UNIVERSITY OF IDAHO
ANIMAL WORKER'S MEDICAL SURVEILLANCE

Consent for Medical Evaluation

Directions: *Please have the employee complete this form if s/he wishes to receive a medical evaluation as part of the University of Idaho's Animal Worker's Medical Surveillance Program.*

I, _____, voluntarily agree to make myself available for a medical evaluation in accordance with the University of Idaho Animal Worker's Medical Surveillance Program at the direction and expense of University of Idaho. Results of the medical evaluation will become a confidential part of my medical record to be retained by the attending physician or by Palouse Medical. I understand that records of this medical evaluation will not become a part of my personnel file at the University of Idaho. This information will be used for evaluation of possible health problems in connection with my employment at the University.

All information will be shared with me if I request it; I understand that no copies of this evaluation will be made available to any other party without my written consent, except when required by law or where there is a specific need to know because of safety, emergency or insurance related reasons.

Any expense for personal medical diagnosis or treatment of conditions discovered through this medical examination and not related to my employment shall be my responsibility.

I hereby grant the Palouse Medical permission to perform such examinations and medical procedures as may be deemed professionally necessary or advisable relating to potentially hazardous occupational exposures.

_____ /_____/_____
Employee's Signature *Date*

Employee's Name: _____

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Directions: Please describe your work/job duties that involve

Employee's Name: _____