

N. C. State University, Student Health Services
Campus Box 7304, 2815 Cates Ave
Raleigh, NC 27695
919-513-0277

Occupational Medicine Exam Request Form
and
Authorization for Release of Medical Information

Last Name _____ First Name _____
Date of Birth _____ Department _____
Campus Tel. No. _____ E-mail Address _____
Supervisor _____ Supervisor's Tel. No. _____
NCSU Employee (✓) _____ or Non-Employee, eg Visitor or Volunteer (✓) _____
PeopleSoft Identification No. _____ (see personnel rep. to get number)

Type of Service Requested (Check all items that apply)

- Respirator medical clearance exam (non-emergency respirator use: Class I exam*)
 Respirator medical clearance exam (emergency respirator use: Class III exam**)
 Pre-employment Physical
 Hearing Test
 Immunizations
 Nuclear Reactor Operator Exam
 Pfiesteria Use Exam
 Travel Clinic Services, include FAS no. _____
 Other (Please specify) _____

*Class I Exam: for half and full face air purifying, powered air purifying, and supplied air respirators. Also for SCBA use in changing out gas cylinders in labs. This exam is provided by Student Health Services.

**Class III Exam: for SCBA use in emergency response activities such as refrigerant gas leaks and chemical spill response. This exam is provided by Duke Occ. Med. Employee may call Duke directly at 919-286-3232 to schedule exam. This form must be signed and sent to Student Health Services.

Appointments for all except Class III exam are scheduled at Student Health Services on Tuesday and Friday mornings. Every effort will be made to schedule an appointment within two weeks of receipt of this form. Please indicate below your preference of days:

Tues. morning _____ Friday morning _____ Either Tues. or Friday _____

Effective November 1, 2005 a \$15 fee will be charged for all appointments that are not kept and/or canceled at least one day in advance, or for same-day emergencies, called in by the supervisor on that day.

Please include second page with this form.

Privacy Protection Policy

I hereby authorize the use and/or disclosure of my individually identifiable health information as described below. I understand that the purpose of my visit is for the purpose of creating protected health information for disclosure to my employer, North Carolina State University. Should I refuse to sign this authorization, the examination requested will not be conducted, and certain tasks cannot be performed because they require a medical examination. If this task is an essential job duty, lack of performance may result in termination of my employment. I further understand that if the person(s) or organization authorized to receive the information is not a health plan or health care provider, the released information could be re-disclosed and would no longer be protected by federal privacy regulations.

1. Personal health information to be disclosed to other health providers: All medical information obtained as a result of the examination identified above.
2. Health Providers (or class of persons) or organization authorized to provide the information: Student Health Services, Duke Occupational Medicine, and _____ (write in name of health care provider if not listed above or N/A for not applicable).
3. Purpose of the requested disclosure: Summarized information to be disclosed by the health provider to those listed in item #4 below is to determine if the employee has a health condition which may interfere with his/her job performance and to comply with OSHA regulations.
4. Person(s) or organization authorized to receive summarized information: My supervisor, Safety Manager and the industrial hygiene section or Environmental Health and Safety occupational medicine program will receive only summarized information as described in item 3 above.
5. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing in a letter provided to the Student Health Services. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.
6. I understand that I will get a copy of this form after I sign it.
7. I have been provided with a copy of NC State University's Notice of Privacy Practice prior to signing this authorization. A copy of the Privacy Practice is located also on the EHSC's Medical Surveillance webpage at: <http://www.fis.ncsu.edu/health/docs/privacy.pdf>.
8. This authorization expires in one year.

Signature of Employee

Date

Signature of Supervisor (required for exam request,
NOT for release of medical information)

Date