



Screening Audiogram History

Date (yyyy-mm-dd)

Personal Information

Reg. No.	Surname	Given Names		Category of Employee <input type="radio"/> Regular <input type="radio"/> Civilian <input type="radio"/> Applicant	
Rank	Age	Sex <input type="radio"/> Male <input type="radio"/> Female	Occupation		Time in This Occupation
Division	Detachment		Section		Cost Center (A9999)

General Information

Reason for this hearing test	<input type="radio"/> Periodic	<input type="radio"/> Enrolment	<input type="radio"/> Release	Approximate Date of Last Hearing Test (yyyy-mm-dd)	
What type of hearing protection do you use?	<input type="radio"/> Muffs	<input type="radio"/> Plugs	<input type="radio"/> Both	<input type="radio"/> Other specify:	
How often do you wear hearing protection?	<input type="radio"/> Always	<input type="radio"/> Mostly	<input type="radio"/> Seldom	<input type="radio"/> Never	

Past Occupational Noise Exposure

Employer	Duration (in years)	Type of Noise Exposed to	Protection Used

Occupational Activities

Indicate, in years, which of the following you are presently being exposed to:

Small Arm	Explosive	Motorcycle	Computer
Rifle	Inside Aircraft	Outboard Motor	Traffic
Stun Grenade	Outside Airport	Snowmobile	Listening Device

Non-Occupational Activities

Indicate, in years, which of the following you are regularly doing or operating:

Active Military Duty	Artillery	Flying	Chainsaw
Hobby Shooting	Loud Music	Power Tools	Racing Cars
Power Mower	Scuba Diving	Musical Instrument	Heavy Equipment

Diseases or Infections

Do you have or have you ever had any of the following?

<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Allergies
<input type="checkbox"/> Meningitis	<input type="checkbox"/> High Fever	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Recurring Sinusitis
<input type="checkbox"/> Cold / Flu	<input type="checkbox"/> Other specify:			

Medical History

Do you have or have you ever had any of the following?

<input type="checkbox"/> Ear Ache or Ear Infection	<input type="checkbox"/> Severe Blow to the Head	<input type="checkbox"/> Balance Problems	<input type="checkbox"/> Excess Wax
<input type="checkbox"/> Ear Surgery	<input type="checkbox"/> Hearing Difficulties in Crowds	<input type="checkbox"/> Hearing Difficulties	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Draining Ear	<input type="checkbox"/> Skull Fracture	<input type="checkbox"/> Hearing Aid
<input type="checkbox"/> Abnormal Hearing Test	<input type="checkbox"/> Examination by an Ear Specialist	<input type="checkbox"/> Ruptured Ear Drum	<input type="checkbox"/> Close Explosion or Blast

Has a close family member had hearing loss before the age of 50? No Yes his / her relationship is:

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Protected B
once completed

Declaration and Consent for Applicants

For applicants only: I declare that the statements made to the Audiogram Examiner are complete and correct to the best of my knowledge and that I have not withheld any relevant information or made any misleading statements.

I consent that this information be provided to the Royal Canadian Mounted Police for pre-selection purposes.

The cost of this examination and reports prepared by the Examiner are my responsibility.

Signature of Applicant

Date (yyyy-mm-dd)

Employee Comments and Signature

Comments

Signature of Employee

Date (yyyy-mm-dd)

Recommendations

To be Completed on the Day of the Examination by the Tester

Time lapse since last noise exposure 24 hours or less More than 24 hours

For applicants only

Please indicate if the **applicant** meets the following minimum RCMP Hearing Standards:

- Hearing loss no greater than 30 dbs in the better ear in the 500 to 3000 Hz range.
- Hearing loss no greater than 30 dbs in the worst ear in the range of 500-2900 Hz and no more than 50 dbs in the worst ear at 3000 Hz.

Meets or Exceeds Does **not** meet Not applicable

New Recommendations

Type of Audiometer

Examined by

Facility

Date of Test (yyyy-mm-dd)

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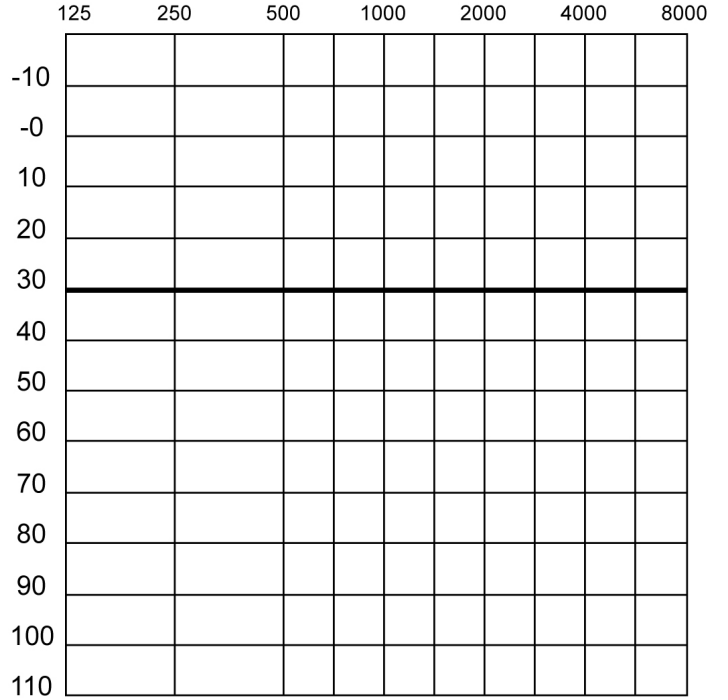
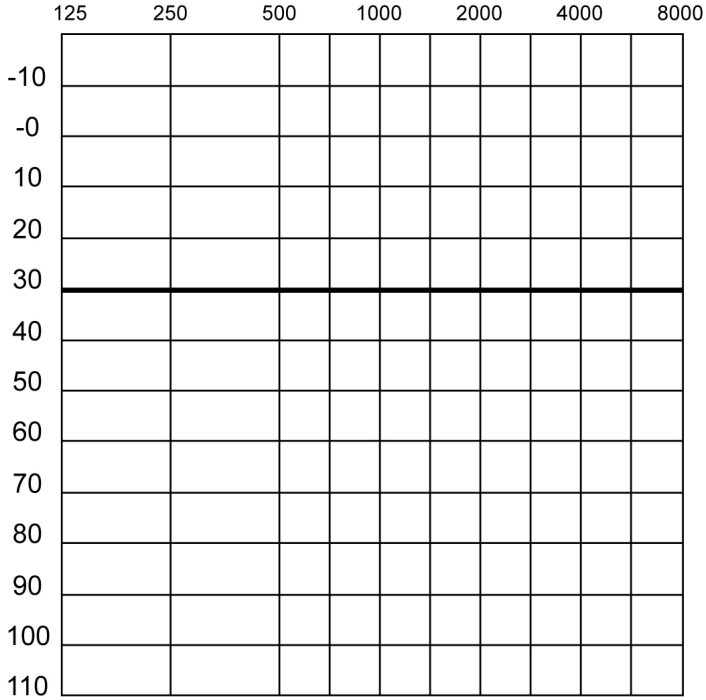
Audiometric Results

Name	Regimental Number	Date (yyyy-mm-dd)
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Graphs and comments below are to be completed by professional examiner once form has been printed.

RIGHT

LEFT



Comments
