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## SUPERVISOR'S MEDICAL SURVEILLANCE AND CERTIFICATION EXAM REFERRAL

### PRIVACY ACT STATEMENT

**AUTHORITY:** SECNAVINST 5100.10L; NMCPHC-TM OM 6260; and SORN EDHA-07 (10 U.S.C. Chapter 55, Medical and Dental Care; 32 CFR 199.17, TRICARE Program, DoDI 6015.23, Delivery of Healthcare at Military Treatment Facilities: Foreign Service Care; Third, Party Collection; Beneficiary Counseling and Assistance Coordinators (BCACs); and E.O. 9397, (SSN), as amended.)

**PURPOSES:** The purpose of this screening is to obtain medical data to document, track, and communicate medical surveillance and certification program requirements, exam completions, and general dispositions (medically qualified, not medically qualified, medically qualified with limitations, etc.) for applicable Department of the Navy military and civilian personnel.

**ROUTINE USE:** The information collected will be used by the employee, supervisor, and medical professionals, including government, military, and contractor or private physicians, in connection with your medical care, and for compliance with laws governing public health matters to determine medical qualifications for supervisor selected jobs or duties/tasks requiring examination. This screening sheet will be destroyed upon input of the information into a permanent electronic record.

**DISCLOSURE:** Disclosure is voluntary. If the requested information is not provided, no penalty may be imposed, but absence of the requested information may result in administrative delays or impact to employment or work assignment.

USN       USMC

**NOTE:** Blocks 1-4 are to be filled out by the Command, except where noted, prior to the worker's arrival at the supporting medical facility. See the form instructions for additional guidance.

### BLOCK 1 - EMPLOYEE INFORMATION

1. Last Name:	2. First Name:	3. DoD ID #:	4. Rank/Rate:	5. E-Mail:
6. Command/Unit Name:		7. Command UIC:	8. Job Title:	
9. Dept/Div/Work Center::				10. Do you Have an Active ESAMS Profile? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure

### BLOCK 2 - COMMAND POINTS OF CONTACT

Supervisor			Command Safety or Medical Surveillance Representative		
11. Last Name:	12. First Name:	13. Rank/Rate:	14. Last Name:	15. First Name:	16. Rank/Rate:
17. E-Mail:		18. Telephone Number:	19. E-Mail:		20. Telephone Number:
21. Supervisor Signature			22. Date/Time of Referral (Supervisor fill in):		

### BLOCK 3 - MEDICAL SURVEILLANCE PROGRAM INFORMATION *(Click appropriate button to add or remove exam rows)*

23.	Exam Type <i>(Supervisor Check One)</i>	Supervisor Select Applicable Program Number and Name <i>(If program not listed type/write in field. Reference list on last page of form)</i>	Supervisor Select Job or Duty/Task Requiring Exam	Disposition or Recommendation <i>(Filled out by Medical)</i>	Next Exam Due <i>(Filled out by Medical)</i>
Exam # 1	<input type="checkbox"/> Baseline <input type="checkbox"/> Periodic <input type="checkbox"/> Termination			<input type="checkbox"/> Medically Qualified <input type="checkbox"/> Not Medically Qualified <input type="checkbox"/> Medically Qualified w/Limitations <input type="checkbox"/> Other/Pending	1
Exam # 2	<input type="checkbox"/> Baseline <input type="checkbox"/> Periodic <input type="checkbox"/> Termination			<input type="checkbox"/> Medically Qualified <input type="checkbox"/> Not Medically Qualified <input type="checkbox"/> Medically Qualified w/Limitations <input type="checkbox"/> Other/Pending	1

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Command UIC: \_\_\_\_\_ DoD ID #: \_\_\_\_\_

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Exam # 3	<input type="checkbox"/> Baseline <input type="checkbox"/> Periodic <input type="checkbox"/> Termination			<input type="checkbox"/> Medically Qualified <input type="checkbox"/> Not Medically Qualified <input type="checkbox"/> Medically Qualified w/Limitations <sup>1</sup> <input type="checkbox"/> Other/Pending <sup>1</sup>	
Exam # 4	<input type="checkbox"/> Baseline <input type="checkbox"/> Periodic <input type="checkbox"/> Termination			<input type="checkbox"/> Medically Qualified <input type="checkbox"/> Not Medically Qualified <input type="checkbox"/> Medically Qualified w/Limitations <sup>1</sup> <input type="checkbox"/> Other/Pending <sup>1</sup>	
Exam # 5	<input type="checkbox"/> Baseline <input type="checkbox"/> Periodic <input type="checkbox"/> Termination			<input type="checkbox"/> Medically Qualified <input type="checkbox"/> Not Medically Qualified <input type="checkbox"/> Medically Qualified w/Limitations <sup>1</sup> <input type="checkbox"/> Other/Pending <sup>1</sup>	
<p>Note: Changes in personnel health or safety status, such as change in exposure risk, change medical condition, change of medication(s), require referral of the employee to Occupational Medicine or the Command MDR to ensure compliance with required occupational surveillance or certification program standards and to address potential impacts on personnel health and safety. Consult command Industrial Hygiene survey report for exposure-based medical surveillance recommendations.</p>					
<sup>1</sup> See Remarks in Field 26					

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Command UIC: \_\_\_\_\_ DoD ID #: \_\_\_\_\_

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**Block 4. OPTIONAL: Would you like to add an Additional Reviewer?** (Additional reviewers may be required by local policies)

**24. OPTIONAL - Additional Reviewer:**

**Select Additional Reviewers Here:**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Rank/Rating: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Remarks:

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

**BLOCK 5: MEDICAL PROVIDER REMARKS**

25. The employee had been counseled regarding the results of this medical evaluation and my recommendations regarding further evaluation?  Yes  No

26. Remarks:

27. Medical Provider First Name:	28. Medical Provider Last Name:	29. Medical Provider E-mail Address:
30. Medical Provider Phone:	31. Signature Date/Time::	32. Medical Provider Signature:

Programs bolded/highlighted on the last page of this form require a written physician's opinion (per Federal Occupational Safety and Health Administration (OSHA). See NMCPHC-TM OM 6260: MEDICAL SURVEILLANCE PROCEDURES MANUAL AND MEDICAL MATRIX (EDITION 11).)

- Show Instructions  
 Hide Instructions

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**List of Occupational Medical Surveillance and Certification Exams**

PROG #	PROGRAM NAME	PROG #	PROGRAM NAME	PROG #	PROGRAM NAME
102	2-Acetylaminofluorene	703	Child Care Worker	215	Methyl Bromide
<b>217</b>	<b>1, 3 Butadiene*</b>	130	Chloroform	166	Methylchloromethyl Ether
197	1,1,1-Trichloroethane	<b>133</b>	<b>Chromic Acid/Chromium VI*</b>	<b>168</b>	<b>Methylene Chloride*</b>
191	1,1,2,2-Tetrachloroethane	134	Coal Tar Pitch Volatiles/PAH	603	Mixed Solvents (VOCs)
137	1,2 Dibromo -3-chloropropane (DBCP)	208	Cobalt	706	Motor Vehicle Operator (DOT)
211	2-Nitropropane	501	Cold	712	Motor Vehicle Operator (non-DOT)
138	3,3-dichlorobenzidine	125	Cresol	713	NCIS
167	4,4-Methylene Bis (2-Chloroaniline)	140	Dinitro-ortho-cresol	172	Nickel (Inorganic)
<b>213</b>	<b>4,4-Methylene Dianiline (MDA)*</b>	141	Dioxane	173	Nickel Carbonyl
106	4-Aminodiphenyl	705	Diver/Hyperbaric Worker	174	Nitrogen Oxides
139	4-dimethylaminoazobenzene	142	Epichlorohydrin	176	Nitroglycerine
175	4-Nitrobiphenyl	143	Ethoxy and Methoxy Ethanol	177	N-Nitrosodimethylamine
601	Acid/Alkali (pH<4.0/pH>11.0)	145	Ethylene Dibromide	503	Noise
103	Acrylamide	146	Ethylene Dichloride	512	Noise (Follow up of STS #1 and/or #2)
104	Acrylonitrile (Vinyl Cyanide)	<b>148</b>	<b>Ethylene Oxide*</b>	179	Organophosphates and Carbanates
105	Allyl Chloride	149	Ethyleneimine	180	Organotin Compounds
170	Alpha Naphthylamine	721	Explosive Handler	214	Ortho Toluidine
108	Anesthetic Gases	720	Explosives Vehicle Operator	194	Ortho Toluidine
207	Animal Associated Disease	<b>707</b>	<b>Firefighter (Comprehensive)*</b>	186	Otto Fuel II (and other Alky nitrates)
109	Antimony	150	Fluorides (Inorganic)	714	Police/Security Guard
112	Arsenic	709	Food Service Personnel	184	Polychlorinated Bipheryls (PCBs)
<b>113</b>	<b>Asbestos Current Worker*</b>	710	Forklift Operator	505	Radiation-Ionizing
116	Asbestos Past Worker (0-10yrs post 1st exp)	<b>151</b>	<b>Formaldehyde</b>	506	Radiation-Laser (Class 3b & 4)
115	Asbestos Past Worker (10+ yrs post 1st exp)	718	Freonr (Haloalkane)	716	<b>**Respirator Users**</b>
701	Aviation	152	Glycidyl Ethers	187	Silica (Crystalline)
723	Barber/Beauty Shop Employees	<b>711</b>	<b>Haz Waste/Emerg. Responders*</b>	189	Styrene
<b>117</b>	<b>Benzene*</b>	110	Hazardous Drugs	717	Submarine Duty
118	Benzidine	719	Health Care Workers (HCS)	190	Sulfur Dioxide
121	Beryllium	502	Heat	192	Tetrachloroethylene
132	Beta-Chloroprene	216	Herbicides	209	Tetryl
171	Beta-Naphthylamine	155	Hydrazines	195	Toluene
185	Beta-Propioactone	156	Hydrogen Cyanide/Cyanide Salts	198	Trichloroethylene
131	Bis-Chloromethyl Ether	158	Hydrogen Sulfide	508	Vibration (Hand/Arm)
<b>178</b>	<b>Blood and/or Body Fluids*</b>	159	Hydroquinone (Dihydroxy Benzene)	511	Vibration (Whole Body)
122	Boron Trifluoride	196	Isocyanates	203	Vinyl Chloride(10+ years exposure)
<b>124</b>	<b>Cadmium (Current Exposure)*</b>	<b>161</b>	<b>Lead (Inorganic)*</b>	204	Vinyl Chloride (Any Exposure)
<b>206</b>	<b>Cadmium (Past Exposure)*</b>	210	Manganese Oxide Fumes	702	Wastewater/Sewage Worker
125	Carbon Black	212	Manmade Mineral Fibers	704	Weight Handling Equipment
126	Carbon Disulfide	163	Mercury	708	Welders/Braziers/NDI Techs
127	Carbon Monoxide	602	Metal Fumes	604	Wood Dust
128	Carbon Tetrachloride	162	Metalworking Fluids	205	Xylene

Consult command Industrial Hygiene survey report for exposure-based medical surveillance recommendations.

\* Bolded/highlighted programs require a written physician's opinion (per Federal Occupational Safety and Health Administration (OSHA). See NMCPHC-TM OM 6260 for more information.

\*\* Military personnel who have been confirmed by their region or activity as "Fit for Full Duty" based on their current military physicals and annual PHA are considered medically qualified to wear any type of respiratory protection (OPNAVINST 5100.23G, paragraph 1508) and are not required to document respirator medical qualification on this form. However, DON civilian respirator users are required to utilize this form and must also complete OPNAV Form 5100/35 Respirator User Questionnaire to document the type of respiratory protection they are qualified to wear.

\*\*\* Supervisors, please ensure your personnel are informed and comply with the following guidance: Any change to the exposure risk, medical condition, or health status (including changes of medication(s) of this employee must be reported to Occupational Medicine or the command Medical Department Representative (MDR) to ensure continued compliance with required occupational surveillance or certification standards and to address potential changes to their health or safety needs.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Command UIC: \_\_\_\_\_ DoD ID #: \_\_\_\_\_

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**NOTE: If desired, these instructions can be hidden by clicking on the "Hide Instructions" checkbox located just under Block 5 (Medical Provider Comments)**

## Supervisor's Medical Surveillance and Certification Exam Referral Form Instructions for Completing

Note: Javascript must be enabled for form to function properly.

Note: For the purposes of this form, "Employee" is defined as the person requiring the medical surveillance or certification exam(s).

Select whether the employee is employed by the "Navy" or "USMC" in the title block.

### Block 1: Employee Information

The Block 1 section should be filled out by the employee and employee's supervisor. Consult with the command Safety Officer/Safety Manager/Safety Representative or Medical Department Representative (MDR) when needed.

1. Employee Last Name: As stated.
2. Employee First Name: As stated.
3. Employee DOD ID#: As stated.
4. Rank/Rate: The employee's military rank and rate (when applicable) or DoN civilian's series.
5. Email: As stated.
6. Command/Unit Name: The employee's current command or unit name.
7. Command Unit Identification Code (UIC): As stated.
8. Job Title: The official title of the employee requiring medical surveillance and/or certification exam(s). (For example: Welder, Hull Technician, Hazmat Coordinator, Aviation Mechanic, etc.).
9. Dept/Div/Work Center: The employee's assigned department, division, and work center/shop area (i.e. where the employee is actually assigned).
10. Active ESAMS Profile: State whether the employee has an active profile/account within the Enterprise Safety Applications Management System (ESAMS). This information will only be used when both the command and supporting medical clinic are using ESAMS to document medical surveillance completion.

### Block 2. Command Points of Contact

The Block 2 section should be filled out by the employee's direct supervisor/command safety/medical surveillance representative, as appropriate.

The Command Safety or Medical Surveillance Representative is the person who manages medical surveillance for the command. This could be the command Safety Officer/Manager, MDR, or other person designated by the command leadership.

11. Supervisor Last Name: As stated.
12. Supervisor First Name: As stated.
13. Supervisor Rank/Rate: The supervisor's military rank/rate (when applicable) or DoN civilian series.
14. Command Safety or Medical Surveillance Representative Last Name: As stated.
15. Command Safety or Medical Surveillance Representative First Name: As stated.
16. Command Safety or Medical Surveillance Representative Last Name: As stated.
17. Supervisor Email: As stated. This e-mail address will be used to return completed form back to supervisor.
18. Supervisor Telephone Number: As stated.
19. Command Safety or Medical Surveillance Representative Email: As stated. This e-mail address will be used to return completed form.
20. Command Safety or Medical Surveillance Representative Telephone Number: As stated.
21. Supervisor Signature: Signature of the direct supervisor attesting that the employee requires the exam(s) listed in Block 3. The signature can be performed digitally or manually. Manually may be required if using a printed, hardcopy of the form.

Last Name:

First Name:

Command UIC:

DoD ID #:

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LDC: None  
POC: DON\_Directives17.fci@us.navy.mil

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22. Supervisor Data/Time of Referral: As stated.

### Block 3. Medical Surveillance Program Information

#### General Block 3 Guidance

- Fill in applicable medical surveillance and/or certification program required in Block 3.
- Block 3 allows documentation of an unlimited number of programs (one program per row).
- Additional rows can be created by clicking on the "+" at the far right of the table.
- Unneeded rows may be deleted by clicking on the "-" at the far right of the table.
- The "A" and "V" symbols (at far right of table) can be used to rearrange the rows into a different order, if desired (but not required).

#### Block 3 Columns Filled out By Supervisor and Safety Officer/Manager and/or Afloat MDR

- Exam Type: Select the applicable exam type. Repeat for each exam row required.
  - o Baseline (pre-placement)
  - o Periodic (performed on a particular schedule specific for that exam)
  - o Termination ("Exit" exam performed upon removal from program or end of employment)
- Selected Applicable Program Number and Name: Select the applicable medical surveillance or certification exam required from the pull-down menu or fill in by hand using information from the list of exams (see table). Repeat in a new row for each exam required.
- Job or Duty/Task Requiring Exam: Document the specific job or ESAMS Duty/Task (if applicable) that requires the exam. (i.e. Forklift Operator, Explosives Handler, Hazmat Technician, etc.).

#### Block 3 Columns Filled Out By Supporting Occupational Health Provider or Afloat MDR

- Disposition or Recommendation: Select the employee's general disposition:
  - o Medically Qualified
  - o Not Medically Qualified
  - o Medically Qualified with Limitations
  - o Other/Pending
- Next Exam Due: The medical provider documents when the next periodic exam is due (if applicable).

### Block 4. Command Program Enrollment/Disenrollment Verification

#### 24. OPTIONAL - Additional Reviewer:

An additional review of medical surveillance program enrollment is sometimes required by local policies. Block 4 allows documentation of this additional review when applicable.

A Specific reviewer can be selected using the drop-down menu.

The additional reviewer verification block contains fields for the reviewer's information (name, contact information, etc.) and for supporting remarks (i.e. CONCUR with enrollment recommendation, DO NOT CONCUR with enrollment recommendation, etc.).

The additional reviewer signature can be performed digitally or manually (when hardcopy). Manual signature may be required if using a printed, hardcopy of the form.

If an additional reviewer is not desired or required by local policies or standard operating procedures, select "Not Applicable".

### Block 5. Medical Provider Remarks

Block 5 should be filled out by the supporting medical provider.

25. Has the employee been counseled regarding the results of this medical evaluation and recommendations regarding further evaluation: As stated.

Last Name:	First Name:	Command UIC:	DoD ID #:
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26. Remarks: Provide general remarks necessary for command supervisory and safety personnel to document medical qualification status or to determine whether further action on the part of line management is recommended (i.e. temporary removal from exposure to health stressor, etc.). Protect personal medical information.

27. Medical Provider First Name: As stated

28. Medical Provider Last Name: As stated

29. Medical Provider Email Address: As stated

30. Medical Provider Phone: As stated

31. Signature Date/Time: As stated

30. Medical Provider Signature: The signature can be performed digitally or manually (when hardcopy)

#### Additional Information

- The entire form (with data) can be communicated electronically via email by clicking on the "Submit PDF" button at the bottom of each page.

- For low bandwidth area: an alternate method of electronic transmittal can be performed by emailing just the form's data file (as opposed to the entire form) by clicking on "Submit XML" button at the bottom of each page. This option requires that the receiver "Import" the XML data file back into Adobe after receipt.

**Adobe Professional 7 or above is required to utilize the "Submit XML" option**

Last Name:

First Name:

Command UIC:

DoD ID #:

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