CURRENT WORK/HEALTH/ EXPOSURE SCREENING TOOL

Name		Date	

1. Job title/occupation: ______________________

Industry sector: ______________________

2. Employment status *(check all that apply):*

- ❑ Full-time
- ❑ Part-time
- ❑ Shift work
- ❑ Modified duties
- ❑ Regulator duties

3. Do you feel any aspect of your health is aggravated by work? ❑ **Yes** ❑ **No**

If yes, how? ______________________

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4. Are you currently exposed to any of the following?

	Yes	No
Biologic agents (moulds, viruses)	❑	❑
Chemicals	❑	❑
Dust or fibres	❑	❑
Extreme heat/cold	❑	❑
Fumes	❑	❑
Heavy lifting	❑	❑

	Yes	No
Loud noise	❑	❑
Metal	❑	❑
Psychological stress	❑	❑
Radiation	❑	❑
Repetitive movement	❑	❑
Vibration	❑	❑

5. Is personal protective equipment (PPE) worn? ❑ **Yes** ❑ **No**

If yes,

- Coveralls ❑
- Glove ❑
- Hearing Protection ❑
- Respirator/mask ❑
- Safety Glasses ❑
- Safety Shoes ❑

Other ______________________

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