



# OCCUPACIONAL HEALTH DECLARATION

**F15**  
Revision 00  
01/07/20VV

Name of Patient: \_\_\_\_\_

Date of Born: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_

ID: \_\_\_\_\_ Function/Sector: \_\_\_\_\_

Med Coordinator of the Program: \_\_\_\_\_ Medical ID \_\_\_\_\_

Med in Charge of the Exam: \_\_\_\_\_ Medical ID \_\_\_\_\_

## EXAM TYPE

- Admission
  Periodic
  Dismissal  
 Return to Work
  Change of Function

## RISCOS

A) Physical	B) Chemical	C) Biologic	D) Ergonomic	E) Others
<input type="checkbox"/> Heat	<input type="checkbox"/> Metallic fumes	<input type="checkbox"/> Bacteria	<input type="checkbox"/> Intense physical effort	<input type="checkbox"/>
<input type="checkbox"/> Cold	<input type="checkbox"/> Gases	<input type="checkbox"/> Fungi	<input type="checkbox"/> Weightlifting	<input type="checkbox"/>
<input type="checkbox"/> Ion radiation.	<input type="checkbox"/> Hydrocarbons	<input type="checkbox"/> Parasites	<input type="checkbox"/> Repetitive movement	<input type="checkbox"/>
<input type="checkbox"/> Non-ion radiation.	<input type="checkbox"/> Mist	<input type="checkbox"/> Protozoa	<input type="checkbox"/> Inadequate posture	<input type="checkbox"/>
<input type="checkbox"/> Noises	<input type="checkbox"/> Mists	<input type="checkbox"/> Virus	<input type="checkbox"/> Shift work	<input type="checkbox"/>
<input type="checkbox"/> Moisture	<input type="checkbox"/> Mineral Dust	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Vibrations	<input type="checkbox"/> Solvents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Organic Vapors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Plastic Fumes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> There are no specific risks for the function performed				

## PROCEDURES PERFORMED

- Visual Acuity
  Electrocardiogram
  Glicemia
  PA \_\_\_\_\_ mmHg
   
 Anamnesis
  Electroencephalogram
  Hemograma
  Parasitological
   
 Audiometry
  Spirometry
  Raio X (tórax)
  Urine

Observações quanto aos exames realizados:

## FINAL CONCLUSION

To comply with all requirements related to the OHS Law applying to the employee referred in this document, I hereby **Declare** that he is:

- APT FOR THE FUNCION  
 APT WITH RESTRICTION: \_\_\_\_\_  
 APT CLINICALY, but waiting for final results of complementary Exams  
 UNFIT FOR THE FUNCTION  
 UNFIT TEMPORARELY, as evaluated by experts: \_\_\_\_\_

Observations: \_\_\_\_\_

Place \_\_\_\_\_ Date: / /

Occupational Physician

Patient