

**INTERNATIONAL OCEAN DISCOVERY PROGRAM  
1000 DISCOVERY DRIVE  
COLLEGE STATION, TEXAS 77845**

**PRE-EXPEDITION PHYSICAL EXAMINATION INFORMATION**

Per the attached policy, as an expedition participant you are required to submit a physical examination report signed by a licensed physician stating that you are physically fit to participate in the expedition.

The attached pre-expedition physical examination must be thoroughly completed by your physician and the results received at IODP no later than September 22, 2017.

**Your physical exam results must be on file at IODP in order for you to board the ship.**

**PHYSICAL EXAM PACKAGE CONTENTS AND INSTRUCTIONS**

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

**IODP Medical Examination Policy & Procedures**

- Attachment 1:**            **Medical History Questionnaire**  
*To be completed and signed by the expedition participant prior to the medical examinations and given to the physician along with all other Attachments.*
- Attachment 2:**            **Medical Exam Requirements**  
*To be given to physician along with all other Attachments.*
- Attachment 3:**            **Exam Form and Certification of Eligibility to Participate**  
*To be completed and signed by physician.*
- Attachment 4:**            **Job Duties of the Participating Scientist**  
*To be given to physician for review, along with all other Attachments.*
- Attachment 5:**            **Emergency Contact Form**  
*To be completed and signed by the participant.*
- Attachment 6:**            **Additional Physical Exam Requirements for Participants with  
Depression/Mental Illness/Emotional Problems  
Letter to physician requesting additional information**

**The participant must return the completed package, including ALL COPIES OF PHYSICAL EXAM RESULTS (blood work results, X-ray reports [if required], etc.), to the following address by the stated deadline.**

Expedition  
372

Human Resources/Insurance Services  
**CONFIDENTIAL**  
International Ocean Discovery Program  
1000 Discovery Drive  
College Station, Texas 77845-3469  
Phone: (979) 845-2583  
Fax: (979) 845-1026

## IODP MEDICAL EXAMINATION POLICY & PROCEDURES NON-IODP EMPLOYEE

### INTRODUCTION

All participants in International Ocean Discovery Program (IODP) scientific expeditions are required to have a complete, comprehensive physical 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 he/she will be eligible for participation in the specified expedition.

The IODP physical exam is valid for twelve months from the date of the exam. Physical exam packages will be sent to participants approximately four months prior to the expedition; in extenuating circumstances, individual packages may be sent earlier upon request. For previous participants, a new exam is required if the previous exam has expired or will expire during the upcoming expedition.

It is the responsibility of the **PARTICIPANT** to return the completed Physical Exam Package (including all test results) to the International Ocean Discovery Program before the stated deadline. The IODP Human Resources/Insurance Services will review the Physical Examination Package (as described below) 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 of the participant.

All medical information will be kept in secure files and treated confidentially. Upon request, participants may take their physical exam file with them at the end of the expedition.

### GENERAL HEALTH CONSIDERATIONS

#### Immunizations

Prior to each expedition, the Human Resources/Insurance Services will obtain the current information on immunizations needed for the ports or areas of operations. These will be listed on Attachment 2, Medical Exam Requirements of the Physical Exam Package. Participants will be notified prior to the expedition if immunization requirements change.

#### Medical Supplies

Medical supplies and medication on board the drill ship 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 his/her 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.

#### Medical History

Participants are to complete information on medical history on Attachment 1-1c. Attachment 2 lists all medical tests required as part of the physical exam. If the expedition 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.

## GENERAL HEALTH CONSIDERATIONS (continued)

### Pregnancy

If a participant suspects she is pregnant, she is advised to see a certified obstetrician/gynecologist. A participant who is pregnant must obtain a certification from a licensed obstetrician/gynecologist. The certification must state that the participant is capable of performing her duties and explain any physical restrictions or limitations. This information is required to determine if participant is eligible for participation in the specified expedition.

### Allergies

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

### Cabins

While on board, it is required that employees/participants must share a cabin.

## **RESPONSIBILITY FOR EXAM EXPENSE**

The USSSP participants will be receiving reimbursement procedure information from the US Science Support Office (USSSP) in a timely manner following the physical packet mailout.

The Non-USSSP participants will be 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 the International Ocean Discovery Program.

**If you have any questions, please feel free to contact:**

Human Resources/Insurance Services  
IODP Administration  
Telephone: (979) 845-2583  
Telex: 792779 IODP TAMU  
Fax: (979) 845-1026

**International Ocean Discovery Program  
Medical History Questionnaire**

**- To Be Completed By Patient -**

Attachment 1

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_ Your Present Job Title: \_\_\_\_\_

How would you rate your present 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 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 which 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 which 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

## Medical History Questionnaire Con't.

Attachment 1a

**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.
- 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 practitioner 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
- Overweight
- Elevated cholesterol levels

## Medical History Questionnaire Con't.

Attachment 1b

For those questions you checked on Attachment 1, 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. (Attach additional sheets if needed)

---

---

---

---

---

---

---

---

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 expedition starts, notification to the ship's operator will be made.  Yes  No

Please Explain:

---

---

---

---

---

Do you have a history of sea sickness or other types of motion sickness?  Yes  No

Please explain:

---

---

---

---

---

### Dates of latest immunizations:

Tetanus \_\_\_\_\_

Diphtheria \_\_\_\_\_

Polio \_\_\_\_\_

Measles, mumps, rubella \_\_\_\_\_

Hepatitis B \_\_\_\_\_

Haemophilus influenzae b (Hib) \_\_\_\_\_

## Medical History Questionnaire Con't.

Attachment 1c

Have you been ill, injured, hospitalized, or under the care of a physician within the past six months? 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, medications prescribed for condition, and prognosis.

(See Attachment 6a for additional exam requirements)

---

---

---

---

---

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.)

Are you presently taking any medication, including psychotropic medication? Please  Yes  No describe:

---

---

---

---

---

## CHECKLIST FOR MEDICAL EXAM REQUIREMENTS

To Be Reviewed by Examining Physician

Attachment 2

The following indicated tests and inoculations should be completed for the International Ocean Discovery Program's Expedition 372 departing from Fremantle, Australia, and returning to Wellington, New Zealand.

<b>TESTS:</b>	<b>REQUIRED:</b>
<b>Complete Blood Count</b>	Yes
<b>Blood Chemistry Profile</b>	Yes
<b>Blood Type</b>	Yes, if no record of blood type exists
<b>TB Skin Test</b>	Yes, unless received BCG inoculation in the past. If individual received BCG in past, physician statement indicating the individual has had a BCG inoculation is required. A <b>Chest X-ray</b> is not required but it is <b>strongly recommended</b> .

### **Additional Tests**

In addition to the tests above, the IODP Health Committee and the Ship's Physician require the following procedures when indicated by medical history, current medical condition, or for participants over 40 years of age. Laboratory results below must be included with this report.

### **Audiogram**

Positive TB Skin Test and/or  
History of Smoking:

**Chest X-Ray** (PA and lateral) **or Physician Statement**  
explaining why a chest X-ray is not medically necessary.

<b>INOCULATIONS:</b>	<b>COUNTRY:</b>	<b>REQUIRED:</b>
Tetanus	All	If more than 10 years since last inoculation
Cholera		No
Yellow Fever		No
Typhoid/Typhus		Recommended
Anti-Malaria precautions		No
Diphtheria		Recommended
Polio		Recommended
Measles, Mumps, Rubella		Recommended
Hepatitis A		Recommended

**TO BE COMPLETED BY PHYSICIAN**

Attachment 3

The information requested herein is required for participation on a research expedition aboard the drill ship JOIDES Resolution. Please note that although a licensed M.D. accompanies all expeditions, medical facilities on board are limited. In an emergency, it could require five days or more to reach a port. Although emergency transportation can sometimes be arranged, it is time-consuming and very expensive. 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 individual, his/her fellow co-workers, and the scientific objectives of the expedition. 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 2). Please refer to Attachment 4 for further information regarding typical physical requirements for expedition 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).

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

\* Does the participant have perforated/ruptured ear drum(s)?  YES  NO

Please explain:

---

---

**TO BE COMPLETED BY PHYSICIAN CON'T**

Attachment 3a

HEIGHT	
cms	ft

WEIGHT	
kgs	lbs

PULSE Rate (per minute)

Blood Pressure (Sys/Dias)

Complete Blood Count  
Blood Chemistry Profile  
TB Skin Test  
Blood Type

	*
	*
	*
	*

Audiogram As required on Attachment 2 \*

Chest X-Rays (PA and Lateral) As required on Attachment 2 \*

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

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

---

---

---

---

---

---

---

**Treatment/Immunizations:**

---

---

---

---

---

---

---

**TO BE COMPLETED BY PHYSICIAN CON'T.**

Attachment 3b

**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 (Attachment 3) and based on the review of medical questionnaire (Attachment 1) and the typical physical requirements (Attachment 4). I performed this physical exam and hereby certify that I am a duly licensed physician.

**Please print or type:**

_____ M.D. _____	
Signature of Examining Physician	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, Audiogram, TB Skin Test, and all other tests performed) to:

Human Resources/Insurance Services  
CONFIDENTIAL  
International Ocean Discovery Program  
1000 Discovery Drive  
College Station, Texas 77845

## **JOB DUTIES - Participating Scientist**

Attachment 4

The Participating Scientist will collect and analyze scientific data, will assist the Curator in taking samples for later study, and will assist the Co-Chief Scientists in writing Scientific Reports. The working environment would be typical of that in a laboratory or office.

While on board the vessel, the scientist will encounter the following:

1. Frequent exposure to moving machinery.
2. Frequent exposure to changes in temperature and/or humidity.
3. Frequent exposure to dust, fumes and gases.
4. Periods of time spent working in confined quarters.

NOTE: The duties, as listed herein, are to provide the examining physician with information relevant to a medical examination and evaluation.

The participant should refer to the shipboard handbook for an explanation of job duties.

**INTERNATIONAL OCEAN DISCOVERY PROGRAM  
EXPEDITION PARTICIPANT EMERGENCY CONTACT FORM**

Attachment 5

Participant Name: \_\_\_\_\_ Expedition: \_\_\_\_\_

SSN (USSSP only) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

**IN AN EMERGENCY YOU MAY CONTACT:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

\*\*\*\*\*

**OR:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

\*\*\*\*\*

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

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date

\*\*\*\*\*

**I do not wish to provide the information requested above.**

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date

**Additional Physical Exam Requirements for Participants with Depression, Mental Illness, and/or Emotional Problems**

Attachment 6

It is IODP'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, IODP 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 6a to your physician or please contact IODP'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 30, 2017

To Whom It May Concern:

\_\_\_\_\_ (Name) \_\_\_\_\_ is scheduled to sail aboard the *JOIDES* Resolution for two months starting in November 2017. \_\_\_\_\_ (Name) \_\_\_\_\_ 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 (~60) days. IODP 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 expedition. You can fax this statement to me 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 he/she is allowed to sail.

Sincerely,

Human Resources Representative