



NW Testing Drug Screens & Physicals
9330 NE Vancouver Mall Drive Suite 201 Vancouver WA 98662
Phone: (360) 597-4543 Fax: (360) 597-4907

Authorization and Release Form

Patient name: _____

Exam Type	<input type="checkbox"/> DOT Physical	<input type="checkbox"/> Workplace Physical
	<input type="checkbox"/> USCG Physical	<input type="checkbox"/> Other, specify: _____
Reason	<input type="checkbox"/> Pre-Employment	<input type="checkbox"/> Recertification
	<input type="checkbox"/> Return to Work	<input type="checkbox"/> Follow Up
Audio	<input type="checkbox"/> Baseline	<input type="checkbox"/> Exit
	<input type="checkbox"/> Annual	<input type="checkbox"/> Re-test
	<input type="checkbox"/> Pre-Employment	

Billing Bill Employer _____ (Company Name)
 Employee Self Pay

Copy of Privacy Statement Offered for Review _____ (Patient Initials)

I, _____ hereby consent to today's exams/tests and authorize NW Testing to release my medical records to the employer listed above. Results to be delivered via confidential fax/email to employer point of contact or Third Party Administrator on file with NW Testing.

I understand that I may be asked to participate in a series of tests called "Human Performance Evaluation" referred to as an HPE. This HPE will test my capability to perform job-related tasks. As with any testing method of this nature, there are inherent risks involved with performance of this evaluation. There is the rare possibility that I might experience some musculoskeletal injury, but because I will controlling the efforts, the risk remains minimal. I understand that I will never be forced to perform a test that I do not want to perform and I can ask to stop the exam/test at any time.

I have read and fully understand the above description concerning the HPE and I agree to participate in this evaluation and subsequent exam/tests.

Patient Signature

Date



Human Performance Evaluation

Patient Name: _____

Evaluator: _____

Do you have any condition (physical, medical, or psychological) that would require special accommodations in order for you to perform your job? No Yes (if yes, please specify below):

		Right	Left	Both
Height		Whisper Test		
Weight		Vision (Correction Y/N)		
BP		Red/Green/Yellow		
Pulse				

Test	Test Parameters	Able	Unable	Comments
Grip strength	Right Average: Normal Range _____ to _____ Left Average: Normal Range _____ to _____			
Push/Pull	100lbs 25 feet with use of hand truck			
Dynamic Lift: Waist to Overhead	Lift 30lbs from waist to overhead			
Maintain Balance	Walk straight line 10ft Balance on each foot x 30 sec			
Flexibility	Kneel (each knee), bend and touch toes, crawl 20 ft			
Aerobic Step Test Dynamic Lift/Carry	Step up & down 12" with 25lb weight in each hand for 1 minutes			
Wrist Flexibility	Hold 10lb dumbbell at arms' length, rotate wrist 180 degrees in both directions x5 per hand			
Carpal tunnel	Raise both hands for 2 minutes then lower			

I, _____ have completed the Human Performance Evaluation and currently I am not experiencing any symptoms or difficulties following the test.

Patient Signature

Date



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Audiometry

Test Date: _____

Patient Name: _____ Employer: _____

Test Reason: ___ Baseline ___ Retest ___ Annual ___ Exit

PLEASE ANSWER YES OR NO TO THE FOLLOWING QUESTIONS	YES	NO
Do you wear hearing protection regularly?		
Have you been exposed to loud noise in the past 14 hours without hearing protection?		
Do you presently have a head cold or severe sinus condition?		
Have you visited a physician for your hearing in the last year?		
Are you aware of any hearing loss?		
Have you had dizziness or balance problems?		
Do you have ringing or roaring in your ears?		
Have you had exposure to firearms?		
Do you take prescription drugs?		
Have you been in military service?		
Have you ever had your hearing tested?		
Have you ever worked in noise?		
Do you have excessive earwax?		
Do you have earaches or ear drainage?		
Do you have noisy hobbies?		
Have you had a severe head injury?		
Comments:		

Otoscope Screening (circle one)

N= appears normal B= appears blocked P= partial blockage U= unknown/not

performed Right Ear: N B P U Left Ear: N B P U

IF BASELINE AUDIOGRAM COMPLETED, AFFIX PRINTOUT HERE

Tech: Beth J Johnson

CAOHC ID # 493515

Last Calibration Date: 2/25/2021

Signature: _____



Pre-Placement Examination Recommendations

Based on the results of examinations and screenings performed at NW Testing, it is indicated that _____ (Patient Name) is:

- Capable of performing proposed job without restrictions
- Capable of performing proposed job with the following restrictions, see below

- Not capable of performing proposed job
- Final recommendations deferred at this time pending review of additional medical information

For the position of: _____

Hearing: Pass/Fail

Vision: Pass/Fail

Color Vision: Pass/Fail

Examiner Comments:

Signature: Melissa Cosgrove NP

Date