Name of Patient:

Date of Born: / / Age:

ID: Function/Sector:

Med Coordinator of the Program:

Med in Charge of the Exam:

Medical ID

Medical ID

#  EXAM TYPE

Admission Periodic Dismissal

Return to Work Change of Function

#  RISCOS

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

 **PROCEDURES PERFORMED**

Visual Acuity Anamnesis Audiometry

Electrocardiogram Electroencephalogram Spirometry

Glicemia Hemograma Raio X (tórax)

PA mmhG Parasitological

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