Occupational Exposures of Reproductive, Developmental, or Breastfeeding Concern
Worker's Statement

After your supervisor has completed the 6260/8, please complete this form and have it with you when you see the healthcare professional.

PLEASE PRINT

Worker _____ (*Last name*) _____ (*First name*) _____ (*M.I.*) _____ (*DoD ID*)

Rank/Rate/ Job Code _____ Today's date _____ (*Day*) _____ (*Month*) _____ (*Year*)

1) Worker's Supervisor Name (Last, First, MI): _____

2) Worker's Phone: _____ Worker's Email: _____

3) Worker's Job Duties (only if different from Supervisor's Statement): _____

FEMALES ONLY: ☐ N/A

4) Are you pregnant? ☐ YES ☐ NO

5) Date last menstrual period began? *(DD MMM YYYY)*: _____ _____ _____

6) Number of previous pregnancies: _____

7) How many of your previous pregnancies resulted in?: Live births: _____ Stillbirths: _____ Miscarriages/Abortions: _____

MALES ONLY: ☐ N/A

8) How many children have you fathered (ever)?: _____

ALL WORKERS:

9) What does your spouse or mate do at work?: _____

10) How many years have you had your current job?: _____

11) What did you do at your previous job?: _____

12) Have you ever become ill or sick because of your current job? ☐ YES ☐ NO

13) Have any of your children had a birth defect? ☐ YES ☐ NO

14) Do you have any injury(ies) or illness(es) for which you see a provider regularly? ☐ YES ☐ NO

15) Do you take medications (prescription or over the counter) regularly? ☐ YES ☐ NO

16) Do you use tobacco or any other drugs? ☐ YES ☐ NO

17) How many drinks containing alcohol do you usually consume per week? ☐ <6 ☐ 6 to 14 ☐ 15 to 21 ☐ 22 or more

18) Give details of any "YES" answers to Questions 12-17 here:

_____

19) What reproductive or developmental hazards are you most concerned about?

_____

20) In your activities at home, recreation, hobbies, second job, etc., are you exposed to any of the following? (check all that apply)

	Self	Partner
Animal danders	☐	☐
Bacteria	☐	☐
Endotoxins	☐	☐
Enzymes and other proteins	☐	☐
Inorganic chemicals	☐	☐
Ionizing radiation	☐	☐
Irregular or shift work	☐	☐
Other hazard (specify below)	☐	☐
Metals (lead, cadmium, etc.)	☐	☐
Microwave and other radio frequency (RF) energy	☐	☐
Mold or fungi overgrowth	☐	☐
Noise	☐	☐
Organic solvents and fuels	☐	☐
Pesticides	☐	☐
Pharmaceuticals/drugs	☐	☐
Strenuous work	☐	☐
Thermal stress (heat or cold)	☐	☐
Vibration	☐	☐
Viruses	☐	☐
Not sure but concerned	☐	☐
None	☐	☐

_____

_____

21) Worker's signature _____ Date: _____

Below this line for Medical Department use only

REVIEWING PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or handwritten entries, give: Name – last, first, middle, DoDID, Gender, Date of Birth, Rank/Grade.)*	MEDICAL FACILITY	STATUS
	DEPARTMENT/SERVICE / RANK/GRADE	DATE OF BIRTH
NAME:	SPONSOR'S NAME	DoD ID
DOB:	RELATIONSHIP TO SPONSOR	RECORD MAINTAINED AT:
DoD ID:		

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