MAYO CLINIC HEALTH SYSTEM

Cannon Falls
Lake City
Red Wing

Occupational Medicine Job-Related Examination Report

This form collects information that is part of the medical record. **Route to Scanning.**

Employee Information

Name *(First, Middle, Last)*	**Exam Type** *(Check all that apply)* ☐ Pre-Placement ☐ Respirator Questionnaire ☐ Periodic ☐ Respirator Exam ☐ DOT ☐ Other _____ ☐ Exposure *(Hazmat, Emergency Response, Lead, Cadmium, Asbestos)*
Birth Date *(Month DD, YYYY)* / History Number	
Date *(Month DD, YYYY)*	
Employer/Job	

Included (√)	Procedures	Completed (√)	Date	Results Pending (√)
	Health questionnaire			
	Physical exam by a medical provider			
	Urine drug screening			
	Pulmonary function test (Spirometry)			
	X-Ray: ____CXR ____B-Reader ____Other			
	Audiogram			
	TB Skin test			
	Lab			

Medical Certification

This employee is:
- ☐ Medically qualified for work of this type
- ☐ Medically qualified for work with restrictions
  - ☐ Pound lifting limit
  - ☐ No work requiring binocular vision
  - ☐ Limited use of right/left arm
  - ☐ Other *(See comments below)*
  - ☐ Decision deferred: further evaluation needed *(See comments below)*
- ☐ Not qualified

Respirator Certification

This employee is:
- ☐ Cleared for unrestricted respirator and personal protective equipment use
- ☐ Cleared for restricted respirator use: No SCBA use
- ☐ Decision deferred: Further evaluation needed *(See comments below)*
- ☐ Not cleared for respirator use)
- ☐ Other *(See comments below)*

Recommended Frequency of respirator examination with a physician or other Licensed health care professional

Exam should consist of: ☐ Questionnaire review ☐ Questionnaire and PFT ☐ Questionnaire, PFT and exam

Frequency: ☐ Annual ☐ Per company policy ☐ Other

Exposure Certification

The employee ☐ **Does** ☐ **Does not** have any detected medical conditions that would place him or her at increased risk of material health impairment from work in Hazardous Waste Operations or Emergency Response, Lead exposure, Asbestos exposure, cadmium exposure (check all that apply), or from respirator use.

☐ The employee has been told of the hazards of smoking (including increased risk of cancer) in relation to his/her possible exposures.

Immunizations

☐ Your vaccines are up to date, no further follow-up is needed	We recommend you have the following vaccines: ☐ Hep B ☐ MMR ☐ Varicella ☐ Other _____

Comments

The employee has been given clear and careful explanation of the results of the medical examination and of any medical condition resulting from exposures that require further evaluation or treatment that are known at this time. Results of pending tests and conditions that relate to his/her exposures that require further evaluation or treatment will be communicated to the employee by mail or telephone.

Medical Provider Signature	Date *(Month DD, YYYY)*

Part 1 - (white original) Mayo Clinic Health System Medical Record • Part 2 - (yellow copy) Employer • Part 3 - (pink copy) Employee