

EMPLOYEE HEALTH

SEND TO EMPLOYEE HEALTH OFFICE, R-23, Suite 405, Dominion Tower

**UNIVERSITY OF MIAMI
CONSENT FORM FOR OCCUPATIONAL HEALTH PROGRAM**

Last name: _____ First name _____

ID number: _____ Work phone # _____

I hereby give permission to the University of Miami Employee Health Office and its designated provider, (hereinafter referred to as "Provider") to provide the following job-related services listed below:

- a.) Physical examination
- b.) Immunizations
- c.) Audiometry
- d.) Medical evaluation for use of a respirator
- e.) Blood collection for serum banking and laboratory testing
- f.) Other healthcare services as may be deemed professionally necessary

I understand that my blood may be examined if deemed medically necessary. I also give permission to the release of pertinent medical information to the current Provider and UM if medically necessary. I understand that this consent allows the disclosure of my confidential medical health records by University of Miami Employee Health Office or the provider to my supervisor and other University of Miami administrators in the event that may need to know this information to implement work restrictions that are necessary to protect my health or the health of others.

REVOCAION: To effectively revoke this consent, I must deliver written notice of revocation to the University of Miami Employee Health Office. Such revocation will not apply retroactively and will be effective from the date received by the Employee Health Office.

WARNING TO EMPLOYEES WHO ARE IMMUNO-COMPROMISED: The administration of live vaccines and/or exposure to job-related hazards may be harmful to you. It is your responsibility as the EMPLOYEE to inform the EMPLOYER of any health factors that may adversely affect your health, including, but not limited to live vaccines and work-related contact with animals.

Employee Name (Print) _____ Date _____

Employee Signature

Witness Name (Print) _____ Date _____

Witness Signature