OCCUPATIONAL HEALTH PERMIT

PRIVACY ACT STATEMENT

Information contained on this form is maintained under the Systems of Records Notice OPM/GOVT-10, Employee Medical File System 21 Records (June, 2010, 75 FR 35099). **AUTHORITY**: Executive Orders 12107, 12196, and 12564 and 5 U.S.C. chapters 11, 33, and 63. **PRINCIPLE**: Reports of on-the-job injuries and medical records, forms, and reports generated as a result of the filing of a claim for Workers' Compensation, whether the claim is accepted or not. (The official compensation claim file is not covered by this system; rather, it is part of the Department of Labor's Office of Workers' Compensation Program (OWCP) system of records.) P**URPOSE:** To document employee's reporting of on-the-job injuries or unhealthy or unsafe working conditions, including the reporting of such conditions to OSHA and actions taken by that agency or by the employing agency. **DISCLOSURE**: **MANDATORY** for processing.

INSTRUCTIONS:
1. Complete in Triplicate
2. Return Original to Supervisor; 1 Copy to Civilian Personnel; 1 Copy to Safety Manager
3. If an Occupational Injury, Form CA-17 with Completed Part "A" MUST also be submitted.

THIS SECTION TO BE COMPLETED BY SUPERVISOR

TO: OCCUPATIONAL HEALTH NURSE

FROM: (Title of Supervisor, Shop or Office, and Location)

NAME OF EMPLOYEE: (First, Middle, Last)	PAYROLL NO:	SSN:
JOB TITLE:	TIME LEFT JOB:	TIME RETURNED:

REASON FOR REFERRAL: ☐ INJURY ☐ ILLNESS ☐ EMPLOYEES REQUEST ☐ OTHER (SPECIFY BELOW)

DATE OF INJURY:	TIME OF INJURY:	DATE REFERRED TO CLINIC:	OCCUPATIONAL: ◯ YES ◯ NO ◯ QUESTIONABLE

REMARKS:

NAME OF SUPERVISOR:	SIGNATURE:	PHONE NUMBER	DATE:

THIS SECTION TO BE COMPLETED BY MEDICAL OFFICER

TIME REPORTED:	TIME RELEASED:	OCCUPATIONAL: ◯ YES ◯ NO ◯ QUESTIONABLE

DEGREE OF INJURY:
☐ FIRST AID ☐ DISPENSARY ☐ HOSPITAL ☐ PERSONAL PHYSICIAN ☐ SENT HOME ☐ OTHER

DISPOSITION OF EMPLOYEE

☐ RETURN FOR FURTHER TREATMENT: TIME: _____ DATE: _____

☐ RETURN TO WORK

☐ DISCHARGED, TREATMENT COMPLETED

☐ RETURN TO LIMITED DUTY AS INDICATED BELOW

☐ NO LIFTING, PULLING OR CARRYING IN EXCESS OF _____ LBS	☐ DESK JOB ONLY
☐ NO EXCESSIVE WALKING, STANDING OR BENDING	☐ NO DRIVING GOVERNMENT VEHICLE
☐ NO EXPOSURE TO SOLVENTS, GREASES, OILS, DETERGENTS, ETC	☐ NO WORKING AROUND MOVING MACHINERY
☐ NO WALKING ON UNEVEN OR SLIPPERY SURFACES	☐ NO WORKING ON LADDERS, SCAFFOLDING, ETC
☐ NO EXPOSURE TO EXTREME TEMPERATURE OR HUMIDITY	☐ ONE HAND JOB ONLY

☐ OTHER: (EXPLAIN IN REMARKS)

REMARKS:

Reset Form

NAME OF MEDICAL OFFICER:	SIGNATURE OF MEDICAL OFFICER:	DATE: (DD MMM YY)