

First Name MI					ast Name				Em	plo	yee ID Nu	mber	(EID)	)	SSN (optional)				
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Company	Nam	e			Denar	t. o	r Bl	dg No.		]	Ph	one No (inc	clude	area c	ode	) To	day's l	Date	
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Job Title			ite ]	Hired Se			x Age			Γ	Birth								
												Male Female						$\neg \neg \vdash$	
									onth	Ye	ar					Month	Day		Year
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				r 1-		_	, <u>, , , , , , , , , , , , , , , , , , </u>					check all that ap		<del>^ </del>				T > 7	***
Ear Surgery Hearing Aid	No No	Right Right	Left Left		Ear Drainage		No No	Right Right		eft eft		Dizziness Chicken Pox	No No			Meningitis Diabetes		No No	Yes Yes
Impacted Wax	No	Right	Left	1 -	Ringing Ears Ear Pain		No	Right		eft		Mumps	No	_	1	Sinus or A	lergies	No	Yes
Best Ear	No	Right	Left		Sudden Loss		Vo	Right		eft		Measles	No	_		Kidney Pro		No	Yes
Have a No Right I		Left		Ruptured Ear		No	Right		eft		High Blood	No	No Yes		Exposed to E		No	Yes	
Hearing Loss		٥			Drum			C			<u> </u>	Pressure				or Explosio	on		
Been exposed t	o loud r	noise in th	e past 1	4 hou	rs?	1	Yes	No	ĪĪ	See	n aı	n audiologist or	physic	ian abou	ıt yo	ur hearing?		Yes	No
Does your hearing ability change frequently?								No				ou ever hospita				Yes	No		
Have trouble hearing or understanding speech?								No		In tl	he p	ast worked arc	und lo				No		
Difficulty heari	_	Yes	No			yes, did you wear hearing protection?							Yes	No					
Difficulty heari		Yes	No			Received yearly training about noise exposures?							Yes	No					
Have you ever	+	Yes	2 2 1 7							Yes	No								
Do you have a				Yes No			_	o you now or have you ever smoked? o you work with solvents (toluene, xylene, styrene)?							Yes	No			
L	ist belo	w comme	ents and	medic	cations.													Yes	No
										Do	you	now routinely						Yes	No
							Do you now routinely wear hearing protection?  Which type do you use?  Ear Plugs Ear Muffs Canal Caps Other												
_												zai r iugs	1 1	zai iviuii	18	Callal Ca	ps	Ouic	A
Firing Range	Pr	neumatic '	Tools	I	Engines		J	ack Hamı	mer		C	hain Saws	Farr	ning		Aircraft	Nail	Gun	
Military	M	otorcycle	S	I	Lawn Mower		I	oud Mus	ic		C	ar Racing	Hu	nting	]	Headsets	Pow	er Saws	3
I have been Patient's S			out m	ny exa	am results a	and	agre	ee to per	rmi	t rel	eas	e of the hear	ring te	st resu	lts t	o my empl	oyer.		
Examiner'	s Sigr	nature: _		_			I	Oate:				(	CAOI	IC No	:				
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Right												** *						-	
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(800) 357-5759

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Left

Employee's Name:									SSN or EID:						Date:						
									Au	ıdio	gra	m									
Baseline Annual Retest									☐ Exit ☐ OSHA				☐ MSHA ☐ FRA ☐ O								
Noise Exposure Level:								Audion Serial N		r:											
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Baseline Left:  Month Day Year								Basel Righ		Month	Day	Yea	r								
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