_\_\_\_

**Type of Fluid**

- |         |                                   |                                   |                               |                                  |
|---------|-----------------------------------|-----------------------------------|-------------------------------|----------------------------------|
| Blood:  | <input type="checkbox"/> Definite | <input type="checkbox"/> Possible | <input type="checkbox"/> None | <input type="checkbox"/> Unknown |
| Stool:  | <input type="checkbox"/> Definite | <input type="checkbox"/> Possible | <input type="checkbox"/> None | <input type="checkbox"/> Unknown |
| Urine:  | <input type="checkbox"/> Definite | <input type="checkbox"/> Possible | <input type="checkbox"/> None | <input type="checkbox"/> Unknown |
| Saliva: | <input type="checkbox"/> Definite | <input type="checkbox"/> Possible | <input type="checkbox"/> None | <input type="checkbox"/> Unknown |

**Volume of Exposure**

**Splash:**

- Small (few drops, short duration)
- Large (several drops, major splash, longer duration)

**Percutaneous:**

- Less severe- i.e. no visible blood
- More severe- i.e. visible blood on device

**Method of Exposure**

- Hollow-bore needle
- Solid needle
- Razor
- Sharp object
- Bite
- Other

**Body Areas Exposed**

- Intact skin
- Non-intact skin
- Intact mucus membrane
- Mucus membrane with lesions
- Eyes
- Other

**Extent of Exposure**

- Puncture-superficial
- Puncture-Deep
- Scratch-superficial
- Laceration
- Splash
- Other

Describe details: \_\_\_\_\_

**Patient:**

- |             |                                   |                                   |  |                                       |
|-------------|-----------------------------------|-----------------------------------|--|---------------------------------------|
| HIV         | <input type="checkbox"/> Negative | <input type="checkbox"/> Positive | Date of test _____                       | <input type="checkbox"/> Never Tested |
| Hepatitis B | <input type="checkbox"/> No       | <input type="checkbox"/> Acute    | <input type="checkbox"/> Chronic carrier | <input type="checkbox"/> Unknown      |
| HepBsAg     | <input type="checkbox"/> Negative | <input type="checkbox"/> Positive | Date of test _____                       | <input type="checkbox"/> Unknown      |
| Hepatitis C | <input type="checkbox"/> No       | <input type="checkbox"/> Acute    | <input type="checkbox"/> Chronic carrier | <input type="checkbox"/> Unknown      |

**Source:**

Known  NO  YES

- |             |                                   |  |  |                                  |
|-------------|-----------------------------------|--|--|----------------------------------|
| HIV         | <input type="checkbox"/> Negative | <input type="checkbox"/> Positive        | Date of test _____                       | <input type="checkbox"/> Unknown |
| Hepatitis B | <input type="checkbox"/> No       | <input type="checkbox"/> Acute infection | <input type="checkbox"/> Chronic carrier | <input type="checkbox"/> Unknown |
| HepBsAg     | <input type="checkbox"/> Negative | <input type="checkbox"/> Positive        | Date of test _____                       | <input type="checkbox"/> Unknown |
| Hepatitis C | <input type="checkbox"/> No       | <input type="checkbox"/> Acute infection | <input type="checkbox"/> Chronic carrier | <input type="checkbox"/> Unknown |

Source Risk Factors: \_\_\_\_\_

**Personal Protective Equipment in use at the time of exposure:**

- Gloves
- Goggles
- Gown
- Mask

**HIV PEP:**

HIV Exposure Code (see worksheet) \_\_\_\_\_

**FIGURE 1. Determining the need for HIV postexposure prophylaxis (PEP) after an occupational exposure \***

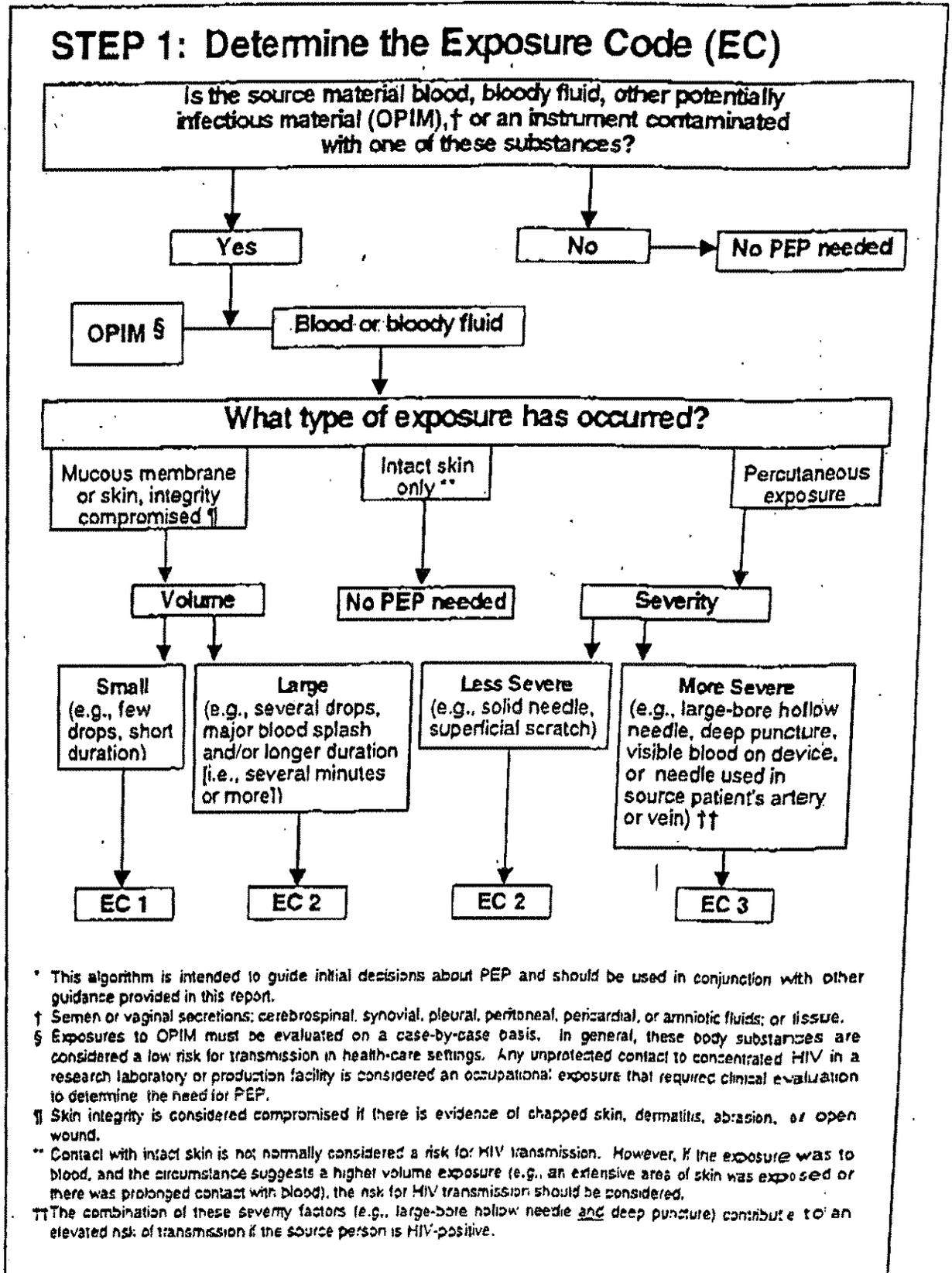
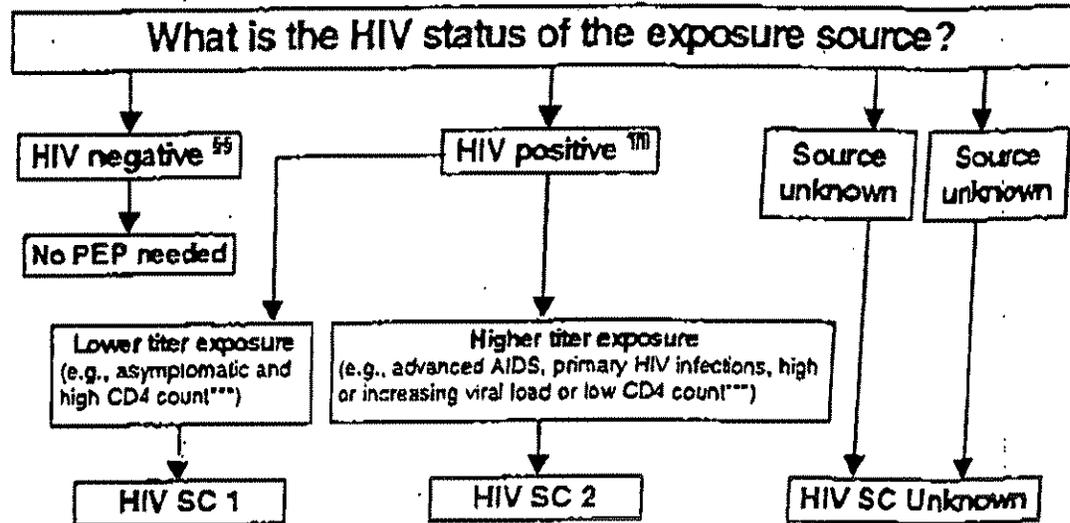


FIGURE 1. Determining the need for HIV postexposure prophylaxis (PEP) after an occupational exposure \* — Continued

### STEP 2: Determine the HIV Status Code (HIV SC)



§§ A source is considered negative for HIV infection if there is laboratory documentation of a negative HIV antibody, HIV polymerase chain reaction (PCR), or HIV p24 antigen test result from a specimen collected at or near the time of exposure and there is no clinical evidence of recent retroviral-like illness.

¶¶ A source is considered infected with HIV (HIV positive) if there has been a positive laboratory result for HIV antibody, HIV PCR, or HIV p24 antigen or physician-diagnosed AIDS.

\*\*\* Examples are used as surrogates to estimate the HIV titer in an exposure source for purposes of considering PEP regimens and do not reflect all clinical situations that may be observed. Although a high HIV titer (HIV SC2) in an exposure source has been associated with an increased risk for transmission, the possibility of transmission from a source with a low HIV titer also must be considered.

### STEP 3: Determine the PEP Recommendation

**EC HIV SC PEP Recommendation**

- |         |        |   |
|---------|--------|---|
| 1       | 1      | PEP may not be warranted. Exposure type does not pose a known risk for HIV transmission. Whether the risk for drug toxicity outweighs the benefit of PEP should be decided by the exposed HCW and treating clinician.   |
| 1       | 2      | Consider basic regimen. ¶¶¶ Exposure type poses a negligible risk for HIV transmission. A high HIV titer in the source may justify consideration of PEP. Whether the risk for drug toxicity outweighs the benefit of PEP should be decided by the exposed HCW and treating clinician. |
| 2       | 1      | Recommend basic regimen. Most HIV exposures are in this category; no increased risk for HIV transmission has been observed but use of PEP is appropriate.   |
| 2       | 2      | Recommend expanded regimen. §§§ Exposure type represents an increased HIV transmission risk.  |
| 3       | 1 or 2 | Recommend expanded regimen. Exposure type represents an increased HIV transmission risk.  |
| Unknown |        | If the source or, in the case of an unknown source, the setting where the exposure occurred suggests a possible risk for HIV exposure and the EC is 2 or 3, consider PEP basic regimen.   |

¶¶¶ Basic regimen is four weeks of zidovudine, 600 mg per day in two or three divided doses, and lamivudine, 150 mg twice daily.

§§§ Expanded regimen is the basic regimen plus either indinavir, 800 mg every 6 hours, or nelfinavir, 750 mg three times a day.

Name \_\_\_\_\_

**BLOODBORNE PATHOGEN EXPOSURE PROTOCOL**

Visit	Expected Date	Actual Date	Labs/procedures	Check list
1 Initial Visit			History-including risk assessment form Physical Exam Counseling performed, Consents signed Labs- HIV, HepBsAB, HepC, RPR, ALT* Last tetanus: date _____, Td given yes ___ no ___  PEP started ___ declined ___ Consent signed _____ Combivir +/- IND: 2 week supply given **PEP labs- CBC, LFT, pregnancy test, UA**	
2 One week later			Lab Review/Post-test Counseling Heptovax #1 given ___ not indicated ___ declined ___ Referral to PMD for abnormal baseline labs	
3 **Two week F/U (only if taking PEP)			PEP labs- CBC, LFT, UA** Refill Combivir +/- IND: 2 week supply given	
4 ***Four week F/U (only if taking PEP)			PEP labs- CBC, LFT, UA***	
5 Six week F/U			HIV test #2 given, consent signed _____ Heptovax #2 given ___ not indicated ___ declined ___	
6 One week later			Lab Review/Post-test Counseling	
7 Twelve week/ Three month F/U			HIV test #3 given, consent signed _____ Labs- Hep C, ALT	
8 One week later			Lab Review/Post-test Counseling	
9 Six month F/U			HIV test #4 given, consent signed _____ Labs: HepC, ALT, RPR Heptovax #3 given ___ not indicated ___ declined ___	
10 One week later			Lab Review/Post-test Counseling	
<b>If heptovax series was given</b>				
11 Seven month F/U			Labs- HepBsAB level	
12 One week later			Lab review- Repeat series if negative HBsAB	
<b>High Risk Only</b>				
11 Twelve month F/U			HIV test #5 given, consent signed _____ Labs- HepC, ALT	
12 One week later			Lab Review/Post-test Counseling	

PEP=post exposure prophylaxis  
 \*Not needed if PEP labs are performed  
 \*\* Only if taking PEP  
 \*\*\*Only if taking IND

**CONCENTRA MEDICAL SERVICES**

1415 North 1st Street Phoenix, AZ  
Phone: (602) 261-7886 Fax: (602) 261-7889

**Patient Informed Consent Form: Hepatitis B Vaccine****Hepatitis B:**

Hepatitis B virus is an important cause of viral hepatitis. There is no specific treatment for this disease. The incubation period for Hepatitis B is relatively long: six weeks to six months may elapse between exposure and onset of symptoms. Persistence of viral infection (the chronic Hepatitis B virus carrier state) occurs in 5-10% of persons following acute Hepatitis B.

The serious complications and sequelae of Hepatitis B virus infection include massive hepatic necrosis, cirrhoses of liver, chronic active hepatitis and hepatocellular carcinoma.

Although the vehicles for transmission of the virus are often blood and blood products, viral antigen has also been found in tears, saliva, breast milk, urine, semen and vaginal secretions.

**The Vaccine:**

Hepatitis B vaccine is a non-infectious subunit viral vaccine derived from Hepatitis B surface antigen produced in yeast cells.

The vaccine is free of association with human blood and blood products.

Clinical studies have established that the vaccine when injected into the deltoid muscle induced protective levels of antibody in 95+ % of healthy adults who received the recommended 3-dose regimen.

The duration of protective effect of the vaccine is unknown at present, and the need for booster doses is not yet determined.

**Risks and Possible Side Reactions:**

Hypersensitivity to any component of the vaccine.

**Special Precautions:**

Patients who develop symptoms suggestive of hypersensitivity after an injection should not receive further injections of vaccine.

Because of the long incubation period of Hepatitis B, it is possible for unrecognized infection to be present at the time the vaccine is given. The vaccine may not prevent Hepatitis B infection in such patients.

As with any serious medical problem, if the person has a serious or unusual problem after getting the vaccine, CALL A DOCTOR OR GET THE PERSON TO A DOCTOR PROMPTLY.

### Concentra Medical Centers

1415 North 1st Street Phoenix, AZ  
Phone: (602) 261-7888 Fax: (602) 261-7886

## Patient Informed Consent Form: Hepatitis B Vaccine

### Hepatitis B: Special Precautions:

I have read the information on page one and have had an opportunity to ask questions. I understand the benefits and risks of Hepatitis B vaccine. I understand that I must have 3 doses of the vaccine to confer immunity. As with all medical treatments, there is no guarantee that I will become immune.

I am in general good health. I am not immunosuppressed, on hemodialysis, pregnant, or breast feeding.

Name	SSN	Date of Birth	Age
Address	City	State Zip	Home Phone
Signature	Date		

	Date	Type	Mfg & Lot#	Exp. Date	Given by
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____



**CONCENTRA**  
MEDICAL CENTERS

**HIV Post-exposure Prophylaxis (PEP) Treatment Declination / Consent Form**

I understand that, due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Human Immunodeficiency Virus (HIV) Infection.

- 1. I have been given the opportunity to begin preventive oral medication today at no cost to myself.
- 2. I have been given the opportunity to ask questions of a knowledgeable health care professional concerning my occupational exposure to HIV infection along with the risks and benefits of the preventative medication, and
- 3. my questions have been answered to my satisfaction.

- I decline the HIV preventive medication offered to me. I understand that by declining this medication, I continue to be at risk of acquiring HIV, a serious infection that may lead to Acquired Immunodeficiency Syndrome (AIDS), a condition that leads to death.
- I elect to begin Post Exposure Prophylaxis (PEP). I understand the potential adverse side effects of the medication and the required clinical follow-up and blood tests. I understand that I am to avoid pregnancy while taking PEP medications.

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

Signature: \_\_\_\_\_

DOB: \_\_\_\_\_

Phone #: \_\_\_\_\_

Witness: \_\_\_\_\_



**CONCENTRA  
MEDICAL CENTERS**

**HIV POST-EXPOSURE PROPHYLAXIS (PEP) WORKSHEET**

**Initiation:** ASAP after known or potential exposure to HIV

**Duration:** 4 weeks

**Doses dispensed by Occupational Health Physicians need only cover the time interval between visits or referral to an Infectious Disease Physician.**

**ZDV (AZT) Dose:** 200 mg PO tid

**3TC Dose:** 150 mg PO bid

**IND (Indinavir) Dose:** 800 mg PO tid; add if source patient is ZDV/3TC "experienced" or high risk exposure

**Toxicity monitoring:** Symptoms/focused exam/cbc/chem. panel at baseline and every 2 weeks while on treatment; follow-up serology (After baseline, 6 weeks, 3 months, 6 months, if elevated).

**Treatment Regimes**

Dates \_\_\_\_\_ Baseline - LFT, CBC, BBP Tests, \*UA  
Pregnancy Test (Women child bearing age)  
Combivir #28, 1 P.O. BID

\_\_\_\_\_ 2 Wks \*\* - CBC, LFT, \*UA  
Refill Combivir #28 BID

\_\_\_\_\_ 4 Wks - CBC, LFT, \*UA

\_\_\_\_\_ 6 Wks - Repeat HIV  
Repeat CBC and LFT if elevated

\_\_\_\_\_ 3 Months - Repeat HIV

\_\_\_\_\_ 6 Months - Repeat HIV

\_\_\_\_\_ 1 Year - Repeat HIV

\*UA: If on Indinavir; at baseline, 2 weeks, 4 weeks (see Manual II, V, Page 1.7)

\*\*Therapy is discontinued if:

1. Source HIV Test is negative and there is no epidemiological indicators of increased risk.
2. Side effects/contraindications preclude therapy
3. Completion of 4 week cycle

**APPENDIX E**  
**POST PHYSICIAN**  
**AFFIDAVIT**



**Georgia Peace Officer Standards & Training Council**  
**Peace Officer Application for Certification**

Pg. \_\_\_  
 Of \_\_\_  
 Initial  
 \_\_\_\_\_

**Physician's Affidavit - PAGE 1 of 3**

**PHYSICIAN'S INSTRUCTIONS:**

Please complete this form and answer all questions related to your medical examination of this candidate. Do the following steps:

- 1. Review the candidate's job duties/responsibilities** for which he/she is being employed to make sure that you are familiar with the relevant job demands and working conditions of the specific position for which the candidate is being considered. Additional information such as job descriptions; critical knowledge, skills, or tasks lists; or other items may be provided. A list of job duties and responsibilities should be provided to you by the hiring agency along with this form.
- 2. Complete the patient information** at the bottom of this page and then conduct your physical exam.
- 3. Review the patient's Medical and Physical History.** A Report Form may be provided to you by the candidate or you may use the form commonly used in your medical practice.
- 4. Answer all questions** by checking the appropriate block on each page and providing any comments necessary for the hiring agency's assessment.
- 5. SIGN & DATE** on the appropriate page of this form and **provide** your address & phone #.  
 (Please note that this exam must be conducted by a licensed physician or osteopath, and the form signed by a licensed physician or osteopath **only**. (Forms signed by other personnel such as nurses, nurse practitioners, physician's assistant, or other staff will be rejected.)
- 6. Give all forms to the candidate** for return to the hiring agency.

This candidate, if certified, will have the prerequisites necessary to gain employment at any law enforcement agency in the State of Georgia, including but not limited to the current place of employment. Peace officers are charged with the responsibility of enforcing criminal laws and are subject to deal with violent individuals and situations. Officers are often required to defend themselves and others from physical attacks, subdue resisting individuals, and make decisions under stress concerning the use of deadly force. These types of positions generally require a high level of physical capability.

O.C.G.A. §35-8-8 and POST Rule 464-3-.02 require that candidates be found, after examination by a licensed physician or surgeon, to be free from any physical, emotional, or mental conditions which might adversely affect his/her exercising the powers or duties of a peace officer. Please note that your answers are intended to provide the **hiring agency** with the most useful information possible to base an employment decision, confirm to the Georgia Peace Officer Standards and Training Council that this candidate **meets** the requirements set forth in POST Rule 464-3-.02, and in your medical opinion, this candidate is capable of **safely completing** the required training and **safely performing** the necessary job duties.

Name of Agency Contact (Agency Person Processing Application)	Contact Phone# (Area Code) - Number ( ) - - - - - EXT
---	---

EMAIL ADDRESS OF AGENCY CONTACT  
 @

**SECTION 1: TO BE COMPLETED BY LICENSED EXAMINING PHYSICIAN**

Social Sec#	Last Name	First Name	Middle Name
DATE OF BIRTH (mmddyyyy)	(Jr., Sr., II, III, IV, etc.) Maiden Name	HEIGHT ft in	WEIGHT lbs (without shoes & coat)
		SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	

Job Applied for by the candidate is:



**Georgia Peace Officer Standards & Training Council**  
**Peace Officer Application for Certification**

Pg. \_\_\_  
Of \_\_\_  
Initial \_\_\_

**Physician's Affidavit - PAGE 2 of 3**

**1.) In your opinion, does the candidate have, or is the candidate likely to develop, any physical symptoms or limitations that could impair performance in this position?**

<input type="checkbox"/> No	Proceed to question 2
<input type="checkbox"/> Indeterminate	Describe additional tests or information required prior to making final determination.
<input type="checkbox"/> Yes	Describe the impact of these limitations including the following criteria: <ul style="list-style-type: none"><li>• Job functions affected</li><li>• Nature &amp; degree of severity</li><li>• Duration of impairment (if intermittent or temporary)</li><li>• Likelihood(s) associated with this impact</li></ul>

**2.) In your opinion, could the candidate's performance in this position result in a risk to the health and safety of the candidate or others?**

<input type="checkbox"/> No	Proceed to question 3
<input type="checkbox"/> Indeterminate	Describe additional tests or information required prior to making final determination.
<input type="checkbox"/> Yes	Describe the impact of these limitations including the following criteria: <ul style="list-style-type: none"><li>• Specific job duties/functions and/or working conditions that precipitate the risk:</li><li>• Nature &amp; severity of potential harm:</li><li>• Impact of harm on self and/or others:</li><li>• Likelihood(s) associated with this risk:</li><li>• Imminence and duration of the threat;</li></ul>

Please describe any means, devices or work restrictions that could reduce or eliminate any identified risks to a level not significantly greater than that posed by the average candidate. Include the manner in which the accommodation needs to be implemented, maintained, and monitored; any side effects or risks associated with the accommodation; and a revised estimate of the candidate's viability in this position if it is implemented.



**Georgia Peace Officer Standards & Training Council**  
**Peace Officer Application for Certification**

Pg. \_\_\_  
 Of \_\_\_  
 Initial  
 \_\_\_\_\_

**Physician's Affidavit - Page 3 of 3**

4.) In summary, what is your overall evaluation of the candidate's ability to safely perform the duties of this position? (choose one below)

This candidate has **no physical, emotional, or mental** conditions that might adversely affect his/her ability to perform the duties of a peace officer or take part in training programs relative to law enforcement.

**Comments:**

This candidate has **no physical conditions** that might adversely affect his/her ability, **but** there are some concerns that should be addressed regarding **one or more emotional or mental conditions** that could adversely affect their ability. (Please state recommendations on how to address here.)

**Comments:**

This candidate has **no emotional or mental conditions** that could adversely affect their ability, **but** there are some concerns that should be addressed regarding **one or more physical conditions** that could adversely affect their ability. (Please state recommendations on how to address here.)

**Comments:**

This candidate has **one or more physical, emotional, or mental conditions** that could adversely affect their ability that need to be addressed. (Please state recommendations on how to address here.)

**Comments:**

SIGNATURE OF LICENSED EXAMINING PHYSICIAN (required)

EXAMINING PHYSICIAN'S NAME (printed)

DATE (m/d/yyyy)

\_\_\_\_\_  
 Last First

ADDRESS OF LICENSED EXAMINING PHYSICIAN'S PRACTICE

Phone:  
 Area Code+Number  
 ( )

Street

City, State, Zip

**SECTION 2: HIRING AUTHORITY'S ASSESSMENT**

(TO BE COMPLETED BY HIRING AUTHORITY)

Based on this physician's assessment, can the above named candidate safely perform the essential job demands of the position for which you are hiring?

Yes

Yes, with accommodation. Candidate needs a reasonable accommodation which can be implemented without undue hardship. **NOTE:** Check here if a letter from agency head giving details of accommodation is attached (**required**).

No (If no, provide justification letter.)

SIGNATURE OF AGENCY HEAD OR DESIGNEE (required)

DATE

## APPENDIX 7 - SAMPLE MEDICAL & PHYSICAL HISTORY REPORT FORM

The purpose of the questions in this form is to gather information concerning your health and physical condition, both now and in the past. (POST Rule 464-3-.02 requires that officers be found, after examination by a licensed physician or surgeon, to be free from any physical, emotional, or mental conditions which might adversely affect his/her exercising the powers or duties of a peace officer. ) This information will be used only to determine whether you can safely complete the required training and safely perform such duties. Please answer all of the following questions as fully and completely as you can. If you don't understand a question, or are unsure of how to answer it, leave it blank and request assistance from your hiring agency or your physician. Most individuals will have some "yes" answers, and it is not necessarily a disqualification. **THIS FORM IS FOR THE PHYSICIAN ONLY AND IS TO BE GIVEN BY THE CANDIDATE TO THE PHYSICIAN AT THE EXAM.**

Last Name		First Name		Middle Name
DATE OF BIRTH (mmddyyyy)	Check if applies: <input type="checkbox"/> Jr. <input type="checkbox"/> Sr. <input type="checkbox"/> III <input type="checkbox"/> IV Other: _____	MAIDEN NAME		SEX: <input type="checkbox"/> Male
				<input type="checkbox"/> Female
				Social Security Number:

The job/position that candidate is applying for is: \_\_\_\_\_

AGENCY APPLYING WITH	AGENCY PHONE# (AREA CODE) - NUMBER ( ) - -
NAME OF AGENCY CONTACT(Person Processing Application w/in Agency)	CONTACT PHONE# (AREA CODE) - NUMBER ( ) - -

**ATTESTATION:** I certify under penalty of perjury, that the information given by me is true to the best of my knowledge and belief. I agree and understand that any misstatements of material facts may cause forfeiture on my part of all right to employment as a peace officer in the State of Georgia, may result in dismissal after appointment; or may result in loss of entitlement to disability retirement benefits. My signature also indicates that I understand all of the questions on this medical history form.

CANDIDATE'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

### INDIVIDUAL HISTORY - TO BE COMPLETED BY THE CANDIDATE (Use Ink Only)

**MEDICAL CONDITIONS INSTRUCTIONS:** Do you have or have you ever had any of the following: (Check every item. If "YES", give year of most recent medical occurrence & explain on page 3.)

Health Condition	Yes	Year	No	Health Condition	Yes	Year	No
<b>CARDIOVASCULAR SYSTEM (HEART &amp; BLOOD VESSELS)</b>				<b>SKIN</b>			
1. Heart Attack				12. Rash			
2. Hardening of the arteries (Arteriosclerosis)				13. Hives			
3. High or low blood pressure				14. Moles that bleed/get larger			
4. Heart Murmur				15. Change in color of skin (other than suntan)			
5. Palpitations or irregular heart beat				16. Frequent boils/abscesses			
6. Episodes of chest pains, tightness, discomfort				17. Trouble with fingernails			
7. Shortness of breath				18. Small itching blisters on the side of fingers or palms			
8. Varicose veins				19. Sores that do not heal			
9. Swelling of ankles, feet or legs (edema)				20. Other skin conditions			
10. Leg pains, cramps							
11. Other cardiac conditions							

**APPENDIX 7 - SAMPLE MEDICAL & PHYSICAL HISTORY REPORT FORM**

<i>Health Condition</i>	Yes	Year	No	<i>Health Condition</i>	Yes	Year	No
<b>EYES &amp; VISION</b>				<b>HEAD, NOSE, MOUTH &amp; THROAT</b>			
21. Glaucoma				51. Persistent severe headaches			
22. Cataract				52. Frequent nose bleeds			
23. Eye irritations (itching or burning)				53. Frequent nasal congestion			
24. Eye infection				54. Persistent or severe sinus condition			
25. Defective vision				55. Bleeding gums			
26. Color blindness				56. Persistent or severe dental condition			
27. Injury to eye				57. Hoarse when don't have cold			
28. Eye surgery				58. Difficulty swallowing			
29. Double vision				59. Persistent sore throat			
30. Glasses				60. Loss of taste or smell			
31. Contact lenses				61. Head injury			
				62. Other head, nose, mouth, or throat conditions			
<b>EARS &amp; HEARING</b>				<b>BLOOD/LYMPH (HEMATOLOGIC) SYSTEMS</b>			
32. Hearing difficulties				63. Anemia			
33. Use hearing aid				64. Bleeding disorder			
34. Ringing in the ears (tinnitus)				65. Sickle cell disease or trait			
35. Perforated ear drum				66. Phlebitis/blood clot			
36. Persistent or severe ear infection				67. Blood transfusion			
37. Other ear or hearing conditions							
<b>RESPIRATORY SYSTEM (LUNGS &amp; BREATHING)</b>				68. Chills, fever, night sweats			
38. Persistent or severe colds				69. Lymph node or persistent glandular swelling			
39. Persistent or severe cough				70. Other conditions of blood or lymph			
				<b>GASTROINTESTINAL SYSTEM (STOMACH &amp; INTESTINES)</b>			
40. Coughing blood				71. Persistent or severe nausea or indigestion			
41. Asthma or breathing difficulty				72. Persistent or severe stomach pain			
42. Emphysema				73. Vomiting blood			
43. Pneumonia				74. Persistent or severe vomiting			
44. Tuberculosis				75. Hernia (rupture)			
45. Other lung or breathing condition				76. Stomach or duodenal ulcer			
<b>LIVER, SPLEEN, &amp; GALLBLADDER</b>				77. Colitis			
46. Cirrhosis				78. Hemorrhoids or piles			
47. Hepatitis				79. Change in bowel habits			
48. Yellow jaundice				80. Block stool or blood in stool			
49. Gallstones				81. Persistent or severe constipation			
50. Other conditions of liver, spleen, or gallbladder							

**APPENDIX 7 - SAMPLE MEDICAL & PHYSICAL HISTORY REPORT FORM**

<i>Health Condition</i>	Yes	Year	No	<i>Health Condition</i>	Yes	Year	No
<b>KIDNEYS &amp; URINARY TRACT</b>				<b>GASTROINTESTINAL SYSTEM (STOMACH &amp; INTESTINES) cont.</b>			
82. Kidney stones				111. Persistent or severe diarrhea			
83. Kidney infection				112. Pancreatitis			
84. Blood or pus in urine				113. Appendicitis			
85. Pain or burning when urinating				114. Other conditions of stomach or intestines			
86. Frequent urination				<b>MUSCULOSKELETAL SYSTEM</b>			
87. Albumen or protein in urine				115. Arthritis			
88. Prostate condition				116. Bursitis/tendonitis			
89. Burning discharge from penis				117. Swollen or painful joints			
90. Other conditions of kidneys or urinary tract				118. Dislocations			
<b>REPRODUCTIVE SYSTEM (FEMALES ONLY)</b>				119. Painful or trick shoulder			
91. Pregnant at present				120. Elbow problems			
<b>NEUROLOGICAL (NERVOUS) SYSTEM</b>				121. Wrist or hand problems			
92. Epilepsy, convulsions, seizures				122. Back pain			
93. Periods of blackouts/loss of consciousness				123. Back surgery			
94. Fainting spells				124. Trick or locked knee			
95. Dizzy Spells (vertigo)				125. Knee surgery			
96. Memory difficulty				126. Foot problems			
97. Tremor of the hands or head				127. Bone infection			
98. Paralysis of any type				128. Broken or fractured bone			
99. Stroke				129. Persistent or severe muscle aches or pains			
100. Severe numbness, tingling or weakness				130. Other Musculoskeletal conditions			
101. Dyslexia/learning difficulty				<b>ENDOCRINE/METABOLIC SYSTEM</b>			
102. Other conditions of neurological (nervous) system				131. Diabetes			
<b>CANCER</b>				132. Thyroid condition or disease			
103. Surgery				133. Hypoglycemia			
104. Radiation Therapy				134. Unexplained weight gain or loss			
105. Chemotherapy				135. Unusual loss or growth of body hair			
106. Immunotherapy				136. Gout			
107. Hormone Therapy				137. Osteoporosis or other bone disease			
108. Breast							

## APPENDIX 7 - SAMPLE MEDICAL & PHYSICAL HISTORY REPORT FORM

<b>Health Condition</b>	Yes	Year	No	<b>Health Condition</b>	Yes	Year	No
<b>CANCER cont</b>				<b>ENDOCRINE/METABOLIC SYSTEM cont</b>			
138. Bone				153. Osteoporosis or other bone disease			
139. Skin				<b>ALLERGIES (CAUSED BY:)</b>			
140. Other				154. Medication			
<b>PSYCHOLOGICAL/MOOD</b>				155. Rheumatic fever			
141. Mental problem requiring hospitalization				156. Food			
142. Suicide/attempted suicide				157. Soaps or detergents			
143. Active psychosis				158. Pollen			
144. Drug, narcotic or alcohol				159. Insect bites/itches			
145. Persistent or severe depression/worry				160. Other:			
146. Other psychological conditions							
<b>INFECTIOUS CHILDHOOD DISEASES</b>							
147. Meningitis/encephalitis							
148. Polio							
149. Mumps							
150. Measels							
151. Venereal Disease							
152. Other:							

EXPLANATION OF ANY ITEMS CHECKED "YES".

CURRENT MEDICATIONS: (Please list.)

**SURGICAL HISTORY:** Have you ever had surgery?  Yes  No

1. Type of Surgery: \_\_\_\_\_

Date (Mo/Yr): \_\_\_\_\_

2. Type of Surgery: \_\_\_\_\_

Date (Mo/Yr): \_\_\_\_\_

3. Type of Surgery: \_\_\_\_\_

Date (Mo/Yr): \_\_\_\_\_

**HOSPITALIZATION HISTORY:** Have you ever had been hospitalized?  Yes  No

1. Reason: \_\_\_\_\_

Date (Mo/Yr): \_\_\_\_\_

2. Reason: \_\_\_\_\_

Date (Mo/Yr): \_\_\_\_\_

3. Reason: \_\_\_\_\_

Date (Mo/Yr): \_\_\_\_\_

**APPENDIX F**

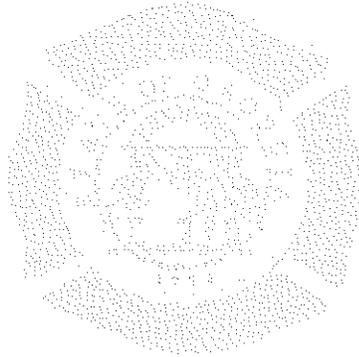
**GA FIREFIGHTERS STANDARD AND**

**TRAINING COUNCIL**

**MEDICAL AFFIDAFIT**

# GEORGIA FIREFIGHTER STANDARDS AND TRAINING COUNCIL

# FIREFIGHTER



## APPLICATION FOR FIREFIGHTER CERTIFICATION

O.C.G.A. 25-4-8 specifies that a person certified must complete the following criteria:

- (a) Be at least 18 years of age.
- (b) Not have been convicted of a felony in any jurisdiction within ten years prior to employment/appointment.
- (c) Have a good moral character as determined by investigation under procedure approved by the council.
- (d) Be fingerprinted and a search made of local, state, and national fingerprint files to disclose any criminal record.
- (e) Be in good physical condition as determined by a medical examination and successfully pass the minimum physical agility requirements as established by the council.
- (f) Possess or achieve within 12 months after employment/appointment a high school diploma or a general education development equivalency.
- (g) Complete the *Georgia Basic Firefighter Training Course* approved by the Council and verified by successful completion of the State Firefighter Certification Test.

This booklet is provided to help the applicant ensure that all of the above items have been met. To apply for certification complete each page and supply all supporting documents as shown. When completed, please send to Georgia Firefighter Standards and Training Council, 1000 Indian Springs Drive, Forsyth, Georgia 31029.

**DO NOT SUBMIT THIS BOOKLET UNTIL IT IS COMPLETE!**  
**Incomplete Booklets will be returned to the sender.**

**MEDICAL AFFIDAVIT**  
**MUST USE THIS FORM**

O.C.G.A. 25-4-8(a)(5) requires that any person certified as a firefighter be in good physical condition as determined by a medical exam. The examining physician, physician assistant, or nurse operating under a physician's authority should complete this form.

O.C.G.A. 25-4-31(a) requires that any person assigned as an airport firefighter at any airport shall, as a minimum, meet the minimum physical fitness requirements as approved by the Georgia Firefighter Standards and Training Council.

Note to medical personnel:

This applicant, if certified, will have met the medical prerequisites necessary to gain employment or appointment at any fire department in the state of Georgia, including but not limited to the current department of which he/she is a member.

Firefighters are charged with the responsibilities of mitigating a variety of emergency and non-emergency situations where life, property, or the environment is at risk. Firefighters may be required to work under extremely harsh environmental conditions requiring them to wear cumbersome protective clothing and equipment while performing strenuous physical activities. They may be required to perform rescue work and/or provide emergency medical treatment to individuals suffering from medical or traumatic emergencies. While performing or participating in these operations firefighters may be required to make decisions that could have serious consequences to life and property.

\_\_\_\_\_ is applying to  
become a certified firefighter. I have examined \_\_\_\_\_  
and to the best of my knowledge this person is in good physical condition.

\_\_\_\_\_  
Physician, Physician Assistant, Nurse (operating under a physician's authority) Name (Please Print)

\_\_\_\_\_  
Address

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date

## PHYSICAL AGILITY TEST COMPLETED

O.C.G.A. 25-4-8(a)(5) requires that any person certified as a firefighter complete a physical agility test as approved by the Council. The Physical Agility Test approved by the Georgia Firefighter Standards and Training Council (GFSTC) is the six-task test known as *The Georgia Certified Firefighters Physical Agility Test*. In lieu of the state approved test, a local test reviewed and accepted by GFSTC may be used.

Having an official from the fire department complete the following may satisfy this requirement:

\_\_\_\_\_  
Candidate's Name

has successfully completed *The Georgia Certified Firefighters Physical Agility Test* or the following accepted test \_\_\_\_\_

Name of Official verifying completion of Physical Agility Test \_\_\_\_\_

Signature of Official verifying completion of Physical Agility Test \_\_\_\_\_

Date test was successfully completed \_\_\_\_\_ Time to Complete test \_\_\_\_\_