One American Way, Norwich, Connecticut 06360
860.886.1463
www.americanamb.com

Observer
Packet & Information

Training Program Affiliation:

☐ American Professional Educational Services

☐ Other:_____

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Individuals that ride/observe with American Ambulance Service, Inc. must have obtained authorization from the Director of Operations before they observe.

Requirements

Observers must:

- Complete all attached paperwork.
- Provide proof of a current PPD test (Tuberculosis) or other documentation of the absence of TB
- Provide copy of current physical (within last year) or other documentation which indicates no physical limitations that would interfere with observing or riding.

Clothing Requirements

All individuals that have met the Observer Requirements will be required to wear the following attire while doing observation time. For safety reasons, earrings are limited to one small stud per ear. No other facial jewelry, oral and/or other visible body piercing will be allowed. Hoop and ear clip type earrings are not permitted.

- A white, blue or black button up shirt with a collar and a white crew neck T-shirt underneath
- Black or navy blue dress slacks or uniform style pants (***NO Blue Jeans***)
- Polished black work-boots or black shoes (***NO Sneakers of any kind)***
- Clothing must be neat & ironed.
- No heavy perfumes or colognes
- Fingernails must be clean & well trimmed, nail polish must be professional (refer to AASI Uniform Policy for specific guidelines)
- Necklaces must be worn inside of shirt. No dangling jewelry is permitted.

Female

- No excessive make-up will be worn
- Hair must be pulled back, away from the face

Male

- Hair must be above the collar and also above the ears.
- Goatees or mustaches are permitted, otherwise must be clean shaven. Area around any facial hair must be clean shaven.

The Management team of American Ambulance Service, Inc. reserves the right to deny any observer from proceeding with observation time if they feel the observer is not in compliance with the list of requirements that have been described above in this document.

Observer Signature-_____ Date- _____

Signature of Parent and/or Guardian, if observer is under 18 years of age

Signature-_____ Date-_____

Relationship- ☐ - Parent ☐ - Grandparent ☐ - Guardian ☐ - Other:_____

Manager -_____ American Number - _____ Date - _____

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Observer Waiver

I, _____ agree that while doing observation time with American Ambulance Service, Inc. I am responsible for following all guidelines, policies and procedures as established by American Ambulance Service, Inc.

As an observer;

- I understand that I am not to assume any patient care responsibilities or take part in any treatment procedures.
- I understand that even though I will not be making direct patient contact that the possibility exists that I may be exposed to Hepatitis B. I have read the attached statement about Hepatitis B and the Hepatitis B vaccine. I have had an opportunity to ask questions and understand the risk and benefits of the Hepatitis vaccination. ***I understand that I either need to provide documentation that confirms I have been immunized or sign the attached immunization waiver.***
- I understand that at no time will I be allowed to operate any vehicle/ambulance owned by American Ambulance Service, Inc. as an observer.
- I understand that I will not be permitted to perform any lifting of patients or any other equipment that may be used during my observation time.
- **I understand that I am required to call 860.886.1463 and speak with an on-duty manager to confirm that the ride time is still scheduled for that day. American Ambulance reserves the right to cancel that day's ride time, due to unforeseen circumstances. If this should happen we will work on setting up another date and time.**

I am aware that American Ambulance Service, Inc. will make every possible effort to conclude my observation time at its scheduled conclusion time. I am aware that due to patient care, company contracts, emergency operations and unforeseen incidents that this may not always be possible. In other words, YOU MAY GET OUT LATE.

Observer Signature-_____ Date- _____

Signature of Parent and/or Guardian, if observer is under 18 years of age

Signature-_____ Date-_____

Relationship- ☐ - Parent ☐ - Grandparent ☐ - Guardian ☐ - Other:_____

Manager -_____ American Number - _____ Date - _____

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Emergency Notification Form

Rider:

Last Name-_____ First Name-_____ Middle Initial-___

Date of Birth- ___/___/___ Sex ☐ Male ☐ Female

Current Address -_____

City- _____ State- _____ Zip Code- _____

Home Phone Number- ( ) _____ Other- ( ) _____

Pertinent Medical Conditions:_____

_____

Current Medications:_____

Allergies- _____

Name of Physician-_____ Phone Number - _____

Name of person to contact, in case of Emergency- _____

Relationship- ☐ - Parent ☐ - Grandparent ☐ - Guardian ☐ - Other:_____

Current Address - _____

City- _____ State- _____ Zip Code- _____

Home Phone Number- ( ) _____ Other- ( ) _____

Observer Signature-_____ Date- _____

Signature of Parent and/or Guardian, if observer is under 18 years of age

Signature-_____ Date-_____

Relationship- ☐ - Parent ☐ - Grandparent ☐ - Guardian ☐ - Other:_____

Manager -_____ American Number - _____ Date - _____

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Confidentiality for Observers

CONFIDENTIALITY

1. Any observers riding with American Ambulance Service, Inc. may witness and be a part of a patient's care and confidential information. It is to be understood that at no time will the events concerning a patient's care or confidential information be released to anyone other than that is involved in the immediate care of that particular patient.

2. The observer agrees not to use or further disclose such information to anyone if he/she inadvertently comes in contact with any confidential information.

3. Observers will take steps to ensure that they will remain only in authorized areas of American Ambulance Service, Inc. and that they will not open any files, desks, boxes, disk storage cases, or any other containers that may potentially contain confidential and proprietary information.

4. The observer will understand that when talking about his/her experience at American Ambulance Service, Inc. only generalized statements in regards to the patient's care may be discussed. At no time will he/she divulge any confidential information in regards to the patient. This is protected information under the federal patient confidentiality law (HIPPA), which if violated could result in prosecution.

5. Any questions regarding this statement or information should be directed to an on-duty manager of American Ambulance Service Inc.

Any violations of this confidentiality provision shall be cause for immediate termination of observation, without notice.

Observer Signature-_____ Date- _____

Signature of Parent and/or Guardian, if observer is under 18 years of age

Signature-_____ Date-_____

Relationship- ☐ - Parent ☐ - Grandparent ☐ - Guardian ☐ - Other:_____

Manager -_____ American Number - _____ Date - _____

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Hepatitis B

Hepatitis B is one of the major diseases of mankind and is a serious global public health problem. It is preventable with safe and effective vaccines that have been available since 1982. Of the two billion people who have been infected with the Hepatitis B virus (HBV), more then 350 million have chronic (lifelong) infections. These chronically infected persons are at high risk of death from cirrhosis of the liver and liver cancer, diseases that kill about one million persons each year. Although the vaccine will not cure chronic hepatitis, it is 95% effective in preventing chronic infections from developing and is the first vaccine, and 116 countries have added this vaccine to their routine immunization programs.

What is Hepatitis?

Hepatitis means inflammation of the liver, and the most common causes is infection with one of the five viruses, called hepatitis A, B, C, D, and E. All of these viruses can cause an acute disease with symptoms lasting several weeks including yellowing of the skin and eyes (jaundice); dark urine; extreme fatigue; nausea; vomiting and abdominal pain. It can take several months to a year to feel fit again. Hepatitis B virus can cause chronic infection in which the patient never gets rid of the virus and many years later develops cirrhosis of the liver or liver cancer. HBV is the most serious type of viral hepatitis and the only type causing chronic hepatitis for which the vaccine is available.

Who gets Hepatitis B?

In much of the developing world, (sub-Saharan Africa, most of Asia and the pacific), most people become infected with HBV during childhood, and 8% to 10% of people in the general population become chronically infected. In these regions liver cancer caused by HBV figures among the first three causes death by cancer in men.

High rates of chronic HBV infections are also found in the Amazon and the southern parts of Eastern and Central Europe. In the Middle East and Indian sub-continent, about 5% are chronically infected. Infection is less common in Western Europe and North America, where less then 1% is chronically infected.

Young children who become infected with HBV are the most likely to develop chronic infection. About 90% of infants infected during the first year of life and 30% to 50% of children infected between one and 4 years of age develop chronic infection. The risk of death from HBV-related liver cancer of cirrhosis is approximately 25% persons who become chronically infected during childhood.

How do people get infected?

Hepatitis B virus is transmitted by contact with blood or bodily fluids of an infected person in the same way as human immunodeficiency virus (HIV), the virus the causes AIDS. ***However, HBV is 50 to 100 times more infectious the HIV.*** The main ways of getting infected with HBV are Perinatal (from mother to baby at the birth); Child-to –child transmission; Unsafe injections and transfusions, and through sexual contact.

Worldwide, most infections occur from infected mother to child, from child to child contact in household settings, and from reuse of non-sterile needles and syringes. In many developing countries, almost all children become infected with the virus.

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In Western Europe and North American the majority of infections are acquired during young adulthood by sexual activity, and injecting drug use. In addition, hepatitis B virus is the major infections occupational hazard of health workers, and most health care workers have received the hepatitis B vaccine.

Hepatitis B virus is not spread by contaminated food or water, and cannot be spread casually in the workplace.

Can chronic hepatitis B and liver cancer be treated?

Liver cancer is almost always fatal, and usually develops between 35 and 65 years of age, when people are maximally productive and with family responsibilities. Chronic hepatitis B in some patients is treated with medication, which can help some patients. However, this therapy cost thousands of dollars wand will never be available to most patients. Patients with cirrhosis are sometimes given liver transports, with varying success. It is preferable to prevent this disease with vaccine than try and curve it

How safe and effective is the vaccine?

Hepatitis B vaccine has an outstanding record of safety and effectiveness. Since 1982, over one billion doses of hepatitis B vaccine have been used worldwide. The vaccine is given as a series of three intramuscular doses. The injection is administered in the thigh or upper arm. After receiving your first dose the second dose administered one month later and the third is six months after the first dose. Studies have shown that the vaccine is 95% effective in preventing children and adults from developing chronic infection if they have not yet been infected. Vaccination is recommended for individuals that have a high risk of being exposed to or infected with HBV. These include:

- ✓ Health care workers, including doctors, dentist, nurses, blood and lab technicians;
- ✓ Emergency workers, including paramedics, EMT's, firefighter, and police;
- ✓ Hemodialysis patients;
- ✓ Military personnel;
- ✓ Morticians and embalmers;
- ✓ Patients and staff of institutions for the mentally handicapped;
- ✓ Inmates of long-term correctional facilities;
- ✓ People with multiple sexual partners;
- ✓ Intravenous drug users;
- ✓ Recipients of certain blood products;
- ✓ Household contacts and sex partners of hepatitis B carries;
- ✓ International travelers

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Hepatitis Waiver Statement

Choose one:

☐ I have not had the Hepatitis B vaccination series, or will not be providing proof of vaccination:

I _____understand the risk and benefits of immunization with Hepatitis B vaccine. Despite the potential benefits, I prefer not to be immunized.

☐ I have had the Hepatitis B vaccination series, and I am submitting documentation

Manager verifying vaccination documentation:

Manager -_____ American Number - _____ Date - _____

Observer Signature-_____ Date- _____

Signature of Parent and/or Guardian, if observer is under 18 years of age

Signature-_____ Date-_____

Relationship- ☐ - Parent ☐ - Grandparent ☐ - Guardian ☐ - Other:_____

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OSHA Respirator Medical Evaluation – 29CFR 1910.134

1.Today's Date:_____

2.Your Name:_____

3.Your Age (to nearest year):_____

4. Sex: ☐ Male ☐ Female **5. Height:** _____ft. _____in **6. Weight:**_____ lbs.

7.You're your Job Title:_____

8. A phone number where the health care professional who will review this questionnaire can reach you:

Area Code ( ) Phone number - _____

9. Best time to reach you at this number:_____

10. Has your employer told you how to contact the health care professional who will review this questionnaire (check one**)** ☐ Yes ☐ No

11. Have you ever worn a respirator? (check one**)** ☐ Yes ☐ No

If "Yes" what type(s)?:_____

_____

12. Do you CURRENTLY smoke tobacco, or have you smoked tobacco in the last month? ☐ Yes ☐ No

13. Have you EVER HAD any of the following conditions?

A. Seizures (fits):	☐ Yes ☐ No
B. Diabetes (sugar disease):	☐ Yes ☐ No
C. Allergic reactions that interfere with your breathing:	☐ Yes ☐ No
D. Claustrophobia (fear of closed-in places):	☐ Yes ☐ No
E. Trouble smelling odors:	☐ Yes ☐ No

14. Have you EVER had any of the following pulmonary or lung problems?

A. Abestosis:	☐ Yes ☐ No
B. Asthma:	☐ Yes ☐ No
C. Chronic bronchitis:	☐ Yes ☐ No
D. Emphysema:	☐ Yes ☐ No
E. Pneumonia:	☐ Yes ☐ No
F. Tuberculosis:	☐ Yes ☐ No
G. Silicosis:	☐ Yes ☐ No
H. Pneumothorax (collapsed lung):	☐ Yes ☐ No
I. Lung cancer:	☐ Yes ☐ No
J. Broken ribs:	☐ Yes ☐ No

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K. Any chest injuries or surgeries: ☐ Yes ☐ No
L. Any other lung problem that you've been told about: ☐ Yes ☐ No

15. Do you CURRENTLY have any of the following symptoms of pulmonary illness?

A. Shortness of breath: ☐ Yes ☐ No
B. Shortness of breath when walking fast on level ground or walking up a slight incline: ☐ Yes ☐ No
C. Shortness of breath when walking with other people at an ordinary pace on level ground: ☐ Yes ☐ No
D. Have to stop for a breath when walking at your own pace on level ground: ☐ Yes ☐ No
E. Shortness of breath when washing or dressing yourself: ☐ Yes ☐ No
F. Shortness of breath that interferes with your job: ☐ Yes ☐ No
G. Coughing that produces phlegm (thick sputum): ☐ Yes ☐ No
H. Coughing that wakes you in the morning: ☐ Yes ☐ No
I. Coughing that occurs mostly when you are lying down: ☐ Yes ☐ No
J. Coughing up blood in the last month: ☐ Yes ☐ No
K. Wheezing: ☐ Yes ☐ No
L. Wheezing that interferes with your job: ☐ Yes ☐ No
M. Chest pain when you breathe deeply: ☐ Yes ☐ No
N. Any other symptoms that you think may be related to lung problems: ☐ Yes ☐ No

16. Have you EVER HAD any of the following cardiovascular or heart Problems?

A. Heart Attack: ☐ Yes ☐ No
B. Stroke: ☐ Yes ☐ No
C. Angina: ☐ Yes ☐ No
D. Heart Failure: ☐ Yes ☐ No
E. Swelling in your legs or feet (not caused by walking): ☐ Yes ☐ No
F. Heart arrhythmia (heart beating irregularly): ☐ Yes ☐ No
G. High blood pressure: ☐ Yes ☐ No
H. Any other heart problem that you've been told about: ☐ Yes ☐ No

17. Have you EVER HAD any of the following cardiovascular or heart symptoms?

A. Frequent pain or tightness in your chest: ☐ Yes ☐ No
B. Pain or tightness in your chest during physical activity: ☐ Yes ☐ No
C. Pain or tightness in your chest that interferes with your job: ☐ Yes ☐ No
D. In the past two years, have you noticed your heart skipping or missing a beat: ☐ Yes ☐ No
E. Heartburn or indigestion that is not related to eating: ☐ Yes ☐ No
F. Any other symptoms that you think may be related to heart or circulation problems: ☐ Yes ☐ No

18. Do you CURRENTLY take medications for any of the following?

A. Breathing or lung problems: ☐ Yes ☐ No
B. Heart Trouble: ☐ Yes ☐ No
C. Blood Pressure: ☐ Yes ☐ No
D. Seizures (fits): ☐ Yes ☐ No

19. If you've used a respirator, have you EVER HAD and of the following problems? (If you've never used a respirator, checking the following space and go to question #9) ☐ N/A

A. Eye Irritation: ☐ Yes ☐ No
B. Skin allergies or rashes: ☐ Yes ☐ No
C. Anxiety: ☐ Yes ☐ No
D. General Weakness or Fatigue: ☐ Yes ☐ No
E. Any other problems that interferers with your use of a respirator: ☐ Yes ☐ No

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20. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? ☐ Yes ☐ No

21. Have you EVER LOST vision in either eye (temporarily or permanently): ☐ Yes ☐ No

22. Do you CURRENTLY have any of the following vision problems?

A. Wear contact lenses:	☐ Yes ☐ No
B. Wear glasses:	☐ Yes ☐ No
C. Color blind:	☐ Yes ☐ No
D. Any other eye or vision problems:	☐ Yes ☐ No

23. Have you EVER HAD an injury to your ears, including a broken ear drum: ☐ Yes ☐ No

24. Do you CURRENTLY have any of the following hearing problems?

A. Difficulty hearing:	☐ Yes ☐ No
B. Wear a hearing aid:	☐ Yes ☐ No
C. Any other hearing problem:	☐ Yes ☐ No

25. Have you EVER HAD a back injury: ☐ Yes ☐ No

26. Do you CURRENTLY have any of the following musculoskeletal problems?

A. Weakness in any of your arms, hands, legs, or feet:	☐ Yes ☐ No
B. Back pain:	☐ Yes ☐ No
C. Difficulty fully moving your arms or legs:	☐ Yes ☐ No
D. Pain or stiffness when you lean forward or backward at the waist:	☐ Yes ☐ No
E. Difficulty moving your head up or down:	☐ Yes ☐ No
F. Difficulty Fully moving your head side to side:	☐ Yes ☐ No
G. Difficulty bending at your knees:	☐ Yes ☐ No
H. Difficulty squatting to the ground:	☐ Yes ☐ No
I. Climbing a flight of stairs or a ladder carrying more then 25 lbs:	☐ Yes ☐ No
J. Any other muscle or skeletal problem that interferes with using a respirator:	☐ Yes ☐ No

27. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower then normal amounts of oxygen: ☐ Yes ☐ No

If "yes, " do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions: ☐ Yes ☐ No

28. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemical (e.g. gases, fumes, or dust), or have you come into skin contact with hazardous chemicals: ☐ Yes ☐ No

29. Have you ever worked with any materials, or under any of the conditions, listed below:

A. Asbestos:	☐ Yes ☐ No
B. Silica (e.g. in sandblasting):	☐ Yes ☐ No
C. Tungsten/cobalt (e.g. grinding or welding this material):	☐ Yes ☐ No
D. Beryllium:	☐ Yes ☐ No
E. Aluminum:	☐ Yes ☐ No
F. Coal (for example Mining):	☐ Yes ☐ No
G. Iron	☐ Yes ☐ No

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H. Tin: ☐ Yes ☐ No
I. Dust: ☐ Yes ☐ No
J. Any other hazardous exposures: ☐ Yes ☐ No

If "Yes," descried these exposures:

_____

_____

30. List any second jobs or side business you have:

_____

_____

31. List any previous occupations:

_____

_____

32.. List your current and previous hobbies:

_____

_____

33. Have you ever been in the military service? ☐ Yes ☐ No
If "yes," were you exposed to biological or chemical agents (either in training or combat): ☐ Yes ☐ No

34. Have you ever worked on a HAZMAT team? ☐ Yes ☐ No

35. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in the questionnaire, are you taking any other medications for any reason (including over-the-counter medications): ☐ Yes ☐ No

If "yes," List the medications if you know them:

_____

_____

36. Will you be using any of the following items with your respirator(s)?

A. HEPA Filter: ☐ Yes ☐ No
B. Canisters (for example, gas mask): ☐ Yes ☐ No
C. Cartridges: ☐ Yes ☐ No

37. How often are you expected to use the respirator(s) (check "yes" or "no" for all the answers that apply to you)?:

A. Escape only (no rescue): ☐ Yes ☐ No
B. Emergency rescue only: ☐ Yes ☐ No
C. Less than 5 hours PER WEEK: ☐ Yes ☐ No

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D. Less than 2 hours PER DAY: ☐ Yes ☐ No
E. 2 to 4 hours per day: ☐ Yes ☐ No
F. Over 4 hours per day: ☐ Yes ☐ No

38. During the period you are using the respirator(s), is your work effort:

A. **LIGHT** (less then 200kcal per hour): ☐ Yes ☐ No
If "yes" how long does this period last during the average shift: _____hrs. _____ mins.
*Examples of a light work effort of **sitting** while writing, typing, drafting, performing light assembly work; or STANDING while operating a drill pres (1-3 lbs.) or controlling machines.*

B. **MODERATE** (200 to 350 kcal per hour) ☐ Yes ☐ No
If "yes" how long does this period last during the average shift: _____hrs. _____ mins.
*Examples of moderate work effort are **sitting** while mailing or filing; **driving** a truck or bus in urban traffic; **standing** while drilling, mailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at truck level; **walking** on a level surface about 2 mph or down a 5-degree grade about 3 mp; or **pushing** a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.*

C. ***HEAVY*** (above 350 kcal per hour): ☐ Yes ☐ No
If "yes" how long does this period last during the average shift: _____hrs. _____ mins.
*Example of heavy work are **lifting** a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; **shoveling**; **standing** while bricklaying or chipping castings; **walking** up a 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs).*

39. Will you be wearing protective clothing and/or equipment (other then the respirator) when you're using your respirator: ☐ Yes ☐ No

If "yes," describe this protective clothing and/or equipment:
_____

_____

40. Will you be working under hot conditions (temperature exceeding 77 deg. F): ☐ Yes ☐ No

41. Will you be working under humid conditions? ☐ Yes ☐ No

42. Describe the work you'll be doing while you're using you respirator(s):
_____

_____

43. Describe any special hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaced, life-threatening gases):

_____

_____

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44. Provided the following information, if you know it, for each toxic substance that you'll be exposed to when using your respirator:

Name of the first toxic substance:_____

Estimated maximum exposure level per shift:_____

Duration of exposure for shift:_____

Name of the second toxic substance:_____ _____

Estimated maximum exposure level per shift:_____ __

Duration of exposure for shift:_____

Name of the third toxic substance:_____

Estimated maximum exposure level per shift:_____

Duration of exposure for shift:_____

The name of any other toxic substance that you'll be exposed to while using your respirator:_____

45. Describe any special responsibilities you'll have while using the respirator(s) that may effect the safety and well-being of others (for example, rescue, security):

_____

_____

Employee / Observer Signature: _____

Date:_____

FOR OFFICAL USE ONLY

Reviewed by:_____ Date:_____

Recommendations:☐ Approved for a N-95 Use.
☐ Not approved for a N-95 Use. Must have a Respiratory Exam

Signature:_____

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Respirator Fit Test Record

Observer Name:_____

Respirator Selected: 3M N95
Model #: 8511/ 8110s N95 Particulate Respirator, Other _____

Meets NIOSH 42 CFR 84 N95 Requirements TC-84A-1299

Manufactured by: 3M Occupational Health & Environmental Safety Division
3M Center, Building 275-6W-01
P.O. Box 33275
St. Paul, MN 55133-3275

Fit Test: Qualitive Saccharin/Bitter Solution ____ **PASS** ____ **FAIL**

Mask Size _____

Conditions Affecting Fit:

___ Clean Shaven ____1-2 Day Beard Growth ____2+ Day Growth
____ Moustache ____ Facial Scar ____ Dentures Absent
____ Glasses ____ None ____ Other (specify)

Comments:_____
_____
_____
_____
Observer Acknowledgement of Test Results:

Observer Signature:_____ Date:_____

Test Conducted By:_____ Date:_____

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Observer Checklist

For AASI Management Only:

Observer Waiver complete with signatures (all pages)	_____
Proof of a current PPD test (immunization record, doctor's note)	_____
Proof of current physical (within last year)	_____
Hepatitis B Vaccine documentation or signed Waiver	_____
Respirator test complete including documentation	_____
Reviewed the location of all MSDS books	_____
Reviewed the location of all chemical hazards	_____
Viewed Bloodborne video and documentation complete	_____
Issued an AASI High Visibility Jacket (Employee shall provide their own)	_____
Issued an Observer bag	_____
Introduced Observer to crew they are assigned to for the day	_____
Verified the Observer has met our clothing requirements	_____
Turn this packet all applicable paperwork to Operations Director	_____

*Manager -*_____ *American Number -* _____ *Date -* _____