



Request for Quote

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
 ONE CAPITOL HILL
 PROVIDENCE RI 02908

BUYER: Walsh, Gail M
 PHONE #: 401-574-8122

CREATION DATE : 02-MAR-16
BID NUMBER: 7550363
TITLE: PHYSICAL EXAMINATIONS FOR PRE-SERVICE CANDIDATES (DOC)
BLANKET START : 01-MAY-16
BLANKET END : 30-APR-21
BID CLOSING DATE AND TIME: 31-MAR-2016 02:00:00

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DOA CONTROLLER
ONE CAPITOL HILL, 4TH FLOOR
SMITH ST
PROVIDENCE, RI 02908
US

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DOC ADMINISTRATION
40 HOWARD AVENUE
CRANSTON, RI 02920
US

Requisition Number: 1449082

Note to Bidders: QUESTIONS CONCERNING THIS SOLICITATION MAY BE E-MAILED TO THE DIVISION OF PURCHASES AT GAIL.WALSH@PURCHASING.RI.GOV NO LATER THAN MONDAY, MARCH 14, 2016 AT 5:00 PM (ET). QUESTIONS SHOULD BE SUBMITTED IN A MICROSOFT WORD ATTACHMENT. PLEASE REFERENCE BID #7550363 ON ALL CORRESPONDENCE. QUESTIONS RECEIVED, IF ANY, WILL BE POSTED ON THE WEBSITE AS AN ADDENDUM TO THIS SOLICITATION. IT IS THE RESPONSIBILITY OF ALL INTERESTED PARTIES TO DOWNLOAD THIS INFORMATION.

Line	Description	Quantity	Unit	Unit Price	Total
1	<p>PRE-PLACEMENT PHYSICAL EXAMINATIONS FOR PRE-SERVICE CANDIDATES. QUANTITY WILL BE DEPENDENT ON CLASS SIZE AND NUMBER OF CLASSES PER FISCAL YEAR. THIS NUMBER MAY CHANGE WITHOUT NOTICE.</p> <p>PER ATTACHED SPECIFICATIONS FOR PRE-SERVICE APPLICANT PHYSICAL EXAMS.</p> <p>THE TERM OF THIS CONTRACT WILL BE FIVE YEARS. VENDOR WILL PROPOSE A UNIT COST FOR EACH OF YEARS 1-5 FOR THE SERVICES AS OUTLINED IN THIS BID. IF ONLY ONE UNIT COST IS PROVIDED, THAT UNIT COST WILL BE IN EFFECT FOR THE FIVE-YEAR TERM.</p> <p>YEAR 1 - PRE-PLACEMENT PHYSICAL EXAMS FOR PRE-SERVICE CANDIDATES</p>	1.00	Each		
2	YEAR 2 - PRE-PLACEMENT PHYSICAL EXAMS FOR PRE-SERVICE CANDIDATES	1.00	Each		
3	YEAR 3 - PRE-PLACEMENT PHYSICAL EXAMS FOR PRE-SERVICE CANDIDATES	1.00	Each		
4	YEAR 4 - PRE-PLACEMENT PHYSICAL EXAMS FOR PRE-SERVICE CANDIDATES	1.00	Each		
5	YEAR 5 - PRE-PLACEMENT PHYSICAL EXAMS FOR PRE-SERVICE CANDIDATES	1.00	Each		
6	YEAR 1 - ADDITIONAL EKG TEST FOR PRE-SERVICE CANDIDATES OVER 40	1.00	Each		
7	YEAR 2 - ADDITIONAL EKG TEST FOR PRE-SERVICE CANDIDATES OVER 40	1.00	Each		
8	YEAR 3 - ADDITIONAL EKG TEST FOR PRE-SERVICE CANDIDATES OVER 40	1.00	Each		

It is the Vendor's responsibility to check and download any and all addenda from the RIVIP. This offer may not be considered unless a signed RIVIP generated Bidder Certification Cover Form is attached and the Unit Price column is completed. The signed Certification Cover Form must be attached to the front of the offer



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Line	Description	Quantity	Unit	Unit Price	Total
9	YEAR 4 - ADDITIONAL EKG TEST FOR PRE-SERVICE CANDIDATES OVER 40	1.00	Each		
10	YEAR 5 - ADDITIONAL EKG TEST FOR PRE-SERVICE CANDIDATES OVER 40	1.00	Each		
11	YEAR 1 - ADDITIONAL CHEST X-RAY FOR PRE-SERVICE CANDIDATES	1.00	Each		
12	YEAR 2 - ADDITIONAL CHEST X-RAY FOR PRE-SERVICE CANDIDATES	1.00	Each		
13	YEAR 3 - ADDITIONAL CHEST X-RAY FOR PRE-SERVICE CANDIDATES	1.00	Each		
14	YEAR 4 - ADDITIONAL CHEST X-RAY FOR PRE-SERVICE CANDIDATES	1.00	Each		
15	YEAR 5 - ADDITIONAL CHEST X-RAY FOR PRE-SERVICE CHANDIDATES	1.00	Each		

Delivery: _____

Terms of Payment: _____

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SPECIFICATIONS FOR PRE-SERVICE APPLICANT PHYSICAL EXAMS

Comprehensive Physical for pre-service applicants to include the following:

- A. Complete all information required in the appropriate section of the attached Rhode Island State CS-60 Pre-placement Medical Exam Form.
- B. Complete supplemental back assessment form attached.
- C. Complete supplemental body joint assessment form attached
- D. Determine whether person has tattoo(s) and if so, document location(s) and description(s).
- E. Complete a baseline EKG on each candidate 40 years or older to assist in evaluation. (separate line item)
- F. Provide Mantoux patch test or other skin test for tuberculosis, including follow up reading of test results with candidates.
- G. Provide a chest x-ray for pre-service applicants with a positive reading for Mantoux patch test. (separate line item)
- H. Provide a Pulmonary Function Test to each applicant to determine their suitability to wear a full face negative pressure respirator.
- I. Collect and document information on prescription medication taken over the last three years.
- J. Collect and document names of any health care providers that were seen in the last three years.
- K. Recommend whether or not the candidate possesses the physical capacity to withstand and perform satisfactorily the duties outlined in the Correctional Officer job specifications (attached).
- L. Examinations to be conducted at a site mutually agreed upon by vendor, and Department of Corrections, within a 20 mile radius of the Rhode Island Department of Corrections Training Academy located at 16 Wilma Schesler Lane, Pinel Building, Cranston, Rhode Island, and all necessary medical supplies and equipment will be provided by the vendor.
- M. Complete all physicals and generate documented results within a two to four-week timeframe.

- N. **Term of contract:** The term of contract will be 5 years.
- O. **Cost Proposal:** Vendor will propose a unit cost for each of years 1-5 for the services as outlined in this solicitation. If only one unit cost is presented, it will be assumed that that unit cost would be in effect for the entire period of the contract up to 5 five years.

PRE-PLACEMENT MEDICAL EXAMINATION

COPY OF JOB SPECIFICATION MUST ACCOMPANY THIS FORM

TO THE CANDIDATE: In order to be appointed to the position in state service for which you are a candidate, it is necessary for you to have this certificate filled out by a physician and returned immediately to the Personnel Office of the department hiring you.

Date examined: _____ Job Title: _____
Employee's start date: _____ Name of Dept./Agency: _____ Location: _____

Name: First Middle Last Social Security Number (Optional) Date of Birth

Address: (Street) _____ Telephone: _____
(City) _____ (State) _____ (Zip Code) _____

Date of Last Physical _____ Name of Personal Physician: _____
Address: _____

Occupation, kind of work usually done _____
Have you ever received compensation from any employer or insurance carrier? _____ Yes _____ No
If yes, please explain _____

SERVICE HISTORY

1. Have you ever been rejected for military service? _____ Yes _____ No
2. Branch _____ No. years _____ Type of Discharge _____ Discharge Date _____
3. Have you ever received military disability benefits _____ Yes _____ No
If yes, please explain: _____

PERSONAL HISTORY

Check if you have had any of the following conditions in the past year.

1. Chest pain <input type="checkbox"/>	10. Eye problems <input type="checkbox"/>	19. Muscle weakness <input type="checkbox"/>
2. Shortness of breath <input type="checkbox"/>	11. Skin problems <input type="checkbox"/>	20. Epilepsy <input type="checkbox"/>
3. Persistent cough <input type="checkbox"/>	12. Hearing Loss <input type="checkbox"/>	21. Fainting <input type="checkbox"/>
4. High blood pressure <input type="checkbox"/>	13. Allergies <input type="checkbox"/>	22. Dizziness <input type="checkbox"/>
5. Heart trouble <input type="checkbox"/>	14. Asthma <input type="checkbox"/>	23. Headaches <input type="checkbox"/>
6. Swelling of feet <input type="checkbox"/>	15. Painful joints <input type="checkbox"/>	24. Hernia <input type="checkbox"/>
7. Stomach pains <input type="checkbox"/>	16. Swollen joints <input type="checkbox"/>	25. Diabetes <input type="checkbox"/>
8. Poor appetite <input type="checkbox"/>	17. Broken bones <input type="checkbox"/>	26. Cancer <input type="checkbox"/>
9. Jaundice <input type="checkbox"/>	18. Back/neck injury <input type="checkbox"/>	27. Specify Site _____ <input type="checkbox"/>
		28. Other (Specify) _____ <input type="checkbox"/>

Item No.	Explanation of items checked above

29. What medicine(s) do you take regularly? _____
30. List any serious injuries, hospitalizations or surgical operations. Give details. _____

Injury/Hospitalization/Surgery	Hospital	From - To

Use separate page if further explanation is required

31. Do you smoke? _____ Yes _____ No _____ Formerly
If you are a former smoker, how many years did you smoke? (Date) _____

Immunizations: Which of the following immunizations or tests have you received?

- | | | | |
|------------|--------------|---------------------------------|--------------|
| 1. Measles | (Date) _____ | 6. Hepatitis Vaccine | (Date) _____ |
| 2. Mumps | _____ | 7. Other | _____ |
| 3. Rubella | _____ | 8. Mantoux, patch test or other | _____ |
| 4. Polio | _____ | skin test for tuberculosis | _____ |
| 5. Tetanus | _____ | Date _____ Results _____ | |

I have answered truthfully all of the above questions and I have withheld nothing regarding my past or present health. Should I be employed, and the State discovers any false statement(s), it may result in immediate dismissal.

Signature of Applicant _____
Date _____

TO BE FILLED OUT BY PHYSICIAN

Ht.	Wt.	Temp.	Resp.	B.P.	Pulse	Hair Color	Eye Color	Right or Left Handed

(Findings)	(Findings)
1. Vision: Far Right _____	11. Heart Sounds _____
2. Vision: Far Left _____	12. Lung/Chest Auscultation _____
3. Vision: Near Right _____	13. Abdomen Exam _____
4. Vision: Near Left _____	14. Inguinal Exam _____
5. Color Perception _____	15. Rectal Exam _____
6. Depth Perception _____	16. Neurological Exam _____
7. Hearing - Left _____	17. Speech _____
8. Hearing - Right _____	18. Skin _____
9. Mouth and Fauces Teeth _____	19. Development/Appearance _____
10. Lymph Glands _____	

Physical Activities: Limitations

	(Yes)	(No)		(Yes)	(No)	Describe any muscular weakness or handicap _____ _____ _____
Walking	_____	_____	Stooping	_____	_____	
Reaching	_____	_____	Kneeling	_____	_____	
Standing	_____	_____	Lifting	_____	_____	
Pushing	_____	_____	Other (Specify)	_____	_____	
Pulling	_____	_____				

Recommendations/Work Restrictions: Please list any working conditions and/or physical activities that should be limited or avoided to satisfactorily perform the duties in the applicant's job specifications.

After making a physical examination of this candidate and reviewing his/her medical history, I find that (s)he possesses _____, does not possess _____ the physical capacity to withstand and perform satisfactorily the duties outlined in the accompanying job specifications.

Physician's remarks _____

Date _____ Signature of Physician _____
Address _____

BODY JOINT ASSESSMENT

NAME _____ SS _____

1. Do you have any limitation of movement in any of the major joints listed below: (circle L (left) or R (right) if yes)

Shoulder(s)	L	R	___ Yes	___ No
Elbow(s)	L	R	___ Yes	___ No
Wrist(s)	L	R	___ Yes	___ No
Hip(s)	L	R	___ Yes	___ No
Knee(s)	L	R	___ Yes	___ No
Ankle(s)	L	R	___ Yes	___ No

2. If yes, please explain the limitation, i.e. overhead reaching, bending, stooping:

3. Have any of your joints been sore in the past. ___ Yes ___ No
If Yes, which? _____ and when? _____

4. Are these joint(s) sore now? ___ Yes ___ No

5. Which of the following make your joint(s) sore?
___ exercise ___ bending ___ sitting
___ lifting ___ stooping ___ sleeping
___ reaching ___ writing ___ nothing in particular

6. Have you had a joint problem (see list above) or injury that caused time out-of-work?
___ Yes ___ No

If Yes, what caused it? ___ work injury ___ car accident ___ sports
___ home accident ___ other ___ nothing in particular

How long were you out of work? _____

Have you had to leave a job because of any problems associated with joint pain or limitation of movement? ___ Yes ___ No

Did you need x-rays? ___ Yes ___ No

Did you need an MRI, CAT Scan or myelogram? ___ Yes ___ No

Have you had surgery on any of the joints listed above? ___ Yes ___ No

Are you now on any restrictions? ___ Yes ___ No

7. Are you taking any pain medication now? ___ Yes ___ No

If so, what are you taking and why? _____

Signature _____ Date: _____

BACK ASSESSMENT

NAME _____ SS# _____

- 1. Do you have any difficulty with strenuous lifting and exercise? Y N
- 2. Are you used to hard physical work? Y N
- 3. How physical was your most recent job? (check one)
 unemployed for _____ months sit-down work light activity
 active very active very hard labor
- 4. In the last 12 months, how physical has your exercise been?
 no exercise light average above average very active
- 5. Has your back been sore in the past? Y N If Yes, when? _____
- 6. Is your back sore now? Y N
- 7. Which of the following make your back sore?
 exercise lifting sitting
 sleeping driving nothing in particular
- 8. Have you ever had a back or neck problem or injury that caused time out of work?
 Y N
 (If No, go to questions 9)
 If Yes, what caused it? work injury car accident
 accident at home other nothing in particular

 How long were you out of work? _____
 Have you had to leave a job because of your back or neck problem? Y N
 Did you need back or neck x-rays? Y N
 Did you need physical therapy? Y N
 Did you need an MRI, CAT Scan, or myelogram Y N
 Have you had back or neck surgery? Y N
 Are you now on any restrictions due to your back or neck? Y N
 Have you ever had a recurrence of your back problem? Y N
- 9. Are you ever bothered with sciatica or a "pinched nerve" in your thigh or leg? Y N
- 10. Have you ever had numbness or paralysis of a leg or foot? Y N
- 11. Are you taking any pain medication now? Y N
 If so, what are you taking and why? _____

Signature _____ Date _____

CLASS TITLE:

CORRECTIONAL OFFICER

Class Code: 02184200

Pay Grade: 21A

EO Code: D

CLASS DEFINITION:

GENERAL STATEMENT OF DUTIES: To be responsible for safeguarding the custody and well-being of inmates confined in a State Correctional Institution; to supervise their conduct and to maintain order and discipline among them; to carry out plans for their training and rehabilitation; and to do related work as required.

SUPERVISION RECEIVED: Works under the general supervision of a superior officer from whom are received general and specific orders, instructions and assignments; work is reviewed by frequent inspections for effectiveness and conformance to institutional policies, rules and regulations.

SUPERVISION EXERCISED: Supervises the work and training of inmates.

ILLUSTRATIVE EXAMPLES OF WORK PERFORMED:

To be responsible for safeguarding the custody and well-being of inmates confined in a State Correctional Institution.

To supervise the conduct of and to maintain order and discipline among inmates.

To assist inmates on matters pertaining to their adjustment to institutional conditions and to assist them in their personal, emotional and adjustment problems or to direct them to the proper persons for guidance.

To carry out plans for the training and rehabilitation of inmates.

To operate devices for locking and unlocking security doors, cells and close custody facilities and to be accountable for all keys used for these purposes.

To make regular and irregular inmate counts and to make reports thereon to a superior officer.

To carry firearms in the performance of outer perimeter security duty and emergency assignments; to maintain proficiency in their use, care and operation.

To be responsible for strict control over rifles, tools and other items which are hazardous from the custodial standpoint.

To exercise constant vigilance to observe any unusual activities or movements of individuals or groups indicative of attempted escape and riot, strike of minor irregularities and to report same to a superior.

To inspect inmate quarters to see that they are in sanitary and orderly condition.

To directly supervise inmates in housing units, in recreational fields and assembly areas, as required by the duties of the post to which assigned.

To search inmates and living quarters for the detection of pilferage and to prevent the possession of contraband.

To conduct orientation training for newly committed inmates.

To do related work as required.

REQUIRED QUALIFICATIONS FOR APPOINTMENT:

KNOWLEDGES, SKILLS AND CAPACITIES: The ability to acquire knowledge of the practices, methods and techniques of adult correctional and custodial work; the ability to safeguard and supervise inmates and to maintain discipline; the ability to cooperate and work with other employees engaged in carrying out plans for the rehabilitation of inmates; the ability to meet and deal effectively with others in resolving problems related to assigned functions; the capacity to observe the attitude and mental, physical and other reactions of inmates; the capacity to acquire skill in the use of firearms; and related capacities and abilities.

EDUCATION AND EXPERIENCE:

Education: Such as may have been gained through: graduation from a senior high school; and

Experience: Such as may have been gained through: employment in private or public work involving the supervision of others and the enforcement of rules and regulations.

Or, any combination of education and experience that shall be substantially equivalent to the above education and experience.

SPECIAL REQUIREMENT:

The following conditions of employment must be met at time of appointment:

Must have successfully completed the eight week correctional officer training program.

Must be capable of performing (with or without reasonable accommodations) the essential duties as evidenced by a physician's certificate from a physician designated by the Department of Corrections.

In accordance with RIGL 42-28.3-1 no person shall be appointed temporary, probationary, or permanent until they shall have been evaluated and tested by a certified psychologist and receive a satisfactory rating which shall be in writing.

No such appointee shall be given a permanent appointment to a position within this class unless he shall have met all of the above requirements.

"Every effort will be made to reasonably accommodate an individual who has a disability. Therefore, nothing in this specification shall be interpreted to prohibit the use of such accommodation in order to perform the essential functions of this class."

Class Revised: May 17, 1992

Editorial Review: 3/15/03

**RHODE ISLAND DEPARTMENT OF CORRECTIONS
TRAINING ACADEMY**

Respirator Medical Evaluation Questionnaire

Please complete the following questions to qualify to be fit tested for any type respirator. We currently use N-95 half-face mask for protection against airborne pathogens. For those employees who are involved on the DECOM TEAM, a full-face respirator, a powered air purifying, supplied air, or self contained breathing apparatus respirators are used.

PART A. Section 1. (MANDATORY) Questions 1 through 12 must be completed by everyone wearing *any* respirator as well as every employee who has been selected to use an N-95 respirator.

1. Today's Date _____
2. Your Name _____
3. Your Age _____
4. Male / Female
5. Height _____ ft. _____ in.
6. Weight _____ lbs.
7. Job Title Correctional Officer Candidate
8. Phone number where you can be reached by the health care professional who reviews this questionnaire (include area code) _____
9. Best time to phone you at this number _____
10. Has your employer told you how to contact the health care professional who will review this questionnaire?
Yes X No _____
11. Check the type of respirator you will use (you can check more than one category):
 - a. X N, R, or P disposable respirator (filter-mask, non-cartridge type only)
 - b. X Other type (i.e., half or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).
12. Have you worn a respirator? Yes _____ No _____
If Yes, what type(s): _____

**RHODE ISLAND DEPARTMENT OF CORRECTIONS
TRAINING ACADEMY**

PART A. Section 2. Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator.

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? Yes ___ No ___

2. Have you ever had any of the following conditions?
 - a. Seizures (fits) Yes ___ No ___
 - b. Diabetes (sugar disease) Yes ___ No ___
 - c. Allergic reactions that interfere with your breathing Yes ___ No ___
 - d. Claustrophobia (fear of closed-in places) Yes ___ No ___
 - e. Trouble smelling odors Yes ___ No ___

3. Have you ever had any of the following pulmonary or lung problems?
 - a. Asbestosis Yes ___ No ___
 - b. Asthma Yes ___ No ___
 - c. Chronic bronchitis Yes ___ No ___
 - d. Emphysema Yes ___ No ___
 - e. Pneumonia Yes ___ No ___
 - f. Tuberculosis Yes ___ No ___
 - g. Silicosis Yes ___ No ___
 - h. Pneumothorax (collapsed lung) Yes ___ No ___
 - i. Lung cancer Yes ___ No ___
 - j. Broken ribs Yes ___ No ___
 - k. Any chest injuries or surgeries Yes ___ No ___
 - l. Any other lung problem that you've been told about Yes ___ No ___

4. Do you currently have any of the following symptoms of pulmonary or lung illness?
 - a. Shortness of breath Yes ___ No ___
 - b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline Yes ___ No ___
 - c. Shortness of breath when walking with other people at an ordinary pace on level ground Yes ___ No ___
 - d. Have to stop for breath when walking at your own pace on level ground Yes ___ No ___
 - e. Shortness of breath when washing or dressing yourself Yes ___ No ___
 - f. Shortness of breath that interferes with your job Yes ___ No ___
 - g. Coughing that produces phlegm (thick sputum) Yes ___ No ___
 - h. Coughing that wakes you early in the morning Yes ___ No ___
 - i. Coughing that occurs mostly when you are lying down Yes ___ No ___
 - j. Coughing up blood in the last month Yes ___ No ___
 - k. Wheezing Yes ___ No ___
 - l. Wheezing that interferes with your job Yes ___ No ___
 - m. Chest pain when you breathe deeply Yes ___ No ___
 - n. Any other symptoms that you think may be related to lung problems Yes ___ No ___

5. Have you ever had any of the following cardiovascular or heart problems?
 - a. Heart attack Yes ___ No ___
 - b. Stroke Yes ___ No ___
 - c. Angina Yes ___ No ___
 - d. Heart failure Yes ___ No ___
 - e. Swelling in your legs or feet (not caused by walking) Yes ___ No ___
 - f. Heart arrhythmia (heart beating irregularly) Yes ___ No ___
 - g. High blood pressure Yes ___ No ___
 - h. Any other heart problem that you've been told about Yes ___ No ___

6. Have you ever had any of the following cardiovascular or heart symptoms?
 - a. Frequent pain or tightness in your chest Yes ___ No ___

**RHODE ISLAND DEPARTMENT OF CORRECTIONS
TRAINING ACADEMY**

- b. Pain or tightness in your chest during physical activity Yes ___ No ___
 c. Pain or tightness in your chest that interferes with your job Yes ___ No ___
 d. In the past two years, have you noticed your heart skipping or missing a beat Yes ___ No ___
 e. Heartburn or indigestion that is not related to eating Yes ___ No ___
 f. Any other symptoms that you think may be related to heart or circulation problems Yes ___ No ___
7. Do you currently take medication for any of the following problems?
 a. Breathing or lung problems Yes ___ No ___
 b. Heart trouble Yes ___ No ___
 c. Blood pressure Yes ___ No ___
 d. Seizures (fits) Yes ___ No ___
8. If you've used a respirator, have you ever had any of the following problems? (If you've never used a respirator, check here _____ and go to question 9.)
 a. Eye irritation Yes ___ No ___
 b. Skin allergies or rashes Yes ___ No ___
 c. Anxiety Yes ___ No ___
 d. General weakness or fatigue Yes ___ No ___
 e. Any other problem that interferes with your use of a respirator Yes ___ No ___
9. Would you like to talk to the healthcare professional who will review this questionnaire about your answers to this questionnaire? Yes ___ No ___

Questions 10-18 must be answered by all employees and DECON TEAM members who have been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA)

10. Have you ever lost vision in either eye (temporarily or permanent)? Yes ___ No ___
11. Do you currently have any of the following vision problems?
 a. Wear contact lenses Yes ___ No ___
 b. Wear glasses Yes ___ No ___
 c. Color blind Yes ___ No ___
 d. Any other eye or vision problem Yes ___ No ___
12. Have you ever had an injury to your ears, including a broken ear drum? Yes ___ No ___
13. Do you currently have any of the following hearing problems?
 a. Difficulty hearing Yes ___ No ___
 b. Wear a hearing aid Yes ___ No ___
 c. Any other hearing or ear problem Yes ___ No ___
14. Have you ever had a back injury? Yes ___ No ___
15. Do you currently have any of the following musculoskeletal problems?
 a. Weakness in any of your arms, hands, legs, or feet Yes ___ No ___
 b. Back pain Yes ___ No ___
 c. Difficulty fully moving your arms and legs Yes ___ No ___
 d. Pain or stiffness when you lean forward or backward at the waist Yes ___ No ___

**RHODE ISLAND DEPARTMENT OF CORRECTIONS
TRAINING ACADEMY**

- e. Difficulty fully moving your head up or down Yes ___ No ___
- f. Difficulty fully moving your head side to side Yes ___ No ___
- g. Difficulty bending at your knees Yes ___ No ___
- h. Difficulty squatting to the ground Yes ___ No ___
- i. Climbing a flight of stairs or a ladder carrying more than 25 pounds Yes ___ No ___
- j. Any other muscle or skeletal problem that interferes with using a respirator Yes ___ No ___

16. Have you ever worked on a HAZMAT team? Yes ___ No ___

17. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications)? Yes ___ No ___

If Yes, name the medications _____

18. Will you be wearing protective clothing and/or equipment (other than the respirator) when you are using you're using your respirator? Yes X No ___

If Yes, describe this protective clothing and/or equipment: There may be times when conducting a cell extraction, the equipment is worn over the uniform, such as, chest protector, shin guards, helmet and rubber gloves

**RHODE ISLAND DEPARTMENT OF CORRECTIONS
TRAINING ACADEMY**

NOTE: CANDIDATE DO NOT COMPLETE THIS SECTION

TESTING Yes No	<input type="checkbox"/> Approved <input type="checkbox"/> Approved with restrictions <input type="checkbox"/> Denied <input type="checkbox"/> More Information Needed
Medical Dept. Use Only Baseline Pulmonary Function Test	
Restrictions/Remarks	
Occ Health/Infection Control/Licensed Health Provider	
Signature	Date

Contract Terms and Conditions

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Terms and Conditions

BID STANDARD TERMS AND CONDITIONS

TERMS AND CONDITIONS FOR THIS BID

PURCHASE AGREEMENT BID

BIDDING (a) A single price shall be quoted for each item against which a proposal is submitted. This price will be the maximum in effect during the agreement period. Any price decline at the manufacturer's level shall be reflected in a reduction of the agreement price to the State. (b) Quantities, if any, are estimated only. The agreement shall cover the actual quantities ordering during the period. Deliveries will be billed at the single, firm, awarded unit price quoted regardless of the quantities ordered. (c) Bid price is net F.O.B. destination and shall include inside delivery at no extra cost. (d) Bids for single items and/or a small percentage of total items listed, may, at the State's sole option, be rejected as being non-responsive to the intent of this request. **ORDERING** (a) The User Agency(s) will submit individual orders for the various items and various quantities as may be required during the agreement period. (b) Exception - Regardless of any agreement resulting from this bid, the State reserves the right to solicit prices separately for any extra large requirements for delivery to specific destinations.

Mailing Address for Bid Proposals issued by the State of Rhode Island, Division of Purchases:

All Bid Proposals must be submitted to the following address:

State of Rhode Island
Department of Administration
Division of Purchases, 2nd Floor
One Capitol Hill
Providence, RI 02908

RIVIP INFO - BID SUBMISSION REQUIREMENTS

It is the Vendor's responsibility to check and download any and all addenda from the RIVIP. This offer may not be considered unless a signed RIVIP generated Bidder Certification Cover Form is attached and the Unit Price column is completed. The signed Certification Cover Form must be attached to the front of the offer. When delivering offers in person to One Capitol Hill, vendors are advised to allow at least one hour additional time for clearance through security checkpoints.

MAILING ADDRESS FOR BID PROPOSALS ISSUED BY THE STATE OF RHODE ISLAND, DIVISION OF PURCHASES

All Bid Proposals must be submitted by mail or hand delivered to:

- State of Rhode Island
- Department of Administration
- Division of Purchases, Second floor
- One Capitol Hill
- Providence, RI 02908-5855

DIVESTITURE OF INVESTMENTS IN IRAN REQUIREMENT:

No vendor engaged in investment activities in Iran as described in R.I. Gen. Laws §37-2.5-2(b) may submit a bid proposal to, or renew a contract with, the Division of Purchases. Each vendor submitting a bid proposal or entering into a renewal of a contract is required to certify that the vendor does not appear on the list maintained by the General Treasurer pursuant to R.I. Gen. Laws §37-2.5-3.

MULTI YEAR AWARD

THIS IS A MULTI-YEAR BID/CONTRACT. PER RHODE ISLAND STATE LAW 37-2-33, CONTRACT OBLIGATIONS BEYOND THE CURRENT FISCAL YEAR ARE SUBJECT TO AVAILABILITY OF FUNDS. CONTINUATION OF THE CONTRACT BEYOND THE INITIAL FISCAL YEAR WILL BE AT THE DISCRETION OF THE STATE. TERMINATION MAY BE EFFECTED BY THE STATE BASED UPON DETERMINING FACTORS SUCH AS UNSATISFACTORY PERFORMANCE OR THE DETERMINATION BY THE STATE TO DISCONTINUE THE GOODS/SERVICES, OR TO REVISE THE SCOPE AND NEED FOR THE TYPE OF GOODS/SERVICES; ALSO MANAGEMENT OWNER DETERMINATIONS THAT MAY PRECLUDE THE NEED FOR GOODS/SERVICES.

INSURANCE REQUIREMENTS

AN INSURANCE CERTIFICATE IN COMPLIANCE WITH PROVISIONS OF ITEM 31 (INSURANCE) OF THE GENERAL CONDITIONS OF PURCHASE IS REQUIRED FOR COMPREHENSIVE GENERAL LIABILITY, AUTOMOBILE LIABILITY, AND WORKERS' COMPENSATION AND MUST BE SUBMITTED BY THE SUCCESSFUL BIDDER(S) TO THE DIVISION OF PURCHASES PRIOR TO AWARD. THE INSURANCE CERTIFICATE MUST NAME THE STATE OF RHODE ISLAND AS CERTIFICATE HOLDER AND AS AN ADDITIONAL INSURED. FAILURE TO COMPLY WITH THESE PROVISIONS MAY RESULT IN REJECTION OF THE OFFEROR'S BID. ANNUAL RENEWAL CERTIFICATES MUST BE SUBMITTED TO THE AGENCY IDENTIFIED ON THE PURCHASE ORDER. FAILURE TO DO SO MAY BE GROUNDS FOR CANCELLATION OF CONTRACT.

NOTE: IF THIS BID COVERS CONSTRUCTION, SCHOOL BUSING, HAZARDOUS WASTE, OR VESSEL OPERATION, APPLICABLE COVERAGES FROM THE FOLLOWING LIST MUST ALSO BE SUBMITTED TO THE DIVISION OF PURCHASES PRIOR TO AWARD: * PROFESSIONAL LIABILITY INSURANCE (AKA ERRORS & OMISSIONS) - \$1 MILLION OR 5% OF ESTIMATED PROJECT COST, WHICHEVER IS GREATER. * BUILDER'S RISK INSURANCE - COVERAGE EQUAL TO FACE AMOUNT OF CONTRACT FOR CONSTRUCTION. * SCHOOL BUSING - AUTO LIABILITY COVERAGE IN THE AMOUNT OF \$5 MILLION. * ENVIRONMENTAL IMPAIRMENT (AKA POLLUTION CONTROL) - \$1 MILLION OR 5% OF FACE AMOUNT OF CONTRACT, WHICHEVER IS GREATER. * VESSEL OPERATION - (MARINE OR AIRCRAFT) - PROTECTION & INDEMNITY COVERAGE REQUIRED IN THE AMOUNT OF \$1 MILLION.