



Occupational Medicine Forms

| EMPLOYER INFORMATION | |
|----------------------|-------|
| Date: | Time: |

Form of ID: DL Employee Badge Other:

| EMPLOYEE INFORMATION | | |
|----------------------|-------------------------|------|
| First Name: | Date of Birth: | Age: |
| Last Name: | Social Security Number: | |
| Address: | Home Phone: | |
| City, State, Zip: | Work Phone: | |
| Email: | Cell Phone: | |

| EMERGENCY CONTACT / PARENT OR LEGAL GUARDIAN | |
|--|---------------------|
| Emergency Contact / Parent or Legal Guardian Name: | |
| Address: | |
| City, State, Zip | Contact Home Phone: |
| Employee Relationship to Contact: | Contact Work Phone: |
| | Contact Cell Phone: |

| MEDICAL CONSENT AND RELEASE OF INFORMATION |
|---|
| <p>I hereby authorize UCR Health Centers to furnish any information pertaining to employee's pre-employment screening and worker's compensation information to the employer listed above. I authorize UCR Health Centers to provide such medical care or services as determined to be necessary for employment at the above listed company. I hereby release and hold harmless UCR Health Centers for any acts or omissions arising from the good-faith provision of these services.</p> <p>Employee / Parent / Legal Guardian Signature X _____</p> |

| PLEASE CHECK: | | PLEASE ANSWER: | | YES | NO |
|---------------|---------------------|---|--|-----|----|
| | TB SCREENING | HAS EMPLOYEE EVER TESTED +VE TO PREVIOUS PPD? | | | |
| | ANNUAL TB TESTING | | | | |
| | URINE DRUG SCREEN | | | | |
| | CHEST X-RAY | | | | |
| | HEPATITIS B VACCINE | HAS EMPLOYEE EVER RECEIVED PREVIOUS HEP. B VACCINE? | | | |
| | HEPATITIS B TITER | | | | |
| | INFLUENZAE VACCINE | | | | |

FOR INTERNAL USE ONLY

| | |
|------------------|-----------------|
| TIME OF ARRIVAL: | STAFF INITIALS: |
|------------------|-----------------|