



TOWN OF ROCKY HILL
761 Old Main Street, Rocky Hill, CT 06067
HEARING CONSERVATION PROGRAM
(Rev. 03/13/2019)

Print Name: _____
Last Name First Name MI

Employee ID # _____

Date of Birth: _____ / _____ / _____
Month Day Year

Date of Hire: _____ / _____ / _____
Month Day Year

Gender: Male Female

Noise Dose: _____

Hearing Protector Type: _____

Hearing Protector Model # _____

Date of Last Annual Training:
_____ / _____ / _____
Month Day Year

Job Location: _____

Supervisor: _____

Department:
Facilities
Parks
Public Works
Other: _____

Job Title:
Crew Leader
Custodian: Full-time Part-time
Head Custodian
Maintainer I
Maintainer II
Maintainer III
Mechanic
Head Mechanic
Transfer Station Attendant: Full-time Part-time
Other: _____

Attach Audio Strip Here

Y / N

1. **Do you have a history of hearing loss?**
If yes, which ear(s)? Right Left
2. **Do you wear hearing aid(s)?**
If yes, which ear(s)? Right Left
3. **Do you currently have a head cold, sinus infection, or hay fever?**
4. **In the last 30 days, have you had any of the following:**
Ear Infection
Ear Pain
Draining from ear
Ruptured Ear Drum
Dizziness
Ringing in ears
Any hearing loss
5. **Have you ever had any of the following:**
Recurrent Ear Infections
Sever Ear Pain
Draining from ear
Ruptured Ear Drum
Dizziness
Ringing in ears
Ear Injury
Head Injury
Tubes placed in ear
Other Ear Surgery
Mumps
Meningitis
Excessive Ear Wax
6. **In the last 14 hours, have you been exposed to loud noise at work or at home?**
If yes, did you wear hearing protection?
Yes No

Y / N

7. **Have you ever been exposed to loud noise from:**
Airplanes
Chainsaws
Explosive Devices
Gunfire
Heavy Machinery
Military Service
Motorcycles
Music
Power Boats
Snowmobiles
Tractors or other farm equipment
Workplace
Other Source: _____
- When exposed to loud noise, how often do you wear hearing protection?**
Always Usually
Sometimes Never
8. **Have you ever had these health conditions?**
Diabetes
Hypertension
9. **Have you ever taken these medications?**
Water pill (e.g. Lasix)
High dose aspirin (more than 5 tablets per day)
10. **Have you ever received these treatments?**
IV Antibiotics
Chemotherapy
11. **Have you ever been in the military or reserves?**
If yes, which service? _____
If yes, when did you serve? _____

To be completed by Audiometric Testing Staff

Left Ear Exam: **TM Clear:** No Yes **Wax Present:** No Yes, circle: small moderate occluded
 Right Ear Exam: **TM Clear:** No Yes **Wax Present:** No Yes, circle: small moderate occluded
 Test Date: _____ Type of Test: Pre-placement Baseline Annual Retest Exit

LEFT EAR							RIGHT EAR						
500	1000	2000	3000	4000	6000	8000	500	1000	2000	3000	4000	6000	8000

Audiometer Model: _____ Serial # _____ Calibration Date: _____
 Technician Signature: _____ Employee Signature: _____