a single partner, **infinite possibilities.**

EXAMINATION MANAGEMENT SERVICES, INC.

<u>EXAMINER'S TRAINING MANUAL</u>

THE PARAMED EXAM

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THE PARAMED EXAM

1.1 Definition
1.2 Purpose
1.3 Equipment Required
1.4 Preparation, Examiner Identification, and Language Interpreter Considerations
1.5 Procedure
1.5.1 Verification and Recording of Applicant Photo Identification Information
1.5.2 Procedure - Part II - Medical History
- a) Name and Date of Birth
- b) Personal Physician, Practitioner or Health Facility
- c) Date and Reason Last Consulted
- d) Treatment Given and Medication Prescribed or Recommended
- e) Systems Questions
- f) Standard Detailing – Identification and Description of Condition Continuity of Information
- g) Other Questions
  - (1) Questions Requesting Additional History or Verification of the Applicant's Health Status
  - (2) Questions Pertaining to the Use of Tobacco, Alcohol and Drugs
  - (3) Weight History Question
  - (4) Questions Pertaining to Military Deferment, Rejection or Discharge or to Receipt of Pension, Benefits or Payments Due to an Injury, Mental or Physical Condition or Disability
  - (5) Insurance Question
  - (6) Reproductive System Related Questions
  - (7) Family History Questions and Chart
- g) Special Documentation
- h) Dating, Signing, and Witnessing the Form
- i) The Medical Authorization

1.5.3 Procedure - Part III – Physical Measurements
- a) Blood Pressures and Pulses
- b) Height
- c) Chest and Abdominal Measurements
- d) Weight
- e) Urine Specimen Collection and Testing (HOS)
  - (1) The Applicant is Unable to Void
  - (2) Collection for Dipstick Testing Only
  - (3) Home Office Specimen (HOS) Collection/Chain of Custody
- f) Questions
  - (1) Questions Addressed to the Examiner
  - (2) Questions Addressed to the Applicant
- g) Remarks Section
- h) Dating and Signing the Form

1.6 Processing and Handling
1.7 Special Situations – Part II and Part III
a) An Interpreter is Required
b) The Applicant is Unable to Read and/or Write
c) The Applicant is a Minor (Juvenile)
d) Chain of Custody Procedure for Minors (Juveniles)The Applicant Refuses to Sign
e) The Applicant Refuses to Sign

MEDICAL HISTORY SPECIAL DETAILING GUIDE

1.1 DEFINITION

A paramedical examination (paramed or basic) is the recording of data by a personal interview with the proposed insured (applicant) to obtain an accurate medical history, physical measurements and a urine specimen.

Because this service is solely for the objective collection of insurance exam information, the service does not include discussing with the applicant any personal information unrelated to the exam, opinions regarding insurability, lab testing or results, medical advice/recommendations or treatment, or other business activities.

The sequence of the examination is as follows:

- Introduction and identification of the examiner, identification of the applicant by photo ID verification and explanation of procedures
- Interviewing applicant and recording health history (Part II)
- Obtaining and recording physical data (Part III) in the following order:
  - First blood pressure
  - Pulse (an additional pulse is required, take a second pulse).
  - Second blood pressure (additional readings are required, wait 5 minutes then take the third and fourth blood pressures).
  - Height by tape – taken without shoes
  - Chest and abdominal measurements on males only
  - Weight by scale
  - Urine specimen collection and dipstick testing (Home Office Specimen, if required)
  - Other supplemental services, if required

1.2 PURPOSE

To provide a quality report of complete and concise medical information, thereby enabling the underwriter to make an informed decisions regarding the underwriting risk and issuance of the policy.

1.3 EQUIPMENT REQUIRED

An attaché or briefcase containing:

- Order ticket
- Clipboard
- Ballpoint pen with black ink
- Supplemental Services form
- Aneroid sphygmomanometer with appropriate size cuff
- Stethoscope
- Urine dipstick and container with label showing timing and color chart instructions
- Watch which indicates seconds
- Tape measure (metal, 8 ft.)
- Weighing scale (300 lb. capacity)
- Designated lab urine kit containing:
  - Lab ID/Authorization form
  - Urine specimen container(s)/vial(s)
  - Urine collection cup with temperature strip

  - Disposable gloves (extra gloves in case they are needed)
- Additional supplies (in case they are needed):
  - Extra appropriate lab urine kit and extra tubes (in case of vacuum loss)
  - Extra urine specimen supplies (disposable collection cups with temperature strips, dipsticks and dipstick container)
  - If required, approved state HIV Notice and Consent form

1.4 PREPARATION, EXAMINER IDENTIFICATION, AND LANGUAGE INTERPRETER CONSIDERATIONS

Check your case for required equipment. Arrive promptly, introduce yourself, **show your photo I.D. card** to the applicant and explain the purpose of your visit. Ask the applicant to select a location with comfortable seating in a relaxed and private atmosphere. A third person may be present if the applicant so chooses (It is encouraged that a third person be present when a male examiner interviews/examines a female applicant and /or when an exam is performed at a residence. *If an EKG has been ordered with an exam for a female applicant, only a female paramedical examiner can perform the service. Male paramedical examiners are not authorized to perform an exam service that includes an EKG on a female applicant.*).

The EMSI examiner is to follow all policies and procedures in regards to maintaining the confidentiality and security of applicant information involved with the service.

If the applicant is not at the appointed location at the appointed time, the examiner must wait 15 minutes before leaving the location. Telephone contact should be made to confirm that the applicant is not at the appointed location before leaving. If the applicant no-shows, the examiner must leave a door hanger.

If the EMSI examiner is going to conduct the exam in English, the applicant must be able to speak and understand English. If the applicant cannot speak and understand English, the examiner must be able to conduct the exam in the applicant's language and dialect (if any) or an interpreter (translator) is required. See Special Situations: An Interpreter is required.

Never Conduct An Interview/Exam With The Agent Or Any Agency Personnel In The Same Room.

1.5 PROCEDURE

Print the information on the exam form. Excluding signatures, all information (data, medical history details, etc.) should be **printed** (not cursive) for the best clarity and legibility possible because of the technology that is used for distributing/transferring and storing exam documentation (i.e. faxing, scanning, imaging, microfiche, etc.).

THE USE OF DIGITAL/ELECTRONIC BLOOD PRESSURE EQUIPMENT IS PROHIBITED. BLOOD PRESSURE MUST BE RECORDED USING EVEN NUMBERED VALUES; RECORDING OF ODD NUMBERED READINGS IS PROHIBITED.

THE USE OF DIGITAL/ELECTRONIC WEIGHING SCALES IS PROHIBITED.

ALL MEASUREMENTS ARE RECORDED IN EXACT VALUES; ROUNDING OFF OF READINGS IS PROHIBITED.

1.5.1 Verification and Recording of Applicant Photo Identification Information

Verify applicant's identity by viewing his/her **photo ID**. The applicant's driver's license is the first choice of photo identification used to identify the applicant (showing photograph and signature) if it is available. If the applicant has no driver's license, ask for another form of photo ID such as a state issued ID, passport, or work identification, and record its description as the first entry in the Part II – Medical history portion of the exam form. If the applicant has no form of photo ID, record the applicable phrase, "Applicant does not possess photo ID" (Meaning the applicant does not own any form of photo identification) or "Applicant's photo ID unavailable." (Meaning the applicant does own photo identification, but does not have it with her/him at the exam site.)

If the applicant has no form of photo ID, ask to view his/her social security card and record the SS#. Make sure the applicant's ID matches the name on the order ticket. The applicant's driver's license number should be recorded on the lab ID/authorization in the designated space for DL# as well as specific state of issue to indicate that the applicant's identity was verified.

Also, it is essential that the examiner provide the insurance customer with actual documentation of the driver's license number for positive identification of the applicant on the urine lab ID/authorization for the modified urine chain of custody by following these EMSI procedures: If the HOS (urine) or other specimen is being collected in conjunction with an exam, record the driver's license number as the first entry in the detail area of the Part II-medical history portion of the exam form and in the designated space on the lab ID/authorization.

1.5.2 Procedure – Part II – Medical History

Explain the procedure of obtaining a medical history, physical measurements and a urine specimen to the applicant and answer questions to promote confidence and relaxation. Interview the applicant and complete the Part II heading and medical history of the exam form. Read each question slowly and directly word for word from the form, allowing an adequate amount of time for a response.

a) *Name and Date of Birth*
Confirm the spelling of the applicant's legal name and date of birth and record this information as requested for each page of the exam form.

b) *Personal Physician, Practitioner or Health Facility*
If the applicant is confused about the word "personal," you can ask which "main doctor", other type of practitioner or other provider has his/her medical records. Record the medical provider's **complete name and address** (including suite number, if any, and zip code) and **phone number.** The underwriter needs complete information to contact the medical provider if the applicant's medical records are needed to provide additional information.

If the applicant denies having a personal physician, but was seen by a staff member of a health maintenance organization or program (Kaiser, CIGNA, etc.) or a military or government facility, state type of medical personnel consulted clinic physician, physician assistant, nurse practitioner, chiropractor, therapist, etc. If the applicant was seen by a health maintenance organization or program, record the applicants medical ID number—the usual method by which the record is filed by health organizations and programs. If, however, the applicant was seen by a military or government facility, record the social security number of the responsible military or government employee.

If the medical provider's street address is unknown, consult a telephone directory or make a considerable effort to obtain a complete address. If the address is unavailable, record "address unavailable"; then record city and state. It is essential in these cases to have the applicant try to provide a **phone number**.

If the applicant denies having or being seen by a personal physician, practitioner or health facility, state "none".

c) *Date and Reason Last Consulted*
Record the most exact date possible. If the exact date is not known, record the month and year.

Record the specific symptom(s) which prompted this visit. If there were no symptoms and a physical examination (P.E.) was performed for a reason other than illness or injury, record "Asymptomatic P.E." The outcome of the P.E. should be stated, as well as any tests performed and their results. This P.E. might have been a wellness pre-employment, flight or annual physical, or an insurance exam.

If the applicant states that the last P.E. was an insurance exam, record details, if known, and whether the policy was issued standard or rated. If the policy was rated, record the reason for the rating.

If the most recent contact was a check-up or follow-up exam for a previously diagnosed condition, record the details of that visit in this space, but the specifics of that medical condition should be recorded in the appropriate systems question area.

d) *Treatment Given and Medication Prescribed or Recommended (including diet, exercise, physical therapy, chemotherapy, respiratory therapy, other forms of therapy, homeopathic or alternative therapy treatment, surgical procedures, etc.*
Record specific treatment(s)/therapy(s) given / type of specific medication (prescriptions, vitamins, over-the –counter, herbs) taken, including dosage, frequency if known. If none was prescribed, state "none." Make sure the reason for treatment/RX is clearly recorded.

e) *Systems Questions (Conditions, Illnesses, Diseases and Injuries)*
Read each form carefully; phrasing varies. For example, "Do you have or have you ever had any known indication of …?" or "Have you ever received treatment, attention or advice from any physician, practitioner, health facility, or been told by any of these that you had,…?" Other forms might ask for history for the past five or ten years. Refer to the time frame of the form; however, record all history volunteered by the applicant.

If an applicant mentions a problem which has never been professionally diagnosed (allergies, hemorrhoids, migraine headaches, etc.), record the condition in quotes, then state "self-diagnosed" and/or "self-treated", if applicable, and the related details of the condition and treatment, including vitamins, herbs, over the counter medicines, or other therapies, etc.

Pause after each item, allowing adequate time for thought and a response; for example, "Diseases of the heart…., arteries…., veins…..," clarifying the questions when asked.

Check the "yes" or "no" box of each question.

With each "yes" answer, CIRCLE the appropriate medical condition/item in the question.

RECORD COMPLETE DETAILS FOR THE MEDICAL CONDITION/ITEM IN THE DETAIL AREA OF THE FORM. Listen to the applicants' complete "story" regarding the medical condition/item. Reference the answer by recording question number and letter, and record details using the following sequence:

STANDARD DETAILING – Identification and Description of Condition

(1) Specific diagnosis and area(s) involved, including left and / or right, if applicable. Avoid generalities, such as "allergy," "head injury," or "back strain." Specify the type of allergy, head injury, etc. For example, a specific "seasonal pollen allergy." If the specific diagnosis is unknown, state "specific dx unknown"; then record description.

(2) Date of onset. If not known, record date diagnosed.

(3) Signs and symptoms, including duration and frequency of occurrences, if any.

(4) Names and addresses of all physicians, hospitals and facilities consulted. RECORD COMPLETE NAMES (First and Last names) STREET ADDRESSES INCLUDE SUITE NUMBERS AND ZIP CODES AND PHONE NUMBERS OF MEDICAL PROVIDERS**.** If the street address is unknown, consult a telephone directory or make a considerable effort to obtain a complete address. If the address is unavailable, record "address unavailable", then record city and state, and be sure to get the phone number.

(5) Duration of hospitalization(s), if applicable.

(6) Specific test(s) and diagnostic procedure(s) and study(s) (cardiac catheterization, myelogram, etc.) performed, and result(s). If a test name or result is unknown, state "test name result is unknown."

(7) Specific treatment(s), prescriptions, therapies, including frequency and duration.

- Type/name of medication and dosage, if known.
- Special procedure(s) and surgery, including repair, reconstruction and removal of structure/organs. Avoid generalities such as "knee surgery," "hernia surgery" or "kidney stone removed surgically." Specify the type(s) of knee, hernia or kidney stone surgery. For example, a specific hernia surgery might be "left inguinal herniorrhaphy." If the specific procedure/surgery unknown, record "specific procedure/surgery unknown." Include elective and/or outpatient and cosmetic surgery as well as surgical indication, if any.

  - Diet
  - Physical therapy (exercise, traction, etc.) and frequency
  - Chiropractic treatment. State specifics (spinal adjustment, massage, etc.) and frequency
  - Respiratory therapy
  - Radiation
  - Chemotherapy
  - Counseling/instruction (psychiatric, dietary, back school, biofeedback, etc.)

- Other (support groups and organizations, prosthetic use, including hearing aids, glasses, etc.)

(8) Recovery date

(9) Sequela(e)/complication(s), if any, including details

(10) Recurrence date(s), if any

(11) Time lost from work or usual duties

(12) Activity limitations and / or disability and rating, if any, and update of current status

Portions of this standard detailing may not apply to every medical condition; however, an effort should be made to obtain all facts. When special detailing is required in addition to the standard details above (for such conditions as asthma, eye disorders, heart disorders, pregnancy, etc.), consult the Special Detailing Guide located at the end of this procedure. If a specific detail is unknown, record that detail as "unknown" in the detail area; for example, "blood test result unknown." If the complete "story" is unknown, record "complete details unknown."

Five key words will assist in specific detailing (5 D's):

1. **Date**
2. **Diagnosis**
3. **Doctor**
4. **Duration**
5. **Dosage**

If any part of the history is vague or medically unreasonable, record the applicant's statement in quotation marks.

CONTINUITY OF INFORMATION - Provide continuity of information. The following types of questions may request details relevant to a condition, which was detailed in a systems question. There also may be several questions pertaining to the same condition. To avoid fragmentation and duplication of data, first mentally organize the facts; then record the "entire story" for each appropriate systems question; and then refer to this entry when answering subsequent related questions; for example, "Refer to 3K." Provide additional information, if applicable.

Also, if a specimen is collected and the applicant answers the lab ID/Authorization's medication question "yes" and declares a prescription medication that was not declared on the exam, then make the correction by clarifying the discrepancy with the applicant, obtaining all details about the medication (reason, dosage, frequency, prescribing physician's name, address, and phone number, and adding the information and details in the appropriate place on the exam form. The addition must be initialed and dated by the applicant and examiner.

f. *Other Questions*

(1) Questions Requesting Additional History or Verification of the Applicant's Health Status

These questions often request current health status and / or information that may not have been asked in the systems questions, such as additional medical testing, disorders, hospitalizations, or medical "advice" or "attention," for example,

"Other than the above, have you had medical advice or attention or have you been advised to have medical advice or attention?" Record complete details, if applicable.

(2) *Questions Pertaining to the Use of Tobacco, Alcohol and Drugs*
Provide only the details specifically requested. If the questions are not specific regarding usage of tobacco, alcohol or drugs, record the type, amount, frequency, duration and dates of any lapses. If the word "excessive" is used in the alcohol or drug use / abuse question, the applicant must interpret its meaning.

(3) *Weight History Question*
Record details specifically requested. If the question is not specific, record the number of pounds gained or lost within the specified time frame and the reason.

(4) *Questions Pertaining to Military Deferment, Rejection or Discharge or to Receipt of Pension, Benefits or Payments Due to an Injury, Mental or Physical Condition or Disability.*
Record the medical cause, details and dates.

(5) *Insurance Question*
Record details specifically requested. If the question is not specific, record exam details and whether the policy was issued standard or rated, or if the applicant was declined. If the policy was rated or declined, record the reason for the rating or declination.

(6) *Reproductive System Related Questions*
Ask only those questions applicable to the sex of the applicant and record complete details. Please note that any questions that inquire about breast conditions, lumps, nodules, cysts, inflammation, cancer, etc. are to be asked of male applicants as well (Currently, there is an increased incidence of male breast cancer.). If a question does not apply, record "NA" through the boxes of the non-applicable question.

(7) *Family History Questions and Chart*
Only members of the immediate family who are "blood relations" (parents, siblings) are to be considered unless otherwise specified. Record details specifically requested. The usual details include:

- Identification of medical condition(s)
- Relationship
- Age at onset of health condition(s) mentioned
- Current age and health status
- Age at and cause of death
- Number of living and deceased siblings

Avoid the use of words such as "natural causes," "old age," "cancer," "heart trouble," "liver," etc.; specifics are required; for example, lung cancer, coronary artery disease, hepatitis, pneumonia, etc. If these types of words are all the applicant can offer, place the words in quotes and record "specific dx unknown."

If any of the family history information is unknown, record "unknown" in the appropriate space. If the applicant is adopted without knowledge of family history, record, "Unknown – adopted".

g) *Special Documentation*

No Medical History Reported By The Applicant If the applicant has answered "no" to all questions in the Part II- Medical History with the exception of the family history question, then the examiner will verify the above by asking, "You have never had a medical problem or consulted a doctor, medical facility, therapist or any other type of medical provider for any reason?" If the applicant agrees, inform the applicant that "Medical history denied by applicant," will be recorded in the detail area, and have the applicant initial the statement as well as sign the form.

Additional Space Required For History. If additional space is needed to complete the medical history, use another copy of the insurance form. Label the first form "pg. 1 of 2" and the second form, "pg. 2 of 2." Complete the heading and reference the answer by question number and letter and proceed. This additional form must also be dated, signed and witnessed, including block printing of your name and branch office stamping the Part III side of the form.

Corrections

If there are any errors, correct them by drawing a single horizontal line through the error. Sign your initials beside the correction and ask the applicant to sign his/her initials beside your initials (Corrections made after the document has been signed requires dates recorded by the initialing.). Use of liquid correction fluid or any other form of blocking out documentation is prohibited.

h. *Dating, Signing and Witnessing the Form*

Review the form to check for any errors and to verify that all yes / no boxes are checked or marked "NA," all appropriate spaces are filled and all identified conditions / items are circled and detailed. Ask the applicant to read the form, checking for accuracy.

Date the form in the appropriate space. If the city and state where the exam was performed is requested, record that data in the designated space; for example, "Signed at ___________________," "Dated at __________, __________," etc.
(City) (State) (City) (State)

Check both sides and every page of the form to locate the spaces for the applicant's signature. Ask the applicant to sign his / her legal name in all the appropriate spaces as he / she signed it on the application, Part I. For example, if the application reads "John T. Doe," the exam form should read, "John T. Doe," not " J.T. Doe." This signature is also required to validate the data just recorded on the Part II Medical History.

After verifying that all applicant signature spaces have been signed, witness the signature(s) by signing your full legal name signature and any professional title (R.N., E.M.T., L.P.N., etc.) obtained by license or certification. **Block print** your legal name below your signature. If the title "M.D." appears on the form, draw a single line through it to avoid misrepresentation. Also, if you are an M.D. performing paramed exams, do not include your M.D. title, to avoid the mis-interpretation that a physician's exam was performed.

Remember-Additional information is never added to the Part II after the applicant has signed the form unless the applicant and examiner initial and date the change or addition.

i) *The Medical Authorization*
The date and the applicant's legal signature are required on any authorization that may be attached to the form. If requested, witness with your legal name signature (and title) and block print your name. (A signed and dated medical authorization is necessary if the insurance company decides to obtain further information from physicians, health facilities, or other health providers.)

1.5.3 Procedure – Part III – Physical Measurements

NEVER EXERCISE AN APPLICANT FOR ANY REASON REGARDLESS IF IT IS REQUESTED ON THE EXAM FORM. Always draw a line through the word "exercise" in the BP and Pulse areas of the form.

a) *Blood Pressures and Pulses*
Always use manual BP equipment. The use of a digital sphygmomanometer or any other electronic blood pressure equipment is prohibited.

Blood pressures and pulses are always taken at rest with the applicant in a sitting position with the arm supported.

Two blood pressures are always taken at least three minutes apart, **one from each arm**, and recorded on the form, noting the arm used, "L" or "R," beside each reading.

If the blood pressure reading exceeds 140/90 or as otherwise specified by the insurance company, take at least two more blood pressures, one from each arm. Follow the instructions on the form if more than a total of four blood pressures are required. Always identify the arm used for each blood pressure.

If the applicant's upper arm circumference is over 13 inches, use a large adult-size cuff and make a notation regarding its use in the remarks section of Part III – Physical measurements side of the form.

A **one-minute radial pulse** is always taken and recorded, noting the **number of irregularities**, if any, per minute. If there are no irregularities, checks the appropriate box provided, or record the number "0" (zero) in the appropriate space. DO NOT RECORD "NONE, " "NA," OR A ZERO WITH A MARK THROUGH IT. If the pulse exceeds 90 per minute or as otherwise specified on the insurance form, take a second one-minute pulse and record.

Take the first blood pressure with the applicant sitting and the arm extended in a comfortable, supported position. Locate the brachial artery by palpation. Apply the deflated cuff evenly and snugly around the upper arm with the lower edge about one inch above the brachial artery in the antecubital area (elbow).

Insert ear pieces of the stethoscope in your ears. Locate the radial pulse by palpation, and with the screw on the bulb tight, inflate the cuff by pumping the bulb until the pressure is about 30mm above the point where the radial pulse is no longer palpable. Place the bell portion of the stethoscope over the brachial artery just below the cuff.

Slowly deflate the cuff by loosening the screw on the bulb and allowing air to escape from the cuff as the needle moves from right to left on the gauge or as the mercury drops on the gravity manometer. Listen for the first sounds. (The number on the gauge which coincides with the first sound is the systolic blood pressure reading; the number on the gauge that coincides with the point the sound disappears is the diastolic 5th phase blood pressure reading.)

The Cuff Should Never Be Partially Inflated. Reinflate The Cuff After Allowing It To Deflate Completely; Otherwise, An Inaccurate Blood Pressure Reading Could Result.

Completely deflate the cuff and remove it from the applicant's arm. Record the reading on Part III, identifying the arm used for that reading. (The blood pressure reading is usually recorded as a fraction with the systolic reading over the 5th phase diastolic reading. For example, a systolic reading of 120 and a diastolic reading of 80 would be recorded as 120/80, unless the form provided requests the readings be recorded side-by-side in the designated spaces.)

Record the readings on Part III, identifying the arm used for each reading. If the spaces designated on the form for exercise and recovery blood pressures / pulses are needed, remember to draw a line through the words referring to exercise and recovery. Then use those spaces to record further readings.

Locate the radial artery by palpating the inner aspect of the wrist.

Take a one-minute radial pulse and record the pulse rate. Note the number of irregularities per minute, if any; if none, state "None."

Take a second blood pressure from the opposite arm and record reading.

If a second pulse is indicated, take a second pulse and record.

If a third blood pressure is indicated, allow the applicant to sit comfortably and undisturbed for at least 3-5 minutes, unless otherwise specified by the insurance company form; then take and record the third reading using the arm initially used. Note the arm used. If a fourth blood pressure is indicated, take and record a fourth blood pressure from the opposite arm, also noting the arm used.

If the blood pressure is less than 80/50 or above 180/114 inform the applicant of the reading. Inform them that the range is in between 90/60 to 140/90 and the American Heart Association considers any blood pressure above 140/90 above normal range.

b) Height

Height Is Always Measured By Your Tape. Measure the applicant's height with shoes by having the applicant stand erect with back against a wall. Extend the tape from the floor to the top of the head to determine height and record the measurement on Part III in feet and inches. If the applicant's shoes have high heels, so state in the remarks section of Part III.

c) *Chest and Abdominal Measurements*

Chest And Abdominal Measurements Are Taken On Male Applicants Only. If the applicant is female, record "NA" in the appropriate spaces for chest and abdominal measurements.

Measure the male applicant without a coat or sweater and with shirt pockets empty. Stand to the side of the applicant and ask him to raise his arms away from his sides while you pass the measuring tape around the chest at the level of the nipples. Ask him to lower his arms and forcefully inhale; then measure the chest upon full inspiration. Ask the applicant to exhale completely and measure the chest upon full forced expiration. Then ask him to breath normally. With the applicant relaxed, pass the tape around his abdomen at the level of the umbilicus (navel) and measure. Record chest and abdominal measurements in inches on Part III.

d) *Weight*

Weight is always physically measured using your 300 lb. capacity scale. *DO NOT USE DIGITAL/ELECTRONIC BP EQUIPMENT. Do not ask the applicant an estimated weight for any reason. Do not accept an applicant's offer to use his/her scale or provide you the last weight that they obtained at another time in lieu of an actual physically measured weight. The Applicant Is Always Assisted On And Off The Scale.* Measure weight with the applicant wearing indoor clothing and **WITHOUT shoes**. With the scale on a hard, **uncarpeted floor** to insure stability and an accurate reading, verify that the scale is aligned at "0"; if not, realign. Obtain a weight reading, assisting the applicant on and off the scale. Record the exact weight in pounds (lbs.) in the designated space on the exam form. Do not round off readings.

If the applicant's weight exceeds the weight capacity of your 300 lb. Scale, record a plus (+) sign after the maximum (300 lbs+) and note "weight exceeds scale capacity of 300 lbs. And applicant states weight at _____lbs." In the remarks section of part III. Record date last weighed.

If Any Measurements Cannot Be Obtained, So State And Explain The Reason In The Remarks Section.

e) *Urine Specimen Collection and Testing/HOS*

Wearing Gloves on Both Hands Is Required Whenever Handling Urine. Unless otherwise specified by the customer, the applicant must void at the time of the exam and the urine specimen collected. If an HOS is requested, do not dipstick test the specimen unless otherwise instructed to do so. Never leave the urine specimen container or kit with the applicant.

The appropriate lab ID/authorization form must be completed and notice and consent signed by the applicant before the specimen collection can be performed. The applicant should read the "Notice and Consent " before signing.

An HOS may not initially be required; however, please read the exam form carefully for instructions regarding conditions of positive dipstick results, positive applicant and/or family history (i.e., high blood pressure, diabetes, renal disease, etc.) or high blood pressure readings indicating an HOS is necessary.

(1) The Applicant is Unable to Void

If the applicant cannot void at the time of the exam, record "Applicant unable to void, specimen to follow" in the remarks section. It is your responsibility to make arrangements to obtain a specimen within 24 hours or as soon as possible. (This HOS will be sent in a urine mailer to the insurance company's designated laboratory along with a Supplemental Services form, stating "Applicant unable to void at the time of the original exam, <u>(date</u>).")

(2) Collection for Dipstick Testing Only

If the urine is not going to be collected for an HOS to be sent to the lab, give the applicant a disposable cup and the urine specimen container and request a urine specimen. Instruct the applicant to void into the disposable cup, then pour the urine into the container to the level of the guideline and secure the lid, leaving the preservative tablet in it. Ask the applicant to discard the paper cup and return only the specimen container to you. To help assure a fresh specimen, feel the container to determine if the urine is warm. (If the specimen container does not feel warm to the touch, request another specimen.) If dipstick testing the specimen is indicated, open the dipstick container, remove one dipstick and immediately replace the container lid tightly to prevent moisture damage. Remove the lid of the specimen container and dipstick test for albumin (protein) and glucose (sugar). Totally immerse the reagent squares on the dipstick into the urine, tapping it against the container's edge as you lift it out to rid it of excess urine. Replace the lid tightly to prevent leakage. Allow the required amount of time. Compare the albumin and glucose squares to the color chart printed on the dipstick container to determine the degree of sugar and albumin, if any. Record the results in the designated spaces of Part III according to the dipstick label's instructions. If the readings are negative, record "NEG."

If dipsticking the specimen is not performed and/or if the form requests results of other urine tests that EMSI does not perform (specific gravity, occult blood, etc.), record "NA" in the spaces provided.

(3) Home Office Specimen (HOS) Collection/Chain of Custody

Determine if a Home Office Specimen (HOS) is required by checking the <u>order ticket</u> and the <u>insurance exam form</u>.

If an HOS is required, to be sent to the lab <u>in the presence of the applicant</u>, place the designated lab's tamper evident tape, uniformly across the top of the lid and press the ends of the tape to the sides to seal the lid to the body of the container. <u>Then</u> ask the applicant to initial the tape seal on the container.

Print complete information on the appropriate lab ID/Authorization recording the applicant identification information, the insurance company name, insurance company's name of Home Office or regional office city and state, lab code (lab's letter/numerical code or specific department required by the company and pending policy/member number, if available). Applicant's name, DOB, city and state, date voided, agent/agency, examiner's name and branch office's city and state are also included. Record general office or agency numerical code in the agency space of the form. Record any additional information include date and time of last food/drink. If the slip requires the applicant's signature, ask the applicant to sign it. Then wrap the identification slip around the specimen and place it into the urine mailer.

Have the applicant sign the lab ID/authorization form as required to authorize specimen collection and testing. (If the requirements include urine HIV-1 antibody testing, the applicant must initial the Calypte stickers for the Calypte Subject Information Brochure included in the urine HIV kit.)

Bar-code and label all urine container(s) with applicant's complete name, date of birth, and date of service (in the presence of the applicant). This step must occur before the collection process.

From the time the urine specimen is collected and is sealed with tamper evident tape, it remains in the presence of the applicant. [Be careful to prevent tamper evident tape(s) from obscuring bar-code(s), name/ID label(s), or if applicable, Calypte stickers on the specimen containers.] Check for warmth and any visible signs of contamination, adulteration, (i.e., sediment, discoloration). **Check urine temperature and record** on the lab ID/authorization.

Seal urine container(s) with **tamper evident tape(s)** for transfer to the lab.

Have the applicant tamper evident tape(s) dated and initialed (with signature initials, not printed initials), signifying acknowledgment by the applicant that the specimens was/were indeed his/hers, and that the container(s) was/were sealed in his/her presence. Signs your initials/signature on the tamper evident tape(s) as well.

Have the applicant sign the Chain of Custody provision on the lab ID/authorization form signed by the applicant sign as well if requested.

Record that an HOS is being sent in the appropriate space or remarks section of Part III, documenting the reason and laboratory, if requested. If there are questions regarding any irregularities (menstrual period, medication, etc.), so state in the appropriate space.

Remove gloves and wash your hands in the bathroom if you are performing this procedure in the applicant's home. If the procedure is being performed in an office or other type of workplace, an antiseptic/antibacterial hand cleanser, gel or spray may be applied, then wash your hands as soon as possible afterward.

f) *Questions*

(1) *Questions Addressed to the Examiner*

Record answers to questions addressed to the examiner. These questions often pertain to the examiner weighing and measuring the applicant, observing abnormalities (missing limbs, limp or atrophied arm / leg, etc.) or making an evaluation of an unhealthy or older appearance than stated. Also answer questions regarding business or personal association with either the applicant or the agent.

Do not answer any questions which ask for an opinion regarding the applicant's **insurability,** for example, "Do you feel this applicant is a poor health **risk**?" This type of question is to be answered by a

physician only. Record "NA" in the appropriate space as the answer to this type of question.

If the insurance company provides only one form for both a physician and paramed exam, draw a single diagonal line through the physical assessment portion of the form, which pertains to the M.D. examination.

(2) *Questions Addressed to the Applicant*
Ask the Part III questions addressed to the applicant. Record the answers in the appropriate spaces. These questions often pertain to weight gain / loss, and the use of tobacco, alcohol and drugs.

g) *Remarks Section*
A remarks section is usually provided to record or amplify information that is pertinent to the exam such as observed abnormalities or conflicting information. **It is not for recording medical history details to questions from the Part II medical side of the form.**

If you perform an EKG, blood draw, or other supplemental service at the time a paramed exam is completed, record the information pertaining to that service in the spaces provided or in the Remarks section of Part III.

h) *Dating and Signing the Form*
Review Part III for completeness and accuracy. Date and sign your full legal name **signature** and title, if any. Draw a line through "M.D." or "Medical Examiner" to avoid misrepresentation. (On Metropolitan exams, include your social security number under your signature.)

1.6 PROCESSING AND HANDLING

Branch offices stamp Part III - physical measurements side of the form. - Showing EMSI as the authorized paramedical vendor. In addition to the EMSI name, the stamp must show the EMSI branch address **and phone number**.

Complete the voucher, if attached to the exam form, recording all requested data, including Home Office stamp.

Per your branch office instructions, complete and submit the order ticket, exam form (Supplemental Services form and other related forms, if applicable), sealed HOS and / or other specimens to the branch office or as otherwise instructed. In some cases, the insurance company requires the exam documents be placed in the kit and sent with the specimen(s) to the lab. Please refer to the order instructions for the mailing requirements.

1.7 SPECIAL SITUATIONS – PART II AND PART III

a) *An Interpreter is Required*
If a non-English speaking applicant is interviewed and the examiner is unable to speak the applicant's language fluently, an interpreter is required. The interpreter must be an adult, 18 years of age or older. Print the interpreter's name and relationship to the applicant as the second entry in the detail area of Part II. Then record the reason for using an interpreter in the detail area (specific language and dialect, if any.) Read the questions to the interpreter who, in turn, asks the questions of the applicant. The

interpreter translates the details stated by the applicant to you for recording. Ask the interpreter to read the entire medical history to the applicant to verify accuracy.

If a deaf applicant is interviewed and a sign language interpreter is needed, the same requirements apply as above.

b) *The Applicant is Unable to Read and/or Write*
If the applicant is unable to read and/or write, a third person of the applicant's choosing must be present. The third person must be an adult, 18 years of age or older. Record the third person's name and relationship to the applicant as the second entry in the detail area of Part II. Then record the reason for using a third person in the detail area.

(1) If the applicant is unable to read but is able to sign his / her name, ask the third person to read the entries you have recorded to the applicant.

(2) If the applicant is able to read but unable to write, ask the applicant to make his mark beside the corrections and in the applicant signature space(s). Print "Mark of (applicant's name)" beside the mark. (This mark should be the same as the signature mark on the application, Part I.) Only the signature mark(s) must be witnessed by a third person, not the interview or entries.

c) *The Applicant is a Minor (Juvenile)*
The proposed insured is considered a minor if he / she is under the age of 18 or as otherwise stated on the form. The parent / legal guardian must remain present in the same room during the entire exam process.

Use a juvenile form provided by the insurance customer. If no such form is provided, use their regular form. The minor's name must appear in the heading.

Conduct the interview with the parent or legal guardian and obtain the physical measurements of the minor in the presence of the parent or legal guardian. Take abdominal and chest measurements on male minors who are over 14 years old.

Ask the parent/guardian to sign the form and the medical authorization and block print his/her name below his/her signature, noting the relationship to the applicant. Then record the parent/guardian's driver's license number and state where issued or social security number above his/her signature. Ask the minor applicant to sign the form, if requested and if he/she is capable of signing.

Any specimens collected during a minor's exam require co-signatures and relationship recorded by the parent/legal guardian on the lab ID/Authorization form and any state notice and consent form and co-initialing on specimen tamper evident tape seals.

If the minor is married and is considered legally independent, the presence and signature of the parent / guardian is not required.

d) *The Applicant Refuses to Sign*
If after the history has been recorded, the applicant refuses to sign the form, record "Applicant refused to sign" and the reason in the detail area. Sign and block print your legal name after the entry. Date the form, and notify the branch office.

d) <u>*Chain of Custody Procedure for Minors (Juveniles)*</u>

All procedures for minor applicants require the parent/legal guardian to be present. EMSI Examiners may perform venipunctures on minor applicants who are 15 to 17 years old, fingersticks on minor applicants 5 to 17 years old, and urine collections on any minor applicants who are capable of voiding upon demand (Any assistance required for a very young child's urine collection would be rendered by the parent/legal guardian.). Venipuncture procedures for minors who are 14 years old or younger and fingerstick procedures for minors who are 4 years old or younger must be scheduled to have their specimens collected in an outside clinic or outside laboratory.

Our EMSI examiners' responsibility in Modified Chain of Custody for minor applicants includes performing and/or verifying the following:
Positive identification of minor applicant and completion of lab ID/authorization form provided. The minor applicant's driver's license is the first choice of identification used to identify the applicant (showing photograph and signature) if it is available. Many minor applicants will not be of age to have a license. If the minor applicant has no driver's license, ask for another form of photo ID such as a state issued ID, passport, or work identification, and record it'' description. If the minor applicant has no form of photo ID, record the applicable phrase, "minor does not possess photo ID" or "minor photo ID unavailable." Then ask to view his/her social security card and record the SS#. Make sure the minor applicant's ID matches the name on the order ticket. The minor applicant's driver's license number should be recorded on the lab ID/authorization in the designated space for DL#, as well as specific state of issue to indicate that the minor applicant's identity was verified. Also, it is essential that the EMSI examiner provide the insurance customers with actual documentation of the driver's license number for positive identification of the minor applicant for chain of custody by following these EMSI procedures: If the blood/urine is being collected in conjunction with an exam, record the driver's license number as the first entry in the detail area of the Part II-medical history portion of the exam form as well as in the designated space on the lab ID/authorization. If a specimen is being collected without an exam, unless the customer has requested that the information be recorded only on lab ID/authorization for information transmittal to their company, record the minor applicants driver's license number in the designated space of the EMSI Supplemental Services form as well as on the lab ID/authorization. Also, obtain and record the photo ID of the parent/legal guardian present, noting the relationship to the minor applicant. If the parent/legal guardian has no form of photo ID record the applicable phrase, "does not possess photo ID" or "photo ID unavailable." If parent/legal guardian refuses to show his/her photo ID, record "refused photo ID."

Lab ID/authorization form's notice/consent section signed by the minor applicant (if minor applicant capable) and cosigned by the parent/legal guardian as required to authorize specimen collection and testing. The parent/legal guardian is required to record his/her relationship status as parent/legal guardian beside his/her signature. (If the requirements include urine HIV-1 antibody testing, the minor applicant (if capable) and parent/legal guardian must initial the Calypte stickers for the Calypte Subject Information Brochure included in the urine HIV kit.)

Proper bar-coding and labeling of all specimen tubes, including the purple top, red top, and <u>serum transfer tubes</u>, as well as the urine container(s) with minor applicant's complete name, date of birth, and date of service (in the presence of the minor applicant and parent/legal guardian). This step must occur <u>before</u> the collection process.

From the time the urine specimen is collected and is sealed with tamper evident tape, it remains in the presence of the minor applicant and the parent/legal guardian. [Be careful to prevent tamper evident tape(s) from obscuring bar-code(s), name/ID label(s), or if applicable, Calypte stickers on the specimen containers.] Urine checked for warmth and any visible signs of contamination, adulteration, (i.e., sediment, discoloration). Urine temperature checked and recorded on the lab ID/authorization, if temperature sensor device provided in the lab kit.

Urine container(s) sealed with tamper evident tape(s) for transfer to the lab.

Tamper evident tape(s) dated and initialed (with signature initials, not printed initials)/signed by minor applicant (if minor applicant capable), co-initialed by parent/legal guardian with relationship status recorded by his/her initials/signature, signifying acknowledgment by the minor applicant and parent/legal guardian that the specimens was/were indeed his/hers, and that the container(s) was/were sealed in the minor applicant's and parent/legal guardian presence. The EMSI examiner signs his/her initials/signature on the tamper evident tape(s) as well.

Chain of Custody provision on the lab ID/authorization form signed by the minor applicant (if capable), cosigned by parent/legal guardian with relationship status recorded by the parent's/guardian's signature, and signed by EMSI examiner.

(The other three steps are the lab's responsibility as it relates to Chain of Custody.)

e) *The Applicant Refuses to Sign*

If after the history has been recorded, the applicant refuses to sign the form, record "Applicant refused to sign" and the reason in the detail area. Sign and block print your legal name after the entry. Date the form, and notify the branch office.

MEDICAL HISTORY SPECIAL DETAILING GUIDE

The following disease conditions are frequently reported but not always completely detailed. Each specific condition or category listed here requires special detailing in addition to the standard detailing.

ALLERGY - Seasonal, pollen (specify), chemical, insect, materials, etc. If medication related, record relevant detailing.

ARTHROSCOPIC SURGERY - Type of repair performed at time of surgery.

BURNS - Type (electrical, chemical, etc.); cause; location; severity (1st degree, 2nd degree, etc.) and percent of body surface affected.

CANCER - Specify type if known (i.e. skin - Basal Cell, Melanoma, Kaposi's Sarcoma Metastatic sites.

CESAREAN SECTION - Fetal or maternal indication (disproportion, eclampsia, etc.).

CHEST PAIN - Description (intensity, constant/intermittent); related respiratory involvement related to activity/exertion.

CONVULSIONS - Description of seizure (tonic, clonic, febrile or epileptic), frequency, duration.

DEFORMITY/DISABILITY - Cause (genetic, congenital, injury or disease); description (atrophy, hypertrophy, shortening, malformation).

DIABETES - Dates of diabetic medication and dietary changes.

EAR DISORDERS - Current hearing acuity after procedure/treatment; unilateral or bilateral hearing aid(s) use.

EYE DISORDERS - Current visual acuity after procedure/treatment or glasses.

EPILEPSY - See Convulsions.

HEAD INJURY - Specific diagnosis (concussion, cerebral hemorrhage; subdural hematoma, etc.); related impairments.

HEART DISORDERS/ SURGERY - Specific diagnosis (arteriosclerosis, congestive heart failure, myocardial infarction, murmurs, mitral valve prolapse, etc.).

HEPATITIS - Type (A – infectious, B – serum, toxic, C, D, E, Non-A, Non-B).

HORMONE THERAPY - Indicate need (menopausal, post-hysterectomy, specific endocrine disorders).

HYSTERECTOMY - (Abdominal or vaginal); state specific procedure (total/complete – uterus and cervix, subtotal/partial – uterus only); any additional surgery (i.e., fallopian tubes and/or ovaries).

KIDNEY DIALYSIS - Type (peritoneal, hemodialysis).

KIDNEY DISORDERS - (Pyelonephritis, nephrosis, failure, etc.); injury, congenital, drug-related; unilateral or bilateral.

KIDNEY STONE(S)/SURGERY - Specific surgical procedure (invasive/incisional or non- invasive/internal.).

MEDICATIONS - Frequency of P.R.N. doses, including documentation of birth control and diet pills; specific name of drug required.

NEUROMUSCULAR/NERVOUS SYSTEM DISORDERS - Description of episodic/chronic and/or reversible/ progressive; specific areas affected, and type of involvement (paralysis, contracture, tremors, etc.).

PARALYSIS/PARESIS/PALSY - See <u>NEUROMUSCULAR/NERVOUS SYSTEM DISORDERS</u>.

PREGNANCY - Routine checkups; testing; delivery and confinement specifics; any related abnormalities of pregnancy.

PROSTATE SURGERY - Specific surgical procedure (invasive/incisional or non-invasive/internal). Include any biopsy result.

RENAL DIALYSIS - See <u>KIDNEY DIALYSIS</u>.

RENAL DISORDERS - See <u>KIDNEY DISORDERS</u>.

RHEUMATIC FEVER - Severity, duration, sequela(e).

SEIZURES - See <u>CONVULSIONS</u>.

THYROID DISORDERS - Type (goiter, hyperthyroidism, hypothyroidism, etc.).

EXAMINER TRAINING MANUAL UPDATE

EMSI'S PROCEDURES REGARDING APPLICANT IDENTIFICATION AND MODIFIED CHAIN OF CUSTODY OF BLOOD AND/OR URINE SPECIMENS FOR MINOR INSURANCE APPLICANTS.

All procedures for minor applicants require the parent/legal guardian to be present. EMSI Examiners may perform venipunctures on minor applicants who are 15 to 17 years old, fingersticks on minor applicants 5 to 17 years old, and urine collections on any minor applicants who are capable of voiding upon demand (Any assistance required for a very young child's urine collection would be rendered by the parent/legal guardian.). Venipuncture procedures for minors who are 14 years old or younger and fingerstick procedures for minors who are 4 years old or younger must be scheduled to have their specimens collected in an outside clinic or outside laboratory.

Our EMSI examiners' responsibility in Modified Chain of Custody for minor applicants includes performing and/or verifying the following:

1. Positive identification of minor applicant and completion of lab ID/authorization form provided. The minor applicant's driver's license is the first choice of identification used to identify the applicant (showing photograph and signature) if it is available. Many minor applicants will not be of age to have a license. If the minor applicant has no driver's license, ask for another form of photo ID such as a state issued ID, passport, or work identification, and record it's description. If the minor applicant has no form of photo ID, record the applicable phrase, "minor does not possess photo ID" or "minor photo ID unavailable." Then ask to view his/her social security card and record the SS#. Make sure the minor applicant's ID matches the name on the order ticket. The minor applicant's driver's license number should be recorded on the lab ID/authorization in the designated space for DL#, as well as specific state of issue to indicate that the minor applicant's identity was verified. Also, it is essential that the EMSI examiner provide the insurance customers with actual documentation of the driver's license number for positive identification of the minor applicant for chain of custody by following these EMSI procedures: If the blood/urine is being collected in conjunction with an exam, record the driver's license number as the first entry in the detail area of the Part II-medical history portion of the exam form as well as in the designated space on the lab ID/authorization. If a specimen is being collected without an exam, unless the customer has requested that the information be recorded only on lab ID/authorization for information transmittal to their company, record the minor applicants driver's license number in the designated space of the EMSI Supplemental Services form as well as on the lab ID/authorization. Also, obtain and record the photo ID of the parent/legal guardian present, noting the relationship to the minor applicant. If the parent/legal guardian has no form of photo ID record the applicable phrase, "does not possess photo ID" or "photo ID unavailable." If parent/legal guardian refuses to show his/her photo ID, record "refused photo ID."

2. Lab ID/authorization form's notice/consent section signed by the minor applicant (if minor applicant capable) and cosigned by the parent/legal guardian as required to authorize specimen collection and testing. The parent/legal guardian is required to record his/her relationship status as parent/legal guardian beside his/her signature. (If the requirements include urine HIV-1 antibody testing, the minor applicant (if capable) and parent /legal guardian must initial the Calypte stickers for the Calypte Subject Information Brochure included in the urine HIV kit.)

3. Proper bar-coding and labeling of all specimen tubes, including the purple top, red top, and serum transfer tubes, as well as the urine container(s) with minor applicant's complete name, date of birth, and date of service (in the presence of the minor applicant and parent/legal guardian). This step must occur before the collection process.

4. From the time the urine specimen is collected and is sealed with tamper evident tape, it remains in the presence of the minor applicant and the parent/legal guardian. [Be careful to prevent tamper evident

tape(s) from obscuring bar-code(s), name/ID label(s), or if applicable, Calypte stickers on the specimen containers.] Urine checked for warmth and any visible signs of contamination, adulteration, (i.e., sediment, discoloration). Urine temperature checked and recorded on the lab ID/authorization, if temperature sensor device provided in the lab kit.

5. Urine container(s) sealed with tamper evident tape(s) for transfer to the lab.

6. Tamper evident tape(s) dated and initialed (with signature initials, not printed initials)/signed by minor applicant (if minor applicant capable), co-initialed by parent/legal guardian with relationship status recorded by his/her initials/signature, signifying acknowledgment by the minor applicant and parent/legal guardian that the specimens was/were indeed his/hers, and that the container(s) was/were sealed in the minor applicant's and parent/legal guardian presence. The EMSI examiner signs his/her initials/signature on the tamper evident tape(s) as well.

7. Chain of Custody provision on the lab ID/authorization form signed by the minor applicant (if capable), cosigned by parent/legal guardian with relationship status recorded by the parent's/guardian's signature, and signed by EMSI examiner.

(The other three steps are the lab's responsibility as it relates to Chain of Custody.)

a single partner, **infinite possibilities.**

<u>EXAMINER TRAINING MANUAL UPDATE</u>

EMSI'S PROCEDURES REGARDING APPLICANT IDENTIFICATION AND MODIFIED CHAIN OF CUSTODY OF BLOOD AND/OR URINE SPECIMENS FOR <u>ADULT*</u> INSURANCE APPLICANTS.

<u>Our EMSI examiner's responsibility in Modified Chain of Custody includes performing and/or verifying the following:</u>

1. The applicant's driver's license is the first choice of photo identification used to identify the applicant (showing photograph and signature) if it is available. If the applicant has no driver's license, ask for another form of photo ID such as a state issued ID, passport, or work identification, and record it's description. If the applicant has no form of photo ID, record the applicable phrase, "applicant does not possess photo ID" or "applicant's photo ID unavailable."

   If the applicant has no form of photo ID, ask to view his/her social security card and record the SS#. Make sure the applicant's ID matches the name on the order ticket. The applicant's driver's license number should be recorded on the lab ID/authorization in the designated space for DL#, as well as specific state of issue to indicate that the applicant's identity was verified. Also, it is essential that the examiner provide the insurance customers with actual documentation of the driver's license number for positive identification of the applicant for chain of custody by following these EMSI procedures: If the blood/urine is being collected in conjunction with an exam, record the driver's license number as the first entry in the detail area of the Part II-medical history portion of the exam form as well as in the designated space on the lab ID/authorization. If a specimen is being collected without an exam, unless the customer has requested that the information be recorded only on lab ID/authorization for information transmittal to their company, record the driver's license number in the designated space of the EMSI Supplemental Services form as well as on the lab ID/authorization.

2. Lab ID/authorization form signed by the applicant as required to authorize specimen collection and testing. (If the requirements include urine HIV-1 antibody testing, the applicant must initial the Calypte stickers for the Calypte Subject Information Brochure included in the urine HIV kit.)

3. Proper bar-coding and labeling of all specimen tubes, including the purple top, red top, and <u>serum transfer tubes</u>, as well as the urine container(s) with applicant's complete name, date of birth, and date of service (in the presence of the applicant). This step must occur <u>before</u> the collection process.

4. From the time the urine specimen is collected and is sealed with tamper evident tape, it remains in the presence of the applicant. [Be careful to prevent tamper evident tape(s) from obscuring bar-code(s), name/ID label(s), or if applicable, Calypte stickers on the specimen containers.] Urine checked for warmth and any visible signs of contamination, adulteration, (i.e., sediment, discoloration). Urine temperature checked and recorded on the lab ID/authorization, if temperature sensor device provided in the lab kit.

5. Urine container(s) sealed with tamper evident tape(s) for transfer to the lab.

6. Tamper evident tape(s) dated and initialed (with signature initials, not printed initials)/signed by applicant, signifying acknowledgment by the applicant that the specimens was/were indeed his/hers, and that the container(s) was/were sealed in his/her presence. The EMSI examiner signs his/her initials/signature on the tamper evident tape(s) as well.

7. Chain of Custody provision on the lab ID/authorization form signed by the applicant and by the EMSI examiner.

(The other three steps are the lab's responsibility as it relates to Chain of Custody.)