POLICY

E & B Oilfield Services, Inc. (The COMPANY) is committed to promoting a safe and healthy environment for its employees, students, patients and visitors. Such an environment is possible only when each employee is able to perform his or her job duties in a safe, secure, and effective manner, and remains able to do so throughout the entire time they are working.

Employees who are not fit for duty may present a safety risk to themselves and to others.

This policy outlines the responsible parties and necessary actions when an employee's fitness for duty is in question, the steps necessary to assess the employee's physical or mental capabilities, necessary follow-up, and return to work.

This chapter of the E & B Oilfield Services Inc. dose not supersede or replace any part of Chapter 30 - Non-DOT Drug and Alcohol Policy of this policy.

This policy covers only those situations in which an employee is (1) per-employment physical for employees as required by companies who contract with E & B, or (2) having observable difficulty performing his/her duties in an effective manner that is safe for the employee and/or for his or her co-workers, or (3) posing a serious safety threat to self or others. The policy prescribes the circumstances under which an employee may be referred to an independent, licensed health care evaluator for a fitness for duty evaluation should either of those situations be present.

An employee shall not be allowed to work unless he/she maintains a fitness for duty required for the safe performance of essential job functions, with or without reasonable accommodation. Each employee is required to report to work in an emotional, mental and physical condition (including free of the effects of alcohol and drugs) necessary to perform his or her job in a safe and satisfactory manner.

This policy does not apply to employees with short term, infectious/communicable diseases (e.g., flu, colds). If an employee exhibits symptoms of an infectious/communicable disease, the supervisor may ask the employee to leave the workplace in order to have his/her symptoms evaluated by the employee's own health care provider or by COMPANY's occupational medicine provider, as provided in Chapter 45 - Pandemic Preparedness of this policy.

A fitness for duty evaluation is designed to address behavioral changes or physical changes in an employee that may pose a potential threat to self or others in the workplace. Application of this policy is not intended as a substitute for COMPANY policies or procedures related to chronic performance or behavioral problems or as a substitute for discipline. Supervisors shall continue to address performance or behavioral problems through the performance appraisal process and to implement appropriate corrective or disciplinary action.

The COMPANY is required to comply with federal disability law (primarily the Americans with Disabilities Act of 1990 [ADA]). In general, the ADA prohibits: (1) employers from requiring an employee to submit to a medical examination; and (2) employer inquiries into whether an individual has a disability. However, the protections afforded to employees by the ADA are not without limits. Federal law permits the COMPANY to require a medical examination of an employee if the requirement for the examination is job-related, consistent with business necessity, and if the COMPANY has a reasonable belief that:

(1) the employee's ability to perform essential job functions may be impaired by a medical condition; or

(2) an employee may pose a direct threat (i.e., significant risk of substantial harm to the health and safety of self or others) due to a medical condition.

REFERENCES

- Americans with Disabilities Act of 1990 [ADA

RESPONSIBILITIES

Fitness for duty is a responsibility shared between the Company and its employees.

All employees are responsible for:

1. Performing his/her job responsibilities in a safe and effective manner, with or without reasonable accommodations during the entire time at work;
2. Notifying the supervisor when not fit for duty;
3. Notifying the supervisor when a coworker is observed acting in a manner that indicates the coworker may not be fit for duty;
4. Informing the upper level manager or calling the COMPANY Human Resources for further guidance, if the supervisor's behavior is the focus of concern.
5. Providing relevant medical and psychological information when given the opportunity to do so; and
6. Complying with this policy and any authorized request to submit to an evaluation.

A supervisor is responsible for:

1. Observing the attendance, performance, and behavior of the employees under his/her supervision;
2. Notifying COMPANY Human Resources or their local HR when an employee is exhibiting behavior that suggests he/she may not be fit for duty;
3. Following this policy's procedures for completing an initial observation report when presented with circumstances or knowledge that indicate that an employee may not be fit for duty;
4. Removing and escorting an employee deemed not fit for duty from the worksite unless he/she poses an immediate safety threat in which case the supervisor should call 911;
5. Arranging transportation for the employee from the work site if necessary;
6. Maintaining the confidentiality of an employee's medical information; and
7. Implementing any reasonable accommodation deemed necessary by managment.

The Coordinating Team:

1. Soliciting information from the supervisor regarding employee behaviors or performance, and from the employee regarding any relevant previous medical or psychological treatment information;
2. Identifying who will conduct the fitness for duty evaluation;
3. Receiving the results of the fitness for duty evaluation;
4. Communicating the results to the employee if not done so by the evaluator;
5. Maintaining confidentiality except as detailed in the Confidentiality/ Privacy section above;
6. Coordinating payment by the employee's department for the fitness for duty evaluation;
7. Implementing any recommendations proposed by the FFD evaluation;
8. Discussing recommendations and subsequent accommodations with the supervisor; and
9. Communicating with the employee as to their rights, responsibilities and employment status.

Fitness for Duty Requirements:

An employee is expected to perform essential job functions in a safe and effective manner, and to discuss with his/her supervisor any circumstances that may impact his/her ability to do so. The COMPANY may require professional evaluation of an employee's physical, emotional or mental capacities to determine his or her ability to perform essential job functions. Such evaluations are conducted by an independent, licensed health care professional and are undertaken only after review by the coordinating team. The employee's department is responsible for paying the cost of an evaluation(s). To the extent allowed by law, the COMPANY shall protect the confidentiality of the evaluation and the results.

Employees who have the responsibility for on-call shifts must meet the fitness for duty standard during the entire on-call period.

Non-compliance with a request for a fitness for duty evaluation shall be cause for disciplinary action.

The employee's satisfactory work performance is the basis for continued employment. Participation in a treatment or rehabilitation program does not guarantee continued employment and may not necessarily prevent disciplinary action for violation of COMPANY policies. An employee must comply with all treatment recommendations resulting from a fitness for duty evaluation to be allowed to return to work. A salaried employee referred for an evaluation will be prohibited from appearing for work pending the completion of the evaluation and approval for return to work. During this time, applicable leave policies shall apply. A wage employee (including a temporary employee) referred for an evaluation will be prohibited from working or appearing for work until an evaluation is completed and the employee has been approved to return to work (compensation during this time shall be discontinued).

The Safety committee, HR department or Management:

Before initiating an evaluation, the coordinating team shall consult with the employee's supervisor to gain a clear understanding of the behavior/circumstances that have raised questions about the employee's fitness for duty. A member of the coordinating team shall also notify the employee of the opportunity to provide any relevant previous medical or psychological treatment information. The coordinating team shall determine the appropriateness of fitness for duty testing within a reasonable time after notification from the supervisor, usually within three business days.

While the employee is prohibited from appearing for work until completion of the FFD evaluation and approval to return to work is provided, the coordinating team shall use its discretion to determine whether to allow the employee to work off-site or to represent the COMPANY in any work-related capacity.

Results of the Evaluation:

The results of FFD evaluations performed by qualified, licensed health care professionals shall be presumed to be valid. Results of the evaluation will be received by COMPANY as appropriate. The employee shall be notified of the results of the FFD by the evaluator and/or COMPANY. Only necessary information shall be shared with the coordinating team. A member of the coordinating team will communicate whether the employee may return to work to the employee's supervisor and the respective dean or vice president.

After an evaluation, information given to the employee's supervisor and respective dean or vice president shall be limited to whether the employee may: return to full duty; not return to full duty, in which case the employee will be referred to Human Resources for a benefits discussion; or return to full duty with reasonable accommodations to meet the evaluator's recommendations.

Return to Work:

In conjunction with the employee's supervisor, the coordinating team shall discuss whether any reasonable and necessary accommodations need to be made. Continued employment shall be contingent upon compliance with recommendations provided by the evaluator, such as periodic testing, participation in professional counseling and treatment programs. During this time, applicable leave policies and health plan benefits shall apply. In consultation with the coordinating team, the supervisor and employee should engage in an interactive process to determine if any reasonable accommodations (e.g., re-assignment of duties for a specific period of time, a flexible work schedule) should be implemented. Failure to comply with the recommendations or agreed upon accommodations may result in disciplinary action up to and including possible termination from employment.

Confidentiality/Privacy of Fitness for Duty Evaluations:

Under the Health Insurance Portability and Accountability Act (HIPAA), any document containing medical information about an employee is considered a medical record and is regarded as confidential. Records of fitness for duty evaluations shall be treated as confidential medical records and maintained by COMPANY as appropriate. This information may be shared only on a "need to know" basis. Employees may obtain a copy of the medical report from COMPANY upon written request.

PRE - EMPLOYMENT HEALTH QUESTIONNAIRE

CONFIDENTIAL

NEW HIRE COMPLETE

To assess your medical fitness for employment, you are requested to answer the following questions accurately as possible, and then return the form in the envelope provided direct to E&B Oilfield Services Inc. HR. The answers given will be treated in strict confidence, and the form will be retained by E&B HR as part of your confidential medical record. You will be contacted if further information is required.

PLEASE PRINT – USE BLACK INK

Name (Print): Last	First	Middle	Date of Exam (MM/DD/YY)

Date of Birth (MM/DD/YY)	Age:	Proposed Job Title	☐ Male ☐ Female	Work Contact Number

Proposed Department	Proposed Location/Site	Proposed Supervisor/Manager	Proposed Supervisor/Manager Contact Number

Home Address:	GP Address:
Tel No: Email Address:	Tel No:

HEALTH HISTORY

		YES	NO	If 'YES' please give details:
1.	Do you have any health problems that may have been caused at work?			
2.	Do you have any health problems that you think may affect your performance or safety in work?			
3.	Do you have any problems with hearing?			
4.	Do you have any problems with your eyesight (that is corrected with spectacles / contact lenses)?			
5.	Have you ever suffered from blackouts, fits or faints?			
6.	Do you suffer from any phobias, e.g., Fear of heights, claustrophobia, etc.?			
7.	Have you ever had any mental health problems (including anxiety, depression, nervous breakdown, stress related illness, self-harm, eating disorders, and substance misuse)?			
8.	Do you consider yourself to be in good health at the present time?			
9.	Do you use self-examination techniques?			
10.	Do you have any health problems that cause you difficulty with: • Sitting • Standing • Moving around • Bending, lifting, or carrying • Working with a computer			
11.	Are you taking any medication or are you under any form of treatment at the moment?			
12.	Have you ever been admitted to hospital?			
13.	Are you waiting for any investigations, treatment or admission to hospital?			

PRE - EMPLOYMENT HEALTH QUESTIONNAIRE

CONFIDENTIAL

NEW HIRE COMPLETE

Name (Print – Last, First, Middle)	Date of Birth (MM/DD/YY)	Date of Exam (MM/DD/YY)

14.	Have you consulted a Doctor/GP/Specialist in the last 2 years?			
15.	Have you been absent from work/study due to illness in the last 2 years? If "YES" give details of the number of occasions, the reason for, and duration of each absence.			
16.	Do you have any other medical conditions not mentioned above?			
16.	Do you consider yourself to have a disability?			
17.	Do you drink alcohol? (1 UNIT = ½ pint of beer = ½ glass of wine = 1 measure spirit (25mls)			_____units/week
18.	Any personal or health concerns you wish to discuss with the Doctor?			
19.	Any Occupational Health Issues you wish to discuss?			
20.	Please use this space to provide any additional information: …….. …….. …….. ……..			

SIGNATURE & DATE MUST BE COMPLETED

I certify that the responses to these questions are true and complete to the best of my knowledge. I give permission for a member of the Health Services Team to communicate with any other health professional if further health information is required. I understand that I shall be contacted to obtain my fully informed consent before any report is requested under the Access to Medical Reports Act, 1988.

- I have the right to see the report before it is sent.
- I am entitled to ask the Health Services member to amend or modify the information which I consider inaccurate.
- I have 21 days from the notification to seek access to the report.

Signature:……Name (Please Print)……..Date:……

Examiners comments & findings on completed questionnaire:……

……

……

☐ Fit To employ

☐ Not fit to employ

☐ Further assessment required

Signature of RHP……Name of RHP:……Date:……

RESPIRATORY QUESTIONNAIRE

CONFIDENTIAL

PLEASE PRINT & USE BLACK INK

IDENTIFICATION

Name (Print – Last, First, Middle)	Employee Number#	Date of Exam (MM/DD/YY)
	Date of Birth (MM/DD/YY)	

HEALTH HISTORY

1. Do you smoke e.g. cigarettes, cigars, pipe?

If 'YES' how many per day?.....How many years?..... YES NO

2. Have you had any of the following conditions?

a. Seizures	YES	NO
b. Diabetes	YES	NO
c. Allergic reactions that interfere with your breathing	YES	NO
d. Claustrophobia	YES	NO
e. Trouble with smelling odors	YES	NO

If you have answered 'YES' to any of the above questions, please give details and any medications you take:

……

3. Have you ever had any of the following respiratory problems?

a. Asbestosis	YES	NO	g. Pneumothorax	YES	NO
b. Asthma	YES	NO	h. Lung Cancer	YES	NO
c. Bronchitis	YES	NO	i. Broken Ribs	YES	NO
d. Emphysema	YES	NO	j. Shortness of Breath	YES	NO
e. Pneumonia	YES	NO	k. Persistent Coughing	YES	NO
f. Silicosis	YES	NO	l. Any other problems	YES	NO

If you have answered 'YES' to any of the above questions, please give details and any medications you take:

……

4. Have you had any of the following cardiovascular problems?

a. Heart Problems	YES	NO	d. High Blood Pressure	YES	NO
b. Stroke	YES	NO	e. Swelling in your feet or legs	YES	NO
c. Angina	YES	NO	g. Any other problems	YES	NO

If you have answered 'YES' to any of the above questions, please give details and any medication you take:

……

5. Do you currently have any visual problems? (e.g. wear glasses)
If 'YES' please give details: YES NO

……

6. Do you currently have any hearing problems? (e.g. wear a hearing aid)
If 'YES' please give details: YES NO

……

7. Have you had or currently suffer with musculoskeletal problem?

a. Back Pain	YES	NO
b. Neck Pain	YES	NO
c. Weakness in your arms, hands, legs or feet	YES	NO
d. Any other problems	YES	NO

If you have answered 'YES' to any of the above questions, please give details:

……

8. If you have worn a respirator before, have you ever experienced any of the following problems:

a. Eye Irritation	YES	NO
b. Skin allergies or rashes	YES	NO
c. Anxiety	YES	NO
d. General weakness or fatigue	YES	NO
e. Difficulty breathing	YES	NO

RESPIRATORY QUESTIONNAIRE

CONFIDENTIAL

PLEASE PRINT & USE BLACK INK

IDENTIFICATION

Name (Print – Last, First, Middle)	Employee Number#	Date of Exam (MM/DD/YY)
	Date of Birth (MM/DD/YY)	

9. During the period you are using the respirator, is your work effort:

- ☐ a. LIGHT WORK e.g., Desk work, Control Room, Bench work, Lab work, Operating equipment
- ☐ b. MODERATE WORK e.g., Machine fitting, nailing, Light shoveling, Sweeping
- ☐ c. HEAVY WORK e.g., Lifting floor to waist, pushing a heavy wheelbarrow, Loading a mixer, sawing wood

10. Describe the work you do when using a respirator?

……

……

11. Special working conditions (please tick all that apply)

a. High Temperature		c. Confined Spaces	
b. Working at Height		d. Highly Toxic Materials	

SIGNATURE AND DATE MUST BE COMPLETED

I certify that the responses to this questionnaire are true & complete to the best of my knowledge.

Employee Signature:…….. Employee Name (Please print)……..Date:……

Examiners comments on findings and advice given to employee:

……

……

……

- ☐ Fit
- ☐ Further Assessment required

Signature of RHP:…….....Name of RHP:……Date:……

MEDICAL EXAMINATION FORM

CONFIDENTIAL

PLEASE PRINT & USE BLACK INK

IDENTIFICATION

Name (Print – Last, First, Middle)	Employee Number#	Date of Exam (MM/DD/YY)
	Date of Birth (MM/DD/YY)	

MEDICAL USE ONLY

EXAMINATION RESULTS

Height / cm	Weight / Kg	BMI	BP Initial /	BP Repeat /	Pulse

URINALYSIS /BLOODS

Urinalysis			Bloods		
Glucose	Protein	Blood	Hb	Glucose	Cholesterol

VISION TESTING

Uncorrected Near Vision (both eyes)		Corrected Near Vision (both eyes)		Uncorrected Far Vision (both eyes)		Corrected Far Vision (both eyes)	
Left	Right	Left	Right	Left	Right	Left	Right

PERIPHERAL TESTING

Perimeter	Right Temporal	85°	70°	55°	Nasal 45°	Total
Score	Left Temporal	85°	70°	55°	Nasal 45°	Total
					Both Eyes	Total

ISHIHARA PLATES

	Number passed	Number Failed	TEST PASSED (less than 3 failed total)	TEST FAILED (3 or more failed total)
Plates 2-9 (transforming)				
Plates 1-17 (vanishing)				
Total Plates (from above plates)				

SPIROMETRY & FITNESS TESTING

Spirometry Testing Completed: Pass Fail Refer N/A	Fitness Test Completed: Pass Fail Refer N/A VO2 Max =

AUDIOMETRY

Hearing Test Completed:
HSE Cat: 1 2 3 4 N/A

PHYSICIAN USE ONLY

Examination Area	Normal (N)	Abnormal (describe) / Comment
General Appearance		
Skin		
Eyes	R L	
Ears	R L	
Nose		
Mouth & Throat		
Neck		
Heart		
Lungs/Chest		
Abdomen		
Back		

MEDICAL EXAMINATION FORM

CONFIDENTIAL

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IDENTIFICATION

Name (Print – Last, First, Middle)	Employee Number#	Date of Exam (MM/DD/YY)
	Date of Birth (MM/DD/YY)	

Upper Extremities	R	L	
Lower Extremities	R	L	
Hernia	R	L	
Genitalia			
Veins & Arteries			
Musculoskeletal			
Nervous System			

Other Findings:

……

……

……

SIGNATURE & DATE MUST BE COMPLETED

Employee Signature:…… Employee Name (please Print)……Date:……

To be completed by E&B RHP

Results of this medical examination including recommendations and restrictions have been discussed with the Employee / Applicant

☐ YES ☐ NO

Employee / Applicant has passed medical examination as indicated on demographics form

☐ YES ☐ NO ☐ YES WITH RESTRICTIONS

List restrictions:……

……

If failed exam state reason(s)……

……

……

Examiners comments on findings and advice given to employee:……..

……

……

Signature of RHP:……..Name of RHP:……Date:……..

INITIAL AUDIOMETRIC QUESTIONNAIRE

CONFIDENTIAL

PLEASE PRINT & USE BLACK INK

IDENTIFICATION

Name (Print – Last, First, Middle)	Employee Number#	Date of Exam (MM/DD/YY)
	Date of Birth (MM/DD/YY)	

CURRENT STATUS

1. Have your leisure activities/secondary jobs or military reserve ever involved any of the following?					
a. Playing a musical instrument/play in a band or orchestra	YES	NO	g. Ride a motorcycle	YES	NO
b. Motor racing/motor sports	YES	NO	h. Shooting	YES	NO
c. Attending discos/musical concerts	YES	NO	i. Use of personal stereo/iPod	YES	NO
d. Power boats/skiing	YES	NO	j. Flying	YES	NO
e. Diving	YES	NO	K. Any other noisy activity	YES	NO
f. Power tools/engines	YES	NO			
If you have answered "YES" to any of the above questions, please give details e.g. frequency / duration. Was hearing protection worn? …….....					
2. Have you ever served in the military? BRANCH JOB				YES	NO
3. Have you ever used a firearm If "YES" please give details: ……				YES	NO
4. Were you ever exposed to other noise or explosion during military service? If "YES" please give details: ……				YES	NO

HEARING HISTORY

a. Do you have any known past hearing loss? If "YES" which ear? Left / Right / Both	YES	NO	e. Have you ever had any severe ringing in your ears?	YES	NO
			f. Have you ever had any dizziness?	YES	NO
b. Have you consulted your GP for ear problems or been seen by a specialist?	YES	NO	g. Have you any fluctuating, sudden or rapid hearing loss?	YES	NO
If "YES" what was the outcome?			h. Have you ever taken excessive mycins, quinine or aspirin?	YES	NO
c. Have you ever had an injury / operation to the ear? If "YES" which ear? Left / Right / Both	YES	NO	i. Had any allergies / colds / flu in the past month?	YES	NO
			j. Do you have any family history of hearing loss prior to age 50?	YES	NO
d. Have you ever had an ear infection, any ear pain, ear draining?	YES	NO			
5. Have you ever had any of the following?					
a. Measles	YES	NO	g. Rheumatic Fever	YES	NO
b. Mumps	YES	NO	h. Malaria	YES	NO
c. Meningitis	YES	NO	i. Tuberculosis	YES	NO
d. Chicken Pox	YES	NO	j. Diabetes	YES	NO
e. Scarlet Fever	YES	NO	k. High Blood Pressure	YES	NO
f. Diphtheria	YES	NO	l. Kidney Disease	YES	NO
6. Do you have any problems with hearing protection devices? If "YES" please give details: ……..				YES	NO
7. Do you or have you worn a radio communication earpiece device? If "YES" in which ear and what type? LEFT RIGHT TYPE……..				YES	NO

INITIAL AUDIOMETRIC QUESTIONNAIRE

CONFIDENTIAL

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IDENTIFICATION

Name (Print – Last, First, Middle)	Employee Number#	Date of Exam (MM/DD/YY)
	Date of Birth (MM/DD/YY)	

EXAMINERS OBSERVATION

Otoscopic Observation	**Left**		**Right**	
	Yes	**No**	**Yes**	**No**
Eardrum Visible?				
Eardrum Normal?				
Perforation?				
Other Abnormality?				

Type:……..Serial Number:……Calibration Date:……

SIGNATURE & DATE MUST BE COMPLETED

I certify that the responses to these questions are true & complete to the best of knowledge.

Employee Signature…….Employee Name……Date:……

I confirm that the results of my audiogram have been explained to me and advice was given regarding noise exposure and hearing loss and the correct use/fitting of hearing protection.

Employee Signature…….Employee Name……Date:……

Examiners comments on findings and advice given to employee:

……

……

…….. Fit

to continue Yes / No

Repeat Audiogram 14 hours away from noise Yes / No

Refer for medical opinion Yes / No

HSE Category: ……..

Signature of RHP:…….....Name of RHP:……Date:……