

IODP Expedition Participant Medical Information Packet

Dear participant:

We welcome you to the International Ocean Discovery Program and look forward to your participation in exploring new scientific discoveries aboard the *JOIDES Resolution*.

In preparation for your stay aboard the ship, we are asking you to provide your personal medical history information and to meet with your physician to review your present health status. This requirement is to protect your health and safety because you will be working in confined quarters aboard the ship. The *JOIDES Resolution* has a limited medical facility with a full-time physician who will sail with your expedition, which is often operating remotely, multiple days from port. IODP also strongly recommends a dental exam prior to sailing.

All of the documents listed below are included in this packet. **All completed materials (translated into English, if applicable) must be received by IODP at least 4 months before the start of your expedition. Your completed physical exam results must be on file with IODP in order for you to board the ship. All medical records will be treated as confidential and only shared with IODP HR and the ship's physician.**

Please review the following documents for information regarding IODP medical exam policies:

- IODP Medical Examination Policy and Procedures for Expedition Participants (pages 3–4)

The following documents should be shared with the **physician**:

- IODP Medical History Questionnaire for Expedition Participants (completed by the participant; pages 5–8)
- Information for the examining physician (page 10)
- IODP Expedition Participant Medical Examination Requirements (page 11–12)
- IODP Expedition Participant Job Duties (page 13)
- **IODP Expedition Participant Examination Form (to be completed by the physician; pages 14–15)**
- **Certification of Eligibility (to be completed by the physician; page 16)**
- **Mental Health Treatment Disclosure; if applicable (pages 17–18)**
- **Covid-19 Assessment (page 19)**

The following items must be submitted to **IODP HR**:

- IODP Medical History Questionnaire for Expedition Participants (pages 5–8)
- IODP Expedition Participant Emergency Contact Form (page 9)
- IODP Expedition Participant Examination Form (pages 14–15)
- Certification of Eligibility (page 16)
- Mental Health Treatment Disclosure and physician letter; if applicable (page 18)
- Covid-19 Assessment (page 19)



- Copy of immunization history records (to be **submitted by the participant with each medical submission**)
- Laboratory/results for the following tests:
 - Complete blood count with differential
 - Including but not limited to red blood cells, white blood cells, platelets, Hemoglobin and Hematocrit
 - Blood chemistry profile
 - Including lipids panel to test cholesterol, HDL, LDL, triglycerides
 - Audiogram
 - HgbA1C for those with diabetes
 - TB skin/TB QuantiFERON® blood test
 - Chest X-rays (PA and lateral); if applicable
 - Bruce Protocol Stress Test; if applicable

Please submit your completed packet to:

IODP Human Resources Department
CONFIDENTIAL
International Ocean Discovery Program
1000 Discovery Drive
College Station, TX 77845-3469
USA
Phone: (979) 845-2583
Fax: (979) 845-1026
Email: humanresources@iodp.tamu.edu

IODP Medical Examination Policy and Procedures for Expedition Participants

All participants in International Ocean Discovery Program (IODP) scientific expeditions are required to have a complete, comprehensive medical examination by a licensed physician. The purpose of the examination is to protect the safety and health of all expedition participants and to minimize interference with successful completion of the scientific objectives of each expedition. The results of an individual's exam will determine whether the participant is eligible for participation in the specified expedition.

- Medical Examination Packets will be sent to participants approximately 6 months prior to the expedition; in extenuating circumstances, individual packages may be sent earlier upon request.
- The IODP medical exam is valid for 24 months from the date of the exam.
- For previous participants, a new exam is required if the previous exam has expired or will expire before the upcoming expedition or if there are changes in the participant's health and/or medical conditions.

It is the responsibility of the **participant** to return the completed Medical Examination Packet (including all test results) to IODP before the stated deadline. IODP Human Resources will review the package for completeness and for the physician's recommendation as to whether the individual is fit to withstand the conditions of a 6–8-week expedition. An IODP official or the shipboard physician may require additional medical tests and/or evaluations from the participant.

All medical information will be kept in secure files and treated confidentially.

General Health Considerations

Medical History

Participants must complete the IODP Medical History Questionnaire for Expedition Participants. The IODP Expedition Participant Medical Exam Packet lists all medical tests required as part of the medical exam. **If the participant is unable to provide a medical record evidencing blood type or immunizations, then blood typing and immunizations will be completed as part of the exam.** Participants 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.

Cabins

While on board, participants must share a cabin.

Immunizations

Prior to each expedition, IODP Human Resources will obtain current information on immunizations needed for ports or areas of operations. This information will be found in the packet specific to each expedition. Participants will be responsible for discussing with their physician all immunization requirements and/or changes for ports or areas of operation.

Medical Supplies

Medical supplies and medication on board the drillship are limited. Each participant is responsible for bringing a sufficient amount of any medication or medical supplies for treating an existing condition for the duration of the expedition.

Sea/Motion Sickness

Each expedition participant is encouraged to discuss the possibility of sea/motion sickness with their physician. The physician can provide information and prescribe medications to prevent or control the symptoms. Participants 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 they are pregnant, the participant is required to see a licensed obstetrician/gynecologist. A participant who is pregnant must provide their obstetrician/gynecologist with a written job description for their position and obtain a certification from the obstetrician/gynecologist that states the participant is capable of performing their duties and explaining any physical restrictions or limitations. This information is required to determine whether the participant is eligible to sail on the specified expedition.

Allergies

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

Responsibility for exam expense

US Science Support Office (USSSP) participants will receive reimbursement procedure information from the USSSP office in a timely manner after the IODP Expedition Participant Medical Exam Packet is mailed out. (Please refer to the EPM invitation.)

Non-USSSP participants are responsible for the total cost of the examination, including required immunizations and/or any additional tests. *The expense of the examination is not reimbursable by IODP.*

If you have any questions, please feel free to contact IODP Human Resources at 979-845-2583.



IODP Medical History Questionnaire for Expedition Participants

To be completed by Patient

Date: _____ Age: _____
Name: _____ What is your gender? M / F
Your present job title: _____ Other, please specify _____
Expedition: _____ Do you identify as trans? Yes / No

Please read and sign the following statement:

I certify that the answers given by me on this questionnaire are true, complete, and correct to the best of my knowledge and belief and are made in good faith. I understand that false statements or omissions may void this physical exam and may result in denial of sea duty participation.

I agree that prior to participating on an IODP expedition 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 IODP 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 IODP official shall make the final determination as to my eligibility for shipboard service. I further agree that the assigned IODP official's decision shall be final.

I agree that I am responsible for providing all medication, including psychotropic medication and medical supplies that I may need for the treatment of existing conditions for the duration of the expedition.

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 those responsible for staffing decisions.

I also understand that I am responsible for reporting any serious illness or injury that may occur subsequent to this exam wherein medical evaluation may be necessary to determine my fitness for sea duty. 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 expedition I will notify the assigned IODP official so that eligibility for shipboard service may be determined.

Participant signature: _____ Date: _____

IODP Medical History Questionnaire for Expedition

Participants (continued)

To be completed by Patient

How would you rate your present physical condition?

Poor Fair Good Excellent

*Blood type: _____

***Attach a copy of a medical record indicating your blood type, such as blood donor card, previous blood type results, or physician statement of your blood type.**

All participants are required to attach a copy of their immunization history records to this form for every expedition submission. IODP does not keep records on file.

Dates of latest immunizations: (attach copy of immunization record with each medical submission)

Tetanus: _____	Diphtheria: _____
Measles, mumps, rubella: _____	Polio: _____
Chicken Pox: _____	COVID-19: _____
Hepatitis B: _____	Haemophilus influenzae B (Hib): _____
*BCG: _____	

**if applicable*

1. Please check if any of the following factors have been or are present in your history:

<input type="checkbox"/> Smoker: # of packs a day _____ <input type="checkbox"/> High blood pressure <input type="checkbox"/> Overweight <input type="checkbox"/> Elevated cholesterol <input type="checkbox"/> None apply	<input type="checkbox"/> Sedentary lifestyle coupled with a physically demanding job <input type="checkbox"/> History of heart attack or sudden cardiac death in a first degree relative less than 60 years of age
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2. Do you have any special dietary needs (i.e., vegetarian, etc.)? If so, please explain. There is no guarantee your request can be accommodated, but if we know about them 30 days or more before the expedition starts, notification to the ship’s operator will be made. Yes No



3. 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 annual ophthalmologist report**

- 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's 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 currently 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 practitioner was consulted
- High or low blood pressure, stroke, heart trouble, heart defect, murmur, or other circulatory impairment of blood, arteries
- None apply

4. For each condition you checked on questions 1 and 3, 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 or select N/A. (Attach additional sheets if needed.)

N/A



5. Have you been ill, injured, hospitalized, or under the care of a physician within the past six months? Please explain or select N/A.

N/A

6. 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 and provide details including dates, medications prescribed for condition, and prognosis or select N/A.

Additional documentation will be required

N/A

7. Are you presently taking any medication, including psychotropic medication? Please explain or select N/A.

N/A

8. Do you have a history of sea sickness or other types of motion sickness? Please explain or select N/A.

N/A



IODP Expedition Participant Emergency Contact Form

Participant Information

Name: _____ Cell Phone: _____

Date of Birth: _____ Home Phone: _____

Email: _____

Home Address: _____

Emergency Contact Information

In an emergency you may contact the following people. (Add additional addresses on separate page).

Name: _____ Relationship: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____ Email: _____

Address: _____

Name: _____ Relationship: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____ Email: _____

Address: _____

Name: _____ Relationship: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____ Email: _____

Address: _____

You have my permission to use this information in an emergency situation.

Participant signature: _____ Date: _____

Information for the Examining Physician

The enclosed medical exam is required for participation on a research expedition aboard the research vessel *JOIDES Resolution*. The purpose of this examination is to protect the health and safety of this individual, their fellow co-workers, and the scientific objectives of the expedition.

Although a licensed M.D. accompanies all expeditions, medical facilities on board are limited. Medical evacuation (medivac) by helicopter or alternate vessel is only available within a certain distance from a port, and the research vessel most commonly operates outside of this distance. In the event of an emergency, 5 or more days' travel by sea are commonly required to reach port. Escape during an emergency may require navigating several flights of stairs and water tight doors.

Please bear this in mind as you evaluate your patient's ability to withstand 8 weeks at sea working 12 hours a day, 7 days a week, in close quarters with other shipboard participants.

This packet includes the medical exam requirements for the IODP Physical Examination, information regarding the physical requirements of the expedition, and the following forms for you to complete:

- **IODP Expedition Participant Physical Examination Form (pages 14–15)**
- **Certification of Eligibility (page 16)**
- **Mental Health Treatment Disclosure; if applicable (page 18)**
- **Covid-19 Assessment (page 19)**

In addition, please attach the laboratory results for the following tests:

- Complete blood count
- Blood chemistry profile
- Audiogram for participants over 40 years of age or if indicated on current medical history
- HgbA1C for those with diabetes
- TB skin/TB QuantiFERON® blood test
- Chest X-rays (PA and Lateral); if applicable
- Bruce Protocol Stress Test; if applicable

Please provide all of the above materials to the expedition participant, who will return them to IODP Human Resources.

Please submit the completed packet to:

IODP Human Resources Department
CONFIDENTIAL
International Ocean Discovery Program
1000 Discovery Drive
College Station, TX 77845-3469
Phone: (979) 845-2583 / Fax: (979) 845-1026
Email: humanresources@iodp.tamu.edu

IODP Expedition Participant Physical Examination Requirements

The following tests and inoculations should be completed for the annual physical exam required for IODP expedition participants.

Required tests

- Complete Blood Count (fasting)
- Blood Chemistry Profile (fasting)
 - Including lipids panel to test cholesterol, HDL, LDL, triglycerides
- Blood type
- Audiogram (annually) for participants over 40 years of age or if indicated on current medical history
- HgbA1c (for individuals with diabetes)
 - Annual ophthalmologist report must also be submitted
- TB skin/TB QuantiFERON® blood test
 - Yes, unless the participant received BCG inoculation in the past.
 - If individual received BCG in past, **physician statement** indicating the individual has had a BCG inoculation and a chest X-ray is required.
 - If individual is symptomatic or if TB skin test results are “positive,” then perform chest X-rays (PA and lateral).
- Bruce Protocol Stress Test (if applicable)
 - Males over the age of 40/Women over the age of 50 with one or more risk factors should undergo treadmill stress testing according to the Bruce Protocol.

The Bruce Protocol Stress Test should not be conducted more often than once every 4 years, unless indicated by symptoms or changes in cardiac medical history.

Risk factors for the purpose of this test:

- Cholesterol greater than 240 mg/dl
- Smoking
- Diabetes Mellitus
- Systolic blood pressure greater than 140 mm Hg or diastolic blood pressure greater than 90 mm Hg
- History of heart attack or sudden cardiac death in a first-degree relative less than 60 years of age

Required inoculations

The following inoculations should be completed for all IODP expeditions.

Immunizations:	Required:
Tetanus/Diphtheria/Pertussis (Tdap)	Required if more than 10 years since last immunization
Measles, Mumps, Rubella (MMR)	Required
Polio	Required
Chicken Pox	Required
COVID-19	Recommended
Influenza	Recommended
Typhoid/Typhus	Recommended
Hepatitis A, Hepatitis B	Recommended
Anti-Malaria precaution	No
Cholera	No
Yellow Fever	No

****Please discuss with the patient the need for all required and recommended inoculations.***

If you are unable to provide proof of childhood vaccinations including but not limited to MMR, Diphtheria, Pertussis, Chicken Pox, or Polio, you will be **required** to have a titer (blood) test to prove immunity to these vaccinations **or** receive the vaccination.

IODP Expedition Participant Job Duties and Physical Requirements

The duties of this position involve fine motor skills for delicate tasks, as well as frequent strenuous physical activity including, but not limited to, moving, lifting, and carrying objects weighing as much as **50 pounds** and occasionally more.

The work also requires reaching, standing long hours, walking, bending, and maintaining balance on a moving ship while carrying a load. Walking up and down several flights of stairs many times during the day is required. The elevator is **only** accessible for freight.

The work is performed under confined conditions, with **frequent** exposure to noise, vibration, and potential allergens and **occasional** exposure to outdoor, **extreme** environments. **Rarely**, exposure to toxic gases requires donning full body protective gear and breathing apparatus while performing other duties as listed above.

This work is performed in port and at sea on a research vessel, working 12 hours per day, 7 days per week, for as long as 2 months without a break. The ship does not return to port during a 2-month expedition.

On the job, the participant must perform the following tasks:

Activity	Per Work Day
Bend, climb, push/pull, sit, stand, walk	Frequently
Reach above shoulder level	Frequently
Handle objects, fine finger movement	Frequently
Squat, kneel	Occasionally
Crawl	Rarely

On the job, this participant must be able to lift:

Up to 10 pounds	Frequently
11-50 pounds	Frequently
51-74 pounds	Occasionally
75-100 pounds, over 100 pounds	Only with assistance

On the job, the participant:

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/Works in confined spaces	Frequently



IODP Expedition Participant Examination Form

To be completed by Physician

Physician, please indicate whether observations/results are within normal limits. If not, please provide an explanation.

Height in centimeters (cm) / Feet (ft.)

Weight in kilograms (kg) / Pounds (lbs.)

Pulse rate per minute

Blood pressure (sys/dias)

Pulse Character		Hands and Arms	
Temperature (F)		Skin	
Eyes		Lungs	
Ears*		Cardiac Sounds	
Speech		Cardiac Size	
Teeth		Abdomen	
Gums		Varicocele	
Throat		Hydrocele	
Nasal Passages		Hemorrhoids	
Head		Hernia	
Neck		Legs	
Glands		Feet	
Varicose Veins		Ruptured Ear Drum (Y/N)	

Please provide explanations below.



Indicate any treatment given, including immunizations. Include any comments on the laboratory results attached to this form.



Certification of Eligibility

To be completed by Examining Physician

Patient name: _____

Date of birth: _____

Date of exam: _____

The individual named above has undergone a medical examination in preparation for sailing on an IODP expedition.

The patient has been evaluated based on the medical examination and a review of their medical history questionnaire and a description of their job duties and/or the physical requirements of the expedition.

- This patient **is physically capable** of performing their duties.
- This patient **is not physically capable** of performing their duties. Please explain below.
- This patient **is not cleared to sail** (pending tests and/or further review). Please explain below.

I performed this physical exam and hereby certify that I am a duly licensed physician.	
Signature of examining physician: _____	Date: _____
Physician's name: _____	Physician's license number: _____
Physician's address: _____	
Physician's office telephone number: _____	Physician's office fax number: _____
Physician's office email address: _____	

Additional Physical Exam Requirements for Participants with Depression and/or Mental Disorders

It is IODP's policy to request additional information if a participant indicates they are currently under the care of a physician/psychologist for depression, mental illness, and/or emotional problems within the last 12 months. If applicable, additional items are required:

- A statement from the physician who is/was treating you for depression, mental illness, and/or emotional problems indicating their professional opinion that you are fit to sail for 2 months.

OR

- A statement from the physician who performs the physical indicating that they are aware that you are/were being treated for mental illness, depression, and/or emotional problems and in their professional opinion that you can sail for 2 months.

Please provide the letter on the following page to your physician. This letter explains the working conditions and environment on the ship. This letter requests the physician's professional opinion on how sailing for two months may affect your fitness for sea duty in regards to your recent depression, mental illness, and/or emotional problems diagnosis.

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

Please feel free to call Human Resources at 979-845-2583 if you have any questions regarding this matter.



Mental Health Treatment Disclosure

(Date)

To whom it may concern,

_____ (Name) is scheduled to sail aboard the *JOIDES Resolution* for 2 months starting in _____ (Date). _____ (Name) indicated on the medical history of their seagoing physical examination that they are currently being treated for or have been treated for depression, mental illness, and/or emotional problems within the last 12 months.

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. The participant's work will involve 12 hour shifts 7 days a week for the entire deployment (~60) days. IODP is concerned about this participant sailing due to their 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 the participant's fitness to participate in a 2-month expedition. You may fax this statement to Human Resources at 979-845-1026.

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

Sincerely,

Human Resources Representative

International Ocean Discovery Program
1000 Discovery Drive
College Station, TX 77845-3469
Phone: (979) 845-2583
Fax: (979) 845-1026
Email: humanresources@iodp.tamu.edu

Please mark if not applicable.

N/A

COVID-19 Assessment

Additional Physician Assessment For Participants

The purpose of this form is to assess the COVID-19 risk of those who seek to work on the Research Vessel *JOIDES Resolution*. The ship has a medical doctor and facilities for treating many injuries and illnesses but it does not have the hospital healthcare level capabilities commonly required for treating severely ill COVID-19 patients. If a patient becomes sick with COVID-19 while at sea and requires advanced life-saving intervention, the ship will be diverted to the nearest port where the patient will be evacuated to a hospital. However, if the patient becomes severely ill with COVID-19, the additional time required to reach a hospital could result in death. Hence, it is important to identify those with high risk factors and make informed decisions regarding participation.

In light of this information, the risk assessment should carefully consider the patient’s medical history, current medical condition, vaccination/booster status, and the guidelines provided by the Centers for Disease Control and Protection (CDC) for people who are at higher risk for severe illness from COVID-19. See the box below or go to the CDC source: <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/index.html> and <https://www.cdc.gov/mmwr/volumes/71/wr/mm7101a4.htm>

People Who Are at Higher Risk for Severe Illness

Based on currently available information, **older adults** and people of any age who have serious underlying medical conditions might be at higher risk for severe illness from COVID-19. For all ages, higher risks are associated with the following underlying medical conditions, particularly if not well controlled:

- People with chronic lung, kidney, liver, or neurologic disease
- People who have serious heart conditions
- People who are immunocompromised
- People overweight to obese
- People with diabetes
- People with cancer

Based on the physician’s assessment:

- The patient has a significant risk factor or multiple risk factors that would be considered high risk.
- The patient does not have high risk factors.

Signature of examining physician: _____ **Date:** _____

Physician’s name: _____ Physician’s license number: _____

Transmit this form to: IODP Human Resources, humanresources@iodp.tamu.edu, (979) 845-1026