ODP EMPLOYEE PHYSICAL EXAM PACKET

Attached is the physical exam package, which consists of the following:

Physical Exam Policy
Instructions and General Considerations

Annual or Pre-Cruise Physical Exam
General and Responsibility for Exam Expense

New Employee Physical
General, Responsibility for Exam Expense, and Medical History Records

Attachment 1: Medical History Questionnaire
To be signed by the new employee or cruise participant
New employees must attach copies of immunization records
and blood type to this form.

Attachment 2: Typical Physical Requirements of ODP Employee or Cruise Participant
To be given to physician for review, along with all other Attachments.

Attachment 3: Medical Exam Requirements & Certification of Eligibility to Participate
To be given to physician along with all other Attachments.

Attachment 4: Additional Physical Exam Reimbursements for Participants with
Depression/Mental Illness/Emotional Problems
Letter to physician requesting additional information

Attachment 5: Physical Exam Reimbursement Form for ASPP Personnel only.

New employee physical exams should be returned as soon after completion as possible, prior to
the new employee's first working day.

Annual or pre-cruise examinations should be returned no later than one month prior to
departure to join the ship in port.
INTRODUCTION

The purpose of the Ocean Drilling Program (ODP) Physical Exam requirement is to protect the health and safety of all cruise participants and to minimize interference with successful completion of the scientific objectives of each cruise. Physical examination results will determine eligibility for employment and/or cruise participation. All medical information will be kept in secure files and treated confidentially.

All persons offered employment in seagoing positions, employees in seagoing positions, and cruise participants are required to complete a comprehensive physical examination by a licensed physician according to the terms of the Ocean Drilling Program Physical Exam Policy as detailed in the following pages. Furthermore, ODP may require specific medical or psychological tests and/or evaluations of participant at any time medical conditions warrant.

The reimbursement terms, as outlined in the following pages, are based on a philosophy of payment for examination and evaluation. The Ocean Drilling Program is not responsible for the cost of any medical or psychological treatment necessary for the individual to meet the requirements of this policy.

GENERAL HEALTH CONSIDERATIONS

Immunizations
Current information on immunizations required to enter to the port or country of operation is listed on Attachment 1a. New employees are required to attach a copy of records of immunization history to the Medical History Questionnaire (Attachment 1a). If medical records are not provided, immunizations may be given as part of the exam. ODP will cover the cost of required immunizations.

Medical Supplies
Medical supplies and medication on board the drillship are limited. Each participant is responsible for bringing an adequate supply of medication or medical supplies for treating an existing condition for the duration of a cruise.

Sea/Motion Sickness
Each participant is encouraged to discuss the possibility of sea/motion sickness with his/her physician. The physician may be able to provide information and/or prescribe medications to prevent or control the symptoms. Employees with concerns about sea/motion sickness should also discuss their situation with the ship’s physician as soon as possible after boarding.

Pregnancy
If a participant suspects she is pregnant, she is advised to see a licensed obstetrician/gynecologist. A participant who is pregnant must provide her obstetrician/gynecologist with a written job description for her position and obtain a certification from the obstetrician/gynecologist. The certification must state that the participant is capable of performing her duties and explain any physical restrictions or limitations.

Allergies
To minimize the occurrence of an allergy problem that may arise during a cruise, each participant is asked to bring non-perfumed, non-allergenic hygiene products on the ship.

Medical History
Employees are to complete information on medical history on Attachment 1-1c. Attachment 3 lists all medical tests required as part of the physical exam. If a new employee is unable to provide a medical record evidencing blood type or immunizations, then blood typing and immunizations will be completed as part of the New Employee Exam. Employees are responsible for reporting any serious illness or injury, physical and/or emotional, that is overlooked during the medical examination or that develops after the exam and prior to boarding the ship. In such a situation a follow up medical evaluation may be necessary to determine fitness for sea duty.
ANNUAL OR PRE-CRUISE PHYSICALS

Regular Seagoing Positions

Employees in regular seagoing positions are required to pass a physical exam once per year, or more often if medical conditions warrant. Regular seagoing positions are those which require working at sea on a rotating basis of two months at sea and two to four months on shore (approximately 4 to 6 months at sea each year, depending on the position.) If a regular seagoing employee's physical exam expires while the employee is on official travel days to port call or at sea, he or she will be required to successfully complete the ODP exam prior to participation in a subsequent cruise. Failure to pass the ODP physical exam will result in the employee's restriction from participation in the scheduled cruise and may result in evaluation of continued employment.

Positions Requiring Occasional Sea Duty

Employees in positions which may require occasional sea duty must pass the ODP physical exam prior to sailing but not more than once every twelve months, unless medical conditions warrant additional testing. Failure to pass the ODP physical exam will result in the employee's restriction from participation in the scheduled cruise.

The entire completed package is to be submitted to the ODP Human Resources/Insurance Services. The ODP Human Resources/Insurance Services will review the documents for completeness and for the physician's recommendation. The final decision to allow an employee to sail rests with officials of the Ocean Drilling Program.

RESPONSIBILITY FOR EXAM EXPENSE

The cost of this examination shall be for ODP's account, up to a maximum equal to the rate established for ODP Annual Physical Exams. Exception is granted to employees based at the East Coast Repository and West Coast Repository; their exams will be reimbursed in full.

The cost of required immunizations shall be for ODP's account. Required immunizations are defined as those which are as listed on the medical history questionnaire or those required to enter the country of operation. If the employee has not received a required immunization, or has an expired immunization, then the injections will be given as part of the annual exam.

If additional testing is required by the examining physician in order to make a determination of the employees’ health status after any of the initial test listed are inconclusive, those additional tests shall be for the employees’ account. This also includes any psychological testing or evaluations the examining physician might require in order to make a determination of being fit to sail.

In the event ODP requests any additional tests after the examining physician has determined the employee is fit to sail, these costs will be for ODP’s account. The cost of any treatment, which may be required due to a medical or psychological condition, is for the employees’ account.
NEW EMPLOYEE PHYSICAL

GENERAL

All job offers for seagoing positions will be contingent upon the new employee passing the ODP New Employee physical exam. The exam must be given by a licensed physician; the Ocean Drilling Program (ODP) reserves the right to request a second opinion from another physician.

The exam should be scheduled, completed, and returned to the ODP Human Resources prior to the new employee's first day of work. ODP has the option to request additional medical information or tests which may be taken into consideration if appropriate.

The ODP Human Resources will inform the hiring supervisor and the prospective employee whether the individual has passed the physical exam and is eligible for sea duty participation.

RESPONSIBILITY FOR EXAM EXPENSE

The Ocean Drilling Program will reimburse the new employee up to $300 for the cost of the physical exam providing:

(1) the examination is performed according to ODP requirements; and

(2) the new employee passes the exam.

Any cost above $300 will be for the new employee's account. In addition, charges for procedures not required by ODP will be for the new employee's account. If an employee does not pass the physical exam and pursues further testing/treatment in order to pass, he/she will be responsible for the expense of these tests or treatment. If the employee fails the physical exam, the total cost of the exam will be for his/her account. The hiring supervisor will inform the new employee of this expense responsibility. The employment offer may be withdrawn from a new employee who fails the physical exam.

MEDICAL HISTORY RECORDS

New employees are required to provide copies of medical history records for immunizations and blood type. If no records are provided or records are incomplete, immunizations and blood typing will be done as part of the new employee exam. ODP will cover the costs of these procedures.
Date: __________________________

Name: ___________________________ Age: __________ Sex: M  F

Address: ____________________________________________________________

Phone: _____________________________ Your Present Job Title: __________________

How would you rate your physical condition?

□ Poor    □ Fair    □ Good    □ Excellent

Please read and sign the below statement.

I certify that the answers given by me on this questionnaire are true, complete, and correct to the best of my knowledge and are made in good faith. I understand that false statements or omissions may void this physical exam and may result in the withdrawal of an offer of employment or denial of sea duty participation. I agree that prior to participating on an ODP cruise I will undergo a complete, comprehensive examination by a duly licensed physician and that all of the required medical examination forms and test results will be submitted to the assigned ODP official who will in turn forward these documents to the shipboard doctor. I agree that if the physician performing said evaluation has reservations, in any way whatsoever, the assigned ODP official shall make the final determination as to my eligibility for shipboard service. I further agree that the assigned ODP official's decision shall be final. Successful completion (passing) of this exam does not in anyway obligate the Ocean Drilling Program. I agree that I am responsible for providing all medication including psychotropic medication and medical supplies which I may need for the treatment of existing conditions for the duration of the cruise. I understand that my medical information will be kept confidential; however, if an injury, abnormality, or illness is discovered such that my fitness for sea duty is in question, I understand that it may be necessary to inform my manager and/or supervisor so that staffing decisions can be made. I further agree that if I am subjected to injury or illness after the date of my physical examination and prior to the beginning of the cruise I will notify the assigned ODP official so that eligibility for shipboard service may be determined.

_________________________________________    __________________________
Participant Signature               Date
Have you been ill, injured, hospitalized, or under the care of a physician within the past six months? If yes, please explain: __________________________________________

________________________________________________________________________

________________________________________________________________________

Have you been treated for or under the care of a physician/psychologist for depression, mental illness, and/or emotional problems in the last 12 months? If yes, please explain providing details including dates, medication prescribed for condition, and prognosis. (See Attachment 4 for additional exam requirements) __________________________________________

________________________________________________________________________

________________________________________________________________________

Are you presently taking any medication, including psychotropic medication? □ YES □ NO Please describe: __________________________________________

________________________________________________________________________

________________________________________________________________________

Blood Type: _________ (Please attach copy of medical record indicating blood type, such as blood donor card, previous blood type results, or physician statement of your blood type.)

Dates of latest immunizations:

Tetanus _______
Polio _______
Diphtheria _______
Hepatitis B _______
Measles, mumps, rubella _______
Haemophilus influenzae b (Hib) _______

New employees are required to attach a copy of records of immunization history to this form.
To the best of your knowledge, have you ever had or now have symptoms or a diagnosis of any of the following? Please check all that apply.

- Hernia, skin disorder, or fungus infections.
- Problems with the stomach, intestine, throat, esophagus, ulcers, or digestive disorder.
- Gallbladder disease, hepatitis, jaundice, or other liver disease.
- Asthma, allergies, bronchitis, pneumonia, emphysema, sinus, nasal, tonsils, adenoids, bronchi, trachea, lung, or other respiratory symptoms.
- Abnormal growth or function of thyroid, pancreas, adrenal, or lymph glands.
- Diabetes, anemia, or other blood disorders.
  
  **Diabetic participants are required to submit an opthalmologist report annually.**

- Problems with the kidneys, bladder, prostate, reproductive organs, menstrual disturbance, or other male/female disorder.
- Arthritis, rheumatism, polio, rheumatic fever.
- Cancer, leukemia, Hodgkin's disease, or Kaposi' Sarcoma.
- Injury or problem with the back, muscle, bone, joint, spine, neck; fracture or deformity.
- Tumor, cyst, or growth (benign/malignant); disease or lump(s) in breast.
- Impairment of sight or hearing, cataracts, or ear infections.
- Gain or loss of more than 10-15 pounds in the past year or obesity.
- Any past or present complications of pregnancy (prior history of miscarriage, infertility, toxemia, c-section) or is any person now pregnant?

- Any other medical or surgical advice, treatment, or hospitalization.

- Any chronic or recurring minor ailments, injuries, or other departures from good health, regardless of whether or not a practioner was consulted.

- High or low blood pressure, stroke, heart trouble, heart defect, murmur, or other circulatory impairment of blood, arteries.
Please check if any of the following factors have been or are present in your history:

☐ Smoker, if so # of packs a day __________

☐ High blood pressure

☐ Elevated cholesterol levels

☐ Sedentary lifestyle coupled with a physically demanding job

☐ History of heart attack or sudden cardiac death in a first degree relative less than 60 years of age.

For those questions you checked, please describe the medical or surgical care advised or performed, the date of illness or treatment and your present condition, in the space provided below.

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Do you have any special dietary needs (i.e., vegetarian, etc.)? There is no guarantee your request can be accommodated but if we know about them 30 days or more before the leg starts, notification to the ship’s operator can be made.

☐ Yes ☐ No

Please Explain: ____________________________________________________________________________

__________________________________________________________________________

Do you have a history of sea sickness or other types of motion sickness?

☐ Yes ☐ No

Please explain: ____________________________________________________________________________

PARTICIPANT

Please return this entire package (Medical History Questionnaire, Blood/Urine Test Results, Audiograms, Chest X-Ray Reports, Pulmonary Function Reports, etc.) to:

Human Resources/Insurance Services

CONFIDENTIAL

Ocean Drilling Program

1000 Discovery Drive

College Station, Texas 77845 USA
I. On the job, the employee must perform the following:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Per Work Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bend</td>
<td>Frequently</td>
</tr>
<tr>
<td>Squat</td>
<td>Occasionally</td>
</tr>
<tr>
<td>Crawl</td>
<td>Rarely</td>
</tr>
<tr>
<td>Climb</td>
<td>Frequently</td>
</tr>
<tr>
<td>Reach above shoulder level</td>
<td>Frequently</td>
</tr>
<tr>
<td>Kneel</td>
<td>Occasionally</td>
</tr>
<tr>
<td>Push/Pull</td>
<td>Frequently</td>
</tr>
<tr>
<td>Sit</td>
<td>Frequently</td>
</tr>
<tr>
<td>Stand</td>
<td>Frequently</td>
</tr>
<tr>
<td>Walk</td>
<td>Frequently</td>
</tr>
<tr>
<td>Handle objects</td>
<td>Frequently</td>
</tr>
<tr>
<td>Fine finger movement</td>
<td>Frequently</td>
</tr>
</tbody>
</table>

II. On the job, this employee must be able to lift:

- Up to 10 pounds: Frequently
- 11-24 pounds: Frequently
- 25-34 pounds: Frequently
- 35-50 pounds: Frequently
- 51-74 pounds: Occasionally
- 75-100 pounds: Only with assistance
- Over 100 pounds: Only with assistance

III. On the job, the employee:

- Operates foot controls: Occasionally
- Is around moving machinery: Frequently
- Is exposed to marked changes in temperature and/or humidity: Frequently
- Drives automotive equipment in port: Occasionally
- Is exposed to dust, fumes and gases: Frequently
- Works in confined quarters: Frequently
The following indicated test(s) and/or inoculations should be completed for the annual exam:

<table>
<thead>
<tr>
<th>TESTS:</th>
<th>REQUIRED:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete Blood Count</td>
<td>Yes (Fasting)</td>
</tr>
<tr>
<td>Blood Chemistry Profile (SMAC-12)</td>
<td>Yes (Fasting)</td>
</tr>
<tr>
<td>with PSA</td>
<td>Yes, if male age 40+</td>
</tr>
<tr>
<td>Urinalysis</td>
<td>Yes</td>
</tr>
<tr>
<td>Audiogram</td>
<td>Yes</td>
</tr>
<tr>
<td>HgbA1C</td>
<td>Yes, for individuals with diabetes</td>
</tr>
<tr>
<td>Pap Smear</td>
<td>Yes, for females</td>
</tr>
<tr>
<td>Mammogram</td>
<td>Yes, once every other year for females age 40+</td>
</tr>
<tr>
<td>Bruce Protocol Stress Test</td>
<td>Males over the age of 40 with <strong>one or more risks factors</strong> should undergo treadmill stress testing according to the Bruce Protocol. Women over 50 should be likewise tested. Bruce Protocol Stress Test should not be conducted more often than once every FOUR years, unless indicated by symptoms or changes in cardiac medical history.</td>
</tr>
</tbody>
</table>

**Date of previous stress test:**

**Risk factors for the purpose of this testing are:**

1) Cholesterol greater than 240 mg/dl

2) Smoking

3) Diabetes Mellitus

4) Systolic blood pressure greater than 140 mm Hg or diastolic blood pressure greater than 90 mm Hg.

5) History of heart attack or sudden cardiac death in a first degree relative less than 60 years of age.

**TB Skin Test**

Yes, unless received BCG inoculation in past. *

* If individual is symptomatic or if TB skin test results are "positive", then perform: Chest X-rays (PA and Lateral).
The following inoculations should be completed for Leg 210 departing from Bermuda and returning to St. John's.

<table>
<thead>
<tr>
<th>IMMUNIZATIONS</th>
<th>REQUIRED:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus</td>
<td>Yes, if more than 10 years since last immunization</td>
</tr>
<tr>
<td>Cholera</td>
<td>NO</td>
</tr>
<tr>
<td>Yellow Fever</td>
<td>NO</td>
</tr>
<tr>
<td>Typhoid/Typhus</td>
<td>NO</td>
</tr>
<tr>
<td>Anti-Malaria Precaution</td>
<td>NO</td>
</tr>
<tr>
<td>Polio</td>
<td>NO</td>
</tr>
<tr>
<td>Diphtheria</td>
<td>NO</td>
</tr>
<tr>
<td>Measles,Mumps,Rubella</td>
<td>NO</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>Recommended</td>
</tr>
</tbody>
</table>

Any immunization indicated as not completed on Medical History Sheet Yes
The information requested herein is required for participation on a research cruise aboard the research drillship JOIDES Resolution. Please note that although a licensed M.D. accompanies all cruises, medical facilities on board are limited. In an emergency, it could require five days or more to reach a port. Although emergency transportaion can be arranged, it may not be immediate. Please bear the aforementioned in mind in evaluating your patient's ability to withstand eight weeks at sea working 12 hours per day, 7 days per week. The purpose of this examination is to protect the health and safety of this employee, his/her fellow employees, and the scientific objectives of the cruise. To assist you in this evaluation and in determining what immunizations are required, please refer to the description of physical exam requirements for this participant (Attachment 3). Please refer to Attachment 2 for further information regarding typical physical requirements for cruise participants.

Physician, please indicate whether observations/results are within normal limits. If not within normal limits, please provide an explanation (attach additional page if needed).

<table>
<thead>
<tr>
<th>Pulse Character</th>
<th>Hands and Arms</th>
<th>Temperature (F)</th>
<th>Skin</th>
<th>Eyes</th>
<th>Lungs</th>
<th>Ears *</th>
<th>Cardiac Sounds</th>
<th>Speech</th>
<th>Cardiac Size</th>
<th>Teeth</th>
<th>Abdomen</th>
<th>Gums</th>
<th>Varicocele</th>
<th>Throat</th>
<th>Hydrocele</th>
<th>Nasal Passages</th>
<th>Hemorrhoids</th>
<th>Head</th>
<th>Hernia</th>
<th>Neck</th>
<th>Legs</th>
<th>Glands</th>
<th>Feet</th>
<th>Varicose Veins</th>
</tr>
</thead>
</table>

* Does the employee have perforated/ruptured ear drum(s)? □ YES □ NO

Please explain: ____________________________________________

_______________________________________________________
TO BE COMPLETED BY EXAMINING PHYSICIAN CONTINUED

Attachment 3c

<table>
<thead>
<tr>
<th>HEIGHT</th>
<th>WEIGHT</th>
<th>PULSE</th>
<th>Blood Pressure</th>
</tr>
</thead>
<tbody>
<tr>
<td>cms</td>
<td>ft</td>
<td>kgs</td>
<td>lbs</td>
</tr>
</tbody>
</table>

Urinalysis
Audiogram
Complete Blood Count
Blood Chemistry Profile (SMAC-12)
PSA
TB Skin Test
Pap Smear
Mammogram
Bruce Protocol Stress Test
HgbA1C
Chest X-Rays (PA and Lateral)

As required on Attachment 3

* All Laboratory results must be attached and returned with exam for these tests.

Comments regarding above items (please attach extra page if needed):

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Treatment/Immunizations:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
TO BE COMPLETED BY EXAMINING PHYSICIAN CONTINUED

PHYSICIAN, Please check one:

☐ IT IS MY OPINION THAT THIS PATIENT IS PHYSICALLY CAPABLE OF PERFORMING HIS/HER DUTIES.

☐ THIS PATIENT IS NOT PHYSICALLY CAPABLE OF PERFORMING HIS/HER DUTIES. Please explain below:

☐ THIS PATIENT IS NOT CLEARED TO SAIL PENDING (tests, further review) Please explain below:

________________________________________

________________________________________

________________________________________

________________________________________

This judgement is based on the examination and based on the review of medical questionnaire and the typical physical requirements. I performed this physical exam and hereby certify that I am a duly licensed physician.

Please print or type:

________________________________________

Signature of Examining Physician

M.D.

Date

Physician Name: ____________________________

Physician Address: __________________________

Office Telephone Number: ____________________

Fax Number: ________________________________

PHYSICIAN: The PARTICIPANT must return this entire package (Medical History Questionnaire, Actual Test Results for Blood and Urinalysis, Audiogram, PapSmear/Mammogram, Bruce Protocol Stress Test, TB Skin Test, and all other tests performed to:

________________________________________________________________________________________

Human Resources/Insurance Services
CONFIDENTIAL
Ocean Drilling Program
1000 Discovery Drive
College Station, Texas 77845
Phone# (979) 845-2583
Fax# (979) 845-4857
It is ODP’s policy to request additional information if a participant indicates he/she has been treated for or under the care of a physician/psychologist for depression, mental illness, and/or emotional problems in the last 12 months. Two additional items are required. A statement from the physician who performs the physical indicating that he/she is aware that you are/were being treated for mental illness, depression, and/or emotional problems and in his/her professional opinion that you can sail for two months. Second, ODP also requires a statement from the physician that was/is treating you for depression, mental illness, and/or emotional problems. Please provide the letter in Attachment 4a to your physician or please contact ODP’s Human Resources and we can fax the letter to your physician. This letter explains the working conditions and environment on the ship. In addition, the letter requests the physician’s professional opinion on how sailing for two months may affect your recent depression, mental illness, and/or emotional problems and his/her opinion on your fitness for sea duty in regards to your depression, mental illness, and/or emotional problems.

Until this information is received and is reviewed, a decision can not be made regarding your fitness for sea duty.

Please feel free to call me at 979/845-2583 if you have any questions regarding this matter.
June 13, 2002

To Whom It May Concern:

_________________________ is scheduled to sail aboard the JOIDES Resolution for two
months in __________. _________________________ indicated on the medical history of his/her
seagoing physical examination that he/she is being/was treated for depression, mental illness, and/or
emotional problems.

The location of the ship will be several days from the nearest port. The ship is a closed environment with
close quarters and shared accommodations and in an industrial environment. His/Her work will involve
12 hour shifts, seven days a week for the entire deployment (61) days. ODP is concerned about this
participant sailing due to his/her treatment for depression, mental illness, and/or emotional problems in
relation to shipboard conditions.

Please provide a statement indicating your professional opinion regarding the impact shipboard
conditions may have on this participant in relation to their condition and your opinion on his/her fitness
to participate in a two month cruise. You can fax this statement to me at 979/845-4857.

ODP is requesting this statement to ensure that this participant or others are not going to be put at risk if
he/she is allowed to sail.

Sincerely,

Ollie Berka
Human Resources Advisor