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| **This section to be filled out by the Employee and reviewed by the Examining Health Care Professional.** |
| The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. ‘Genetic information’ as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. |

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| Travel Details |  |
| An employee must have a Travel Health Assessment if any of the following apply:* First international trip
* Frequent international travel (> 1 times per year)
* Frequent travel to Petroleum Deepwater (Woodside Energy Limited) office locations (>1 time per month)
* Travel to and from off-shore locations and remote/high risk on-shore locations as a *visito*r (short term visit < 5 days)

An employee must have a Comprehensive Medical Assessment if any of the following apply:* Concern identified during Travel Health Assessment
* Work at offshore/onshore operational site (not as a visitor)
* Work at remote/high risk locations on-shore (i.e., geo field trips, exploration projects)
* Office Employee and Contractor who is required to travel to offshore/onshore operational sites as a required duty
 |
| **Personal Information** |
| Last Name:       | Address:       |
| First Name:       |       |
| Date of Birth:       | City:       | State:       |
| Sex: [ ]  Male [ ]  Female | Postal / Zip Code:       | Country:       |
| Location:       | Phone No.:       |
| Job Title:       | Email:       |

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| **This section to be filled out by the Employee and reviewed by the Examining Health Care Professional.** |
| The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. ‘Genetic information’ as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. |
| **Personal Information** |  |
| Last Name:        | First Name:        | Date of Birth (mm/dd/yyyy):       |
| **General Health Information** |
| **Present major complaints/health problems** | YES[ ]  | NO[ ]  | If YES, explain       |
| **Personal Physician** (or other medical contact) | [ ]  | [ ]  | If YES, provide name and phone number       |
| **Past hospitalizations, surgeries, major illnesses/injuries, treatment for mental health condition, etc.**  | [ ]  | [ ]  | If YES, provide description and date(s)      |
| **Medication**If YES, list any prescription, over-the-counter medication, dietary supplements that could affect your ability to safely perform the essential functions of your job. | [ ]  | [ ]  | *If YES, provide name, dosage*      |
| **Exposure, Lifestyle and Allergies** |
| **Exposure History** | YES | NO | If YES, describe your exposure in detail |
| *Loud noise* | [ ]  | [ ]  |       |
| *Radiation* | [ ]  | [ ]  |       |
| *Dusts or Fibers* | [ ]  | [ ]  |       |
| *Chemicals or Fumes* | [ ]  | [ ]  |       |
| *Vibration* | [ ]  | [ ]  |       |
| **Lifestyle** | YES | NO | If YES, how often? |
| *Do you smoke?* | [ ]  | [ ]  |       |
| *Do you drink alcohol?* | [ ]  | [ ]  |       |
| *Do you use drugs?* | [ ]  | [ ]  |       |
| *Do you exercise?* | [ ]  | [ ]  |       |
| **Allergies** | YES | NO | If YES, provide details and describe severity |
| *Medicine allergies* | [ ]  | [ ]  |       |
| *Food allergies* | [ ]  | [ ]  |       |
| *Environmental allergies* | [ ]  | [ ]  |       |
| *Other:*       |

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| Previous and Current Conditions (please check the box if you have ever had any of the following) |
| [ ]  Allergies: Seasonal (hay fever) | [ ]  Fatigue: Sleep disorders | [ ]  Numbness / tingling |
| [ ]  Allergies: Sinus trouble | [ ]  GI: Blood in stool | [ ]  Pregnancy: Current (or Suspected) |
| [ ]  Amputation or prosthesis | [ ]  GI: Change in bowel movements | [ ]  Respiratory: Coughed blood |
| [ ]  Back pain / injury  | [ ]  GI: Gall bladder disease | [ ]  Respiratory: Emphysema  |
| [ ]  Blood disorders | [ ]  GI: Recurrent indigestion | [ ]  Respiratory: Asthma / bronchitis |
| [ ]  Breast pain / lump / discharge | [ ]  GI: Stomach pain / ulcer | [ ]  Respiratory: Shortness of breath |
| [ ]  Broken bones | [ ]  GI: Vomiting / nausea | [ ]  Respiratory: Silicosis |
| [ ]  Cancer | [ ]  Head injury or unconsciousness | [ ]  Respiratory: Tuberculosis |
| [ ]  Cardiac: Blood Pressure: High or Low | [ ]  Headaches / migraine | [ ]  Rheumatic fever |
| [ ]  Cardiac: Chest pain or angina | [ ]  Hernia | [ ]  Skin trouble |
| [ ]  Cardiac: Heart disease / Heart attack | [ ]  Immunodeficiency disorder | [ ]  Surgical operation |
| [ ]  Cardiac: Stroke | [ ]  Jaundice or hepatitis | [ ]  Tropical disease (malaria, etc.) |
| [ ]  Cardiac: Thrombosis / Blood clots | [ ]  Joint problems / arthritis / gout | [ ]  Unexplained weight loss / gain |
| [ ]  Dental problems or dentures | [ ]  Kidney disease | [ ]  Unsteady gait / frequent falls |
| [ ]  Diabetes  | [ ]  Kidney stones | [ ]  Urine: Bloody |
| [ ]  Dizziness / fainting | [ ]  Knee problems | [ ]  Urine: Painful passage |
| [ ]  Ears: aches / ringing / drainage | [ ]  Mental Health Issues (depression, etc.) | [ ]  Varicose veins |
| [ ]  Ears: Difficulty hearing | [ ]  Mental Health: Anxiety Disorders | [ ]  Vision: Any difficulties |
| [ ]  Epilepsy / seizures / convulsions | [ ]  Mental Health: Drug/alcohol abuse | [ ]  Vision: Color blindness |
| [ ]  Evacuated from offshore/onshore site | [ ]  Muscle weakness or paralysis | [ ]  Vision: Wear glasses / contacts |
| [ ]  Fatigue: Chronic | [ ]  Neck pain / whiplash | [ ]  Numbness / tingling |
| [ ]  Fatigue: Fall asleep during the day |  |  |
| [ ]  Other (please explain):       |
| **Additional Information** | If you check any of the above boxes, please provide additional information including:* Approximate date(s) of diagnosis
* Any limitations
* If the condition is controlled
* Other pertinent details
 |       |
| **Consent to Release Information** |
| [ ]  Yes[ ]  No | I certify that all information that I have reported is true and correct to the best of my knowledge, and I have not knowingly omitted to report any material information relevant to this form. I hereby authorize the examining medical personnel and/or Physician to disclose any information provided by me in this questionnaire and the results of the medical assessment to the designated medical practitioner of Pet DW (WEL) as applicable in a confidential manner to determine my ability to perform the essential requirements of my job. I understand that the information collected based on the foregoing statements will be kept in a confidential file separate from my personnel file. |
| Printed Name:       | Date:      |
| Signature: |

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| **Office Use Only – To be completed by Health Care Professional** |
| Employee Last Name:       | Employee First Name:       |
| *Please refer to Travel Details and follow recommendations of CDC and/or WHO.*  |
| **Date given** | **Vaccine** | **Lot #** | **Manufacturer** | **Route** | **Site****Given** | **RN** | **Date on VIS** | **EmployeeInitials / Date** |
|       | Hepatitis A |       |       |       |       |       |       |       |
|       | Hepatitis B |       |       |       |       |       |       |       |
|       | Twinrix - Hepatitis A & B |       |       |       |       |       |       |       |
|       | Tdap |       |       |       |       |       |       |       |
|       | Tetanus / Diphtheria |       |       |       |       |       |       |       |
|       | MMR |       |       |       |       |       |       |       |
|       | Polio |       |       |       |       |       |       |       |
|       | Typhoid |       |       |       |       |       |       |       |
|       | Anti-malarial |       |       |       |       |       |       |       |
|       | Yellow fever |       |       |       |       |       |       |       |
|       | Other |       |       |       |       |       |       |       |

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| **Health Care Professional Information** |
| Health Care Professional Name (print):       |
| Clinic Name:       |
| Address:       | City:       |
| State/Province:       | Postal / Zip Code:       | Country:       |
| Health Care Professional Signature:  | Date (mm/dd/yyyy):       |

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| Travel Certificate of Fitness |

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| **This form to be completed by the Employee** |

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| Personal Information |  |
| Last Name:       | Address:       |
| First Name:       |       |
| Date of Birth:       | City:       | State:       |
| Sex: [ ]  Male [ ]  Female | Postal / Zip Code:       | Country:       |
| Employer:       | Phone No.:       |
| Job Title:       | Email:       |

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| ***This section to be filled out by Health Care Professional*** |
| **Health Care Professional's Assessment** |
| This individual has been examined in accordance with the Petroleum Deepwater (WEL) Medical Assessment Procedure, and in my professional opinion is: |
| [ ]  | Fit to Travel |
| [ ]  | Unfit to Travel |
| Date of Examination (mm/dd/yyyy):       |
| Travel Certificate valid for two years unless changes have occurred to current health status.Employee is responsible for requesting country specific health information prior to travel into new locations. This can be obtained through Houston Health Services. |
| **Health Care Professional Information** |
| Health Care Professional Name (print):       |
| Clinic Name:       |
| Address:       | City:       |
| State/Province:       | Postal / Zip Code:       | Country:       |
| Health Care Professional Signature:  | Date (mm/dd/yyyy):       |