From: _____

To: Supervisor, _____ (dept/code)

Subj: PHYSICIAN'S/PROVIDER'S WRITTEN OPINION in the case of

(Name)	(Last 4 ID #)	(Dept/Code)

1. The above noted individual was monitored and/or examined according to 29 CFR 1910.1018 regarding **inorganic arsenic** on _____ (date). On the basis of this examination the following comments are submitted.

   a. A medical condition WAS / WASN'T detected that would place the employee at increased risk of material impairment of the employee's health from exposure to inorganic arsenic.

   b. Limitations on this employee's exposure to inorganic arsenic or use of personal protective equipment such as clothing or respirators ARE / AREN'T recommended, as noted below.

2. The employee has been informed by the physician of the results of the medical examination and any medical conditions which require further explanation or treatment.

(examiner's signature and stamp)	(date)

Original: Employer
Copies: Employee
Medical record
Cognizant Industrial Hygienist (if indicated)

CUI//SP-HLTH
When Filled In

From: _____

To: Supervisor, _____ (dept/code)

Subj: PHYSICIAN'S/PROVIDER'S WRITTEN OPINION in the case of

(Name)	(Last 4 ID #)	(Dept/Code)

1. The above noted individual was monitored and/or examined according to 29 CFR 1910.1001 regarding **asbestos** on _____ (date). On the basis of this examination the following comments are submitted.

   a. A medical condition WAS / WASN'T detected that would place the employee at an increased risk of material health impairment of the employee's health from exposure to asbestos, tremolite, anthophyllite, or actinolite.

   b. Limitations on this employee's use of personal protective equipment such as clothing or respirators ARE / AREN'T recommended, as noted below.

   c. The following results from the medical examination and tests may be related to occupational exposures.

2. The employee has been informed of the results of this medical evaluation and of any medical conditions resulting from asbestos exposure that require further evaluation or treatment.

3. The employee has been informed by the physician of the increased risk of lung cancer attributable to the combined effect of smoking and asbestos exposure.

(examiner's signature and stamp)	(date)

Original: Employer
Copies: Employee
Medical record
Cognizant Industrial Hygienist (if indicated)

CUI//SP-HLTH
When Filled In

From: _____

To: Supervisor, _____ (dept/code)

Subj: PHYSICIAN'S/PROVIDER'S WRITTEN OPINION in the case of

(Name)	(Last 4 ID #)	(Dept/Code)

1. The above noted individual was monitored and/or examined according to 29 CFR 1910.1028 regarding occupational exposure to **benzene** on _____ (date). On the basis of this examination the following comments are submitted.

   a. A medical condition WAS / WASN'T detected that would place the employee at an increased risk of material impairment of the employee's health from exposure to benzene.

   b. Special protective measures recommended to be provided to the employee, or limitations to be placed upon the employee's exposure to benzene, are the following, if any (NONE).

   c. Limitations ARE / AREN'T recommended on this individual's exposure or use of respirators, protective clothing or equipment.

2. The employee has been counseled regarding the results of this medical evaluation and of any medical conditions resulting from benzene exposure that require further evaluation or treatment.

(examiner's signature and stamp)	(date)

Original: Employer
Copies: Employee
Medical record
Cognizant Industrial Hygienist (if indicated)

CUI//SP-HLTH

When Filled In

Subj: PHYSICIAN'S/PROVIDER'S WRITTEN OPINION TO THE EMPLOYEE in the case of

(Name)	(Last 4 ID #)	(Dept/Code)

1. You were monitored and examined according to 29 CFR 1910.1024 for **beryllium occupational medical surveillance** on _____ (date).
2. The following medical conditions that may place you at increased risk from further airborne exposure to beryllium were detected, as circled.
   - ☐ a. Beryllium sensitization as determined by a confirmed positive beryllium lymphocyte proliferation test (BeLPT)
   - ☐ b. Chronic beryllium disease (CBD)
   - ☐ c. Other condition: _____
   - ☐ d. None of the above
3. The following medical conditions related to airborne exposure to beryllium that require further evaluation or treatment were detected, as circled.
   - ☐ a. Beryllium sensitization (confirmed positive BeLPT)
   - ☐ b. CBD
   - ☐ c. Other condition: _____
   - ☐ d. None of the above
4. Because of the above findings, the Occupational Safety & Health Administration (OSHA) requires the following circled recommendations and referrals. (OSHA requires them to be made; you are free to follow any or all of them, and you will not be responsible for payment.)
   - ☐ a. Continued periodic medical surveillance
   - ☐ b. Medical removal from airborne exposure to beryllium
   - ☐ c. Referral for an evaluation at the following CBD diagnostic center.[1]

   - ☐ d. Although you were neither found to have a confirmed positive BeLPT nor diagnosed with CBD, on the basis of my recommendation, you are being referred for an evaluation at the above CBD diagnostic center. (You will not be responsible for payment.)
   - ☐ e. None of the above.
5. The following limitations on your use of respirators, protective clothing, or equipment, or limitations on airborne exposure to beryllium are recommended, as noted.
   - ◯ a. Limitations:

   - ◯ b. No limitations

(physician's signature and stamp)	(date)

Original: Employee
Copy: Medical record

[1] After you have received the initial clinical evaluation at a CBD diagnostic center, you may choose to have any subsequent medical examinations for which you are eligible under the beryllium standard performed at a CBD diagnostic center mutually agreed upon by you and the Navy, and the Navy must provide such examinations at no cost to you.

CUI//SP-HLTH
When Filled In

From: _____

To: Supervisor,_____(dept/code)

Subj: PHYSICIAN'S WRITTEN OPINION TO THE EMPLOYER in the case of

(Name)	(Last 4 ID #)	(Dept/Code)

1. The above noted individual was monitored and examined according to 29 CFR 1910.1024 regarding **beryllium** on _____ (date). On the basis of this examination the following comments are submitted.
   a. The diagnosis is beryllium occupational medical surveillance examination.
   b. Any removal from, or limitations on the activities or duties of the employee or on this employee's use of respirators, protective clothing, or equipment ARE / ARE NOT recommended, as noted below.

2. The following recommendations are included only as authorized by the employee, as indicated by the employee's initials.

Employee authorization (initials)	**Recommendation**	**Circled only if authorized by employee**
	Limitations on airborne exposure to beryllium as follows:	YES / NO
	Continued periodic medical surveillance	YES / NO
	Medical removal from airborne exposure to beryllium	YES / NO
	Referral to CDB diagnostic center	YES / NO

3. I have clearly and carefully explained to the employee the results of the medical examination, including any tests conducted, any medical conditions related to airborne beryllium exposure that require further evaluation or treatment, and any special provisions for use of personal protective clothing or equipment.

(examiner's signature and stamp)	(date)

Original: Employer
Copies: Employee
Medical record
Cognizant Industrial Hygienist (if indicated)

CUI//SP-HLTH
When Filled In

From: _____

To: Supervisor, _____ (dept/code)

Subj: HEALTH CARE PROFESSIONAL'S WRITTEN OPINION in the case of

(Name)	(Last 4 ID #)	(Dept/Code)

1. The above noted individual was evaluated according to 29 CFR 1910.1030 regarding **blood and/or body fluids** on _____ (date). On the basis of this screening, the following comments are submitted.
   a. Hepatitis B vaccination IS / ISN'T recommended for this employee (not considering current immune status but considering contraindications and occupational exposures).
   b. This employee HAS / HASN'T received hepatitis B vaccination.
2. The employee has been informed of the results of this evaluation and about any medical conditions resulting from exposure to blood or other potentially infectious materials which require further evaluation or treatment.

(screener's signature)	(date)

Original: Employer
Copies: Employee
Medical record
Cognizant Industrial Hygienist (if indicated)

CUI//SP-HLTH
When Filled In

From: _____

To: Supervisor, _____ (dept/code)

Subj: PHYSICIAN'S/PROVIDER'S WRITTEN OPINION in the case of

(Name)	(Last 4 ID #)	(Dept/Code)

1. The above noted individual was monitored and/or examined according to 29 CFR 1910.1051 regarding **butadiene** on _____ (date). On the basis of this examination the following comments are submitted.

   a. A medical condition WAS / WASN'T detected that would place the employee at an increased risk of material health impairment of the employee's health from exposure to butadiene.

   b. Limitations on this employee's exposure to butadiene or use of personal protective equipment such as clothing or respirators ARE / AREN'T recommended, as noted below.

   c. The following results from the medical examination and tests may be related to occupational exposures.

2. The employee has been informed of the results of this medical evaluation and of any medical conditions resulting from butadiene exposure that require further explanation or treatment.

(examiner's signature and stamp)	(date)

Original: Employer
Copies: Employee
Medical record
Cognizant Industrial Hygienist (if indicated)

CUI//SP-HLTH
When Filled In

From: _____

To: Supervisor, _____ (dept/code)

Subj: PHYSICIAN'S/PROVIDER'S WRITTEN OPINION in the case of

(Name)	(Last 4 ID #)	(Dept/Code)

1. The above noted individual was monitored and/or examined according to 29 CFR 1910.1027 regarding **cadmium** on _____ (date). On the basis of this examination the following comments are submitted.

   a. The diagnosis is cadmium occupational medical surveillance examination.

   b. A medical condition WAS / WASN'T detected that would place the employee at an increased risk of material health impairment of the employee's health from further exposure to cadmium, including any indications of potential cadmium toxicity.

   c. Any removal from, or limitations on the activities or duties of the employee or on this employee's use of personal protective equipment such as clothing or respirators ARE / AREN'T recommended, as noted below.

   d. The following are the results from the medical examination and any biological or other testing or related evaluations that directly assess the employee's absorption of cadmium.

2. I have clearly and carefully explained to the employee the results of the medical examination, including all biological monitoring results and any medical conditions related to cadmium exposure that require further evaluation or treatment, and any limitation on the employee's diet or use of medications..

(examiner's signature and stamp)	(date)

Original: Employer
Copies: Employee
Medical record
Cognizant Industrial Hygienist (if indicated)

CUI//SP-HLTH
When Filled In

From: _____

To: Supervisor, _____ (dept/code)

Subj: PHYSICIAN'S/PROVIDER'S WRITTEN OPINION in the case of

(Name)	(Last 4 ID #)	(Dept/Code)

1. The above noted individual was monitored and/or examined according to 29 CFR 1910.1026 regarding **chromium** on _____ (date). On the basis of this examination the following comments are submitted.
   a. The diagnosis is chromium occupational medical surveillance examination.
   b. A medical condition WAS / WASN'T detected that would place the employee at increased risk of material impairment to health from further exposure to chromium (VI).
   c. Any removal from, or limitations on the activities or duties of the employee or on this employee's use of personal protective equipment such as respirators ARE / AREN'T recommended, as noted below.

2. I have clearly and carefully explained to the employee the results of the medical examination, including all biological monitoring results and any medical conditions related to chromium exposure that require further evaluation or treatment, and any special provisions for use of protective clothing or equipment.

(examiner's signature and stamp)	(date)

Original: Employer
Copies: Employee
Medical record
Cognizant Industrial Hygienist (if indicated)

CUI//SP-HLTH
When Filled In

From: _____

To: Supervisor, _____ (dept/code)

Subj: PHYSICIAN'S/PROVIDER'S WRITTEN OPINION in the case of

(Name)	(Last 4 ID #)	(Dept/Code)

1. The above noted individual was monitored and/or examined according to 29 CFR 1910.1001 regarding **ethylene oxide (EtO)** on _____ (date). On the basis of this examination the following comments are submitted.

   a. A medical condition IS / ISN'T detected that would place the employee at an increased risk of material health impairment of the employee's health from exposure to ethylene oxide.

   b. Limitations on this employee's use of personal protective equipment such as clothing or respirators ARE / AREN'T recommended, as noted below.

   c. The following results from the medical examination and tests may be related to occupational exposures.

2. The employee has been informed of the results of this medical evaluation and of any medical conditions resulting from ethylene oxide exposure that require further explanation or treatment.

(examiner's signature and stamp)	(date)

Original: Employer
Copies: Employee
Medical record
Cognizant Industrial Hygienist (if indicated)

CUI//SP-HLTH
When Filled In

From: _____

To: Supervisor, _____ (dept/code)

Subj: PHYSICIAN'S/PROVIDER'S WRITTEN OPINION in the case of

(Name)	(Last 4 ID #)	(Dept/Code)

1. The above noted individual was monitored and/or examined according to 29 CFR 1910.1001 regarding **formaldehyde** on _____ (date). On the basis of this examination the following comments are submitted.

   a. A medical condition WAS / WASN'T detected that would place the employee at an increased risk of material health impairment of the employee's health from exposure to formaldehyde.

   b. Limitations on this employee's use of personal protective equipment such as clothing or respirators ARE / AREN'T recommended, as noted below.

   c. The following results from the medical examination and tests may be related to occupational exposures.

2. The employee has been informed of the results of this medical evaluation and of any medical conditions which would be aggravated by exposure to formaldehyde, whether these conditions may have resulted from past formaldehyde exposure or from exposure in an emergency, and whether there is a need for further examination or treatment.

(examiner's signature and stamp)	(date)

Original: Employer
Copies: Employee
Medical record
Cognizant Industrial Hygienist (if indicated)

CUI//SP-HLTH
When Filled In

From: _____

To: Supervisor, _____ (dept/code)

Subj: PHYSICIAN'S/PROVIDER'S WRITTEN OPINION in the case of

(Name)	(Last 4 ID #)	(Dept/Code)

1. The above noted individual was monitored and/or examined according to 29 CFR 1910.120 regarding **hazardous waste operations or emergency response** on _____ (date). On the basis of this examination the following comments are submitted.

   a. The diagnosis is hazardous waste operations or emergency response occupational medical surveillance examination.

   b. A medical condition IS / ISN'T detected that would place the employee at increased risk of material impairment of the employee's health from work in hazardous waste operations or emergency response, or from respirator use. Comments (if applicable):

   c. Any limitations upon the employee's assigned work ARE / AREN'T recommended, as noted below.

   d. If requested by the employee, the results of the medical examination and tests are noted below.

2. I have clearly and carefully explained to the employee the results of the medical examination, and any medical conditions that require further examination or treatment.

(examiner's signature and stamp)	(date)

Original: Employer
Copies: Employee
Medical record
Cognizant Industrial Hygienist (if indicated)

CUI//SP-HLTH
When Filled In

From: _____

To: Supervisor, _____ (dept/code)

Subj: PHYSICIAN'S/PROVIDER'S WRITTEN OPINION in the case of

(Name)	(Last 4 ID #)	(Dept/Code)

1. The above noted individual was monitored and/or examined according to 29 CFR 1910.1025 regarding occupational exposure to **lead** on _____ (date). On the basis of this examination the following comments are submitted.
   a. A medical condition WAS / WASN'T detected that would place the employee at an increased risk of material impairment of the employee's health from exposure to lead.
   b. Special protective measures recommended to be provided to the employee, or limitations to be placed upon the employee's exposure to lead, are the following, if any (NONE).

   c. Limitations ARE / AREN'T recommended on this individual's exposure or use of respirators, including the following.
      i. The employee CAN / CAN'T wear a negative pressure respirator.
      ii. The employee CAN / CAN'T wear a powered air purifying respirator (PAPR).
2. The blood lead level was determined to be _____.
3. The employee has been counseled regarding the results of this medical evaluation and of any medical conditions resulting from lead exposure that require further evaluation or treatment.

(examiner's signature and stamp)	(date)

Original: Employer
Copies: Employee
Medical record
Cognizant Industrial Hygienist (if indicated)

CUI//SP-HLTH
When Filled In

From: _____

To: Supervisor, _____ (dept/code)

Subj: PHYSICIAN'S/PROVIDER'S WRITTEN OPINION in the case of

(Name)	(Last 4 ID #)	(Dept/Code)

1. The above noted individual was monitored and/or examined according to 29 CFR 1910.1052 regarding **methylene chloride (MC)** on _____ (date). On the basis of this examination the following comments are submitted.

   a. Exposure to MC MAY / IS LIKELY TO contribute to or aggravate the employee's existing cardiac, hepatic, neurological (including stroke) or dermal disease

   b. A medical condition WAS / WASN'T detected that would place the employee at an increased risk of material health impairment of the employee's health from exposure to MC.

   c. Limitations on this employee's exposure to MC or on the employee's use of personal protective equipment such as clothing or respirators ARE / AREN'T recommended, as noted below.

   d. The following results from the medical examination and tests may be related to occupational exposures.

2. The employee has been informed that MC is a potential occupational carcinogen, of risk factors for heart disease and the potential for exacerbation of underlying heart disease by exposure to MC through its metabolism to carbon monoxide, and of the results of this medical evaluation and of any medical conditions resulting from MC exposure that require further explanation or treatment.

(examiner's signature and stamp)	(date)

Original: Employer
Copies: Employee
Medical record
Cognizant Industrial Hygienist (if indicated)

CUI//SP-HLTH
When Filled In

From: _____

To: Supervisor, _____ (dept/code)

Subj: PHYSICIAN'S/PROVIDER'S WRITTEN OPINION in the case of

(Name)	(Last 4 ID #)	(Dept/Code)

1. The above noted individual was monitored and/or examined according to 29 CFR 1910.1001 regarding **methylenedianiline (MDA)** on _____ (date). On the basis of this examination the following comments are submitted.

   a. A medical condition WAS / WASN'T detected that would place the employee at an increased risk of material health impairment of the employee's health from exposure to methylenedianiline.

   b. Limitations on this employee's use of personal protective equipment such as clothing or respirators ARE / AREN'T recommended, as noted below.

   c. The following results from the medical examination and tests may be related to occupational exposures.

2. The employee has been informed of the results of this medical evaluation and of any medical conditions resulting from methylenedianiline exposure that require further explanation or treatment.

(examiner's signature and stamp)	(date)

Original: Employer
Copies: Employee
Medical record
Cognizant Industrial Hygienist (if indicated)

From: _____

To: Supervisor, _____ (dept/code)

Subj: PHYSICIAN'S/PROVIDER'S WRITTEN OPINION in the case of

(Name)	(Last 4 ID #)	(Dept/Code)

1. The above noted individual was monitored and/or examined according to 29 CFR 1910.1003 regarding Select Substance: on_____ (date). On the basis of this examination the following comments are submitted:

Any limitations upon the employee's assigned work suitability for employment in the specific exposure ARE / ARE NOT: recommended, as noted below:

2. The employee has been informed by the physician of the results of the medical examination and any medical conditions which require further explanation or treatment.

(examiner's signature and stamp)	(date)

Copy to:
Employer
Employee
Medical record
Cognizant Industrial Hygienist (if indicated)

CUI//SP-HLTH
When Filled In

NOTICE OF SIGNIFICANT THRESHOLD SHIFT

Name	(Last 4 ID #)	Dept/Code

Ref: (a) 29 CFR 1910.95

1. The results of the hearing test provided to you as part of the Navy Hearing Conservation Program indicate that you may have suffered deterioration in your hearing sensitivity. This condition is referred to as a Significant Threshold Shift (STS). Because of the test results, you have been or will be scheduled for one or more hearing tests to confirm the findings. Also, you may be given a medical examination to determine the probable cause of the STS. This written notification is presented under the requirements of reference (a).
2. Audiometric technicians have provided you with properly fitted hearing protection devices and given you a reindoctrination of the Hearing Conservation Program requirements. In addition, the following steps have been taken in response to your change in hearing:

_____ Follow-up Audiogram(s)

_____ Medical Consultation

_____ Referral to Audiologist

_____ Other:

3. In order to preserve your hearing, it is very important that you wear your hearing protection at all times when in areas identified as noise hazardous or in the vicinity of noise hazardous tools, weapons or operations.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION:

(patient's signature)	(date)

(Audiometric Technician’s Signature and Stamp)	(date)

Original: Employer
Copies: Employee
Medical record
Cognizant Industrial Hygienist (IH) (if indicated)

CUI//SP-HLTH
When Filled In

From: _____

To: Supervisor,_____(Dept. / Code)

Subj: PHYSICIAN'S/PROVIDER'S WRITTEN OPINION TO THE EMPLOYER in the case of

(Name)	(Last 4 ID #)	(Dept. / Code)

1. The above noted individual was monitored and examined according to 29 CFR 1910.1053 regarding **crystalline silica** on _____ (Date). On the basis of this examination the following comments are submitted.
   a. The diagnosis is crystalline silica occupational medical surveillance examination.
   b. Limitations on this employee's use of respirators ARE / AREN'T recommended, as noted below.

2. The following recommendations are included only as authorized by the employee, as indicated by the employee's initials.

Employee authorization (initials)	**Recommendation**	**Circled only if authorized by employee**
	Limitations on exposure to respirable crystalline silica as follows:	YES / NO
	Referral to an Occupational Medicine or Pulmonary specialist (because the B-reading is classified as 1/0 or higher or for other reason)	YES / NO

3. I have clearly and carefully explained to the employee the results of the medical examination.

(Examiner's signature and stamp)	(Date)

Original: Employer
Copies: Employee
Medical record
Cognizant Industrial Hygienist (if indicated)

Subj: PHYSICIAN'S/PROVIDER'S WRITTEN OPINION TO THE EMPLOYEE in the case of

(Name)	(Last 4 ID #)	(Dept. / Code)

1. You were monitored and examined according to 29 CFR 1910.1053 for **to crystalline silica medical surveillance** on _____ (Date).
2. The following medical conditions may place you at increased risk from further airborne exposure to respirable crystalline silica, as checked.
   a. ◯ Condition: _____
   b. ◯ None
3. The following medical conditions require further evaluation or treatment were detected, as checked.
   a. ◯ Condition: _____
   b. ◯ None
4. The following limitations on your use of respirators are recommended, as checked and noted.
   a. ◯ Limitations:

   b. ◯ No limitations
5. Because the chest X-ray (called a "B-reading") is classified as 1/0 or higher or for other reason, you should be examined by an Occupational Medicine or Pulmonary specialist.
   a. ◯ Your appointment has been scheduled as follows. If this is not convenient, please contact them to reschedule.

   b. ◯ No specialist referral is recommended.

(Physician's signature and stamp)	(Date)

Original: Employee
Copy: Medical record