ALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE | SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

OCCUPATIONAL EXPOSURE TO BLOOD AND/OR BODY FLUIDS

OCCUPATIONAL HEALTH DEPARTMENT, NHCL ANNAPOLIS, MD 21402-5050

PROVIDER'S WRITTEN OPINION in the case of:

NAME: _____ Code/Dept: _____

1. The above noted individual was examined according to current guidelines regarding exposure to blood and/or body fluid. On the basis of this examination the following comments are submitted.

2. There ARE/ARE NOT recommended limitations upon the employee's ability to receive Hepatitis B vaccination. Limitations, if recommended, are based on the following findings:

3. The employee has been informed of the results of this medical evaluation and about any medical conditions resulting from exposure to blood or other potentially infectious materials, which require further evaluation or treatment.

(Employee's signature) (Date)

(Provider stamp & signature) (Date)

Copies: ~~Employer~~
Employee

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T'S IDENTIFICATION *(Use this space for Mechanical*

RECORDS MAINTAINED AT: ▶	OCC HEALTH, NHC ANNAPOLIS	
PATIENT'S NAME *(Last, First, Middle Initial)*		SEX
RELATIONSHIP TO SPONSOR: SELF	STATUS	RANK/GRADE
SPONSOR'S NAME: SELF	ORGANIZATION	
		DATE OF BIRTH