MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT (*Title and Number*) OPNAVINST 5100.23 Series / NMCPHC TM-OEM-6260.1	ISSUANCE DATE 30 DEC 2005 /AUGUST 2006
LOCAL FORM TITLE *(Optional)* ASBESTOS MEDICAL SURVEILLANCE PROGRAM (AMSP) REMOVAL FORM	

S. Employee requests to be removed from the AMSP.

O. The following medical evidence of asbestos exposure is available and has been reviewed.
Check those that apply.

_____Employee's history of asbestos exposure

_____Chest x-ray reports completed while on the AMSP

_____ B-Reader reports completed while on the AMSP

_____Spirometry results obtained while on the AMSP

_____No medical evidence of asbestos exposure is available

_____List other pertinent findings or information reviewed (example , Industrial Hygiene data)

_____

_____

A. Removal from the AMSP.

P. Check those that apply:

_____Employee counseled on items checked above

_____Employee verbalized understanding of information presented

_____Remove from AMSP

_____Date removed from Current AMSP, if applicable:_____

_____
HCP SIGNATURE / DATE

EMPLOYEE ACKNOWLEDGEMENT: I request removal from the AMSP. Removal from the AMSP does not effect entitlements or benefits from injury/illness caused by asbestos exposure. I may return to the clinic for counseling on asbestos related matters.

_____
EMPLOYEE SIGNATURE / DATE

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	

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