

Internal Occupational Health

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Dear Incoming Housestaff,

Welcome to Froedtert & Medical College of Wisconsin. We look forward to working with you beginning this July!

As part of your onboarding, please complete the attached forms and submit all documentation in one completed packet to Medical College of Wisconsin Affiliated Hospitals Administration by **May 9th, 2025**. For your convenience, a self-addressed, stamped envelope is enclosed for this purpose. We highly recommend keeping a personal copy of all items sent. You may also submit forms electronically to IOHMCWMCWAH@froedtert.com.

Please note the signature sections in the attached documents: By typing my name, I certify that my statements and answers are complete and true to the best of my knowledge.

If you intend to request vaccine exemptions, please reach out to IOH at 1-414-805-7997 and press option 1 to speak to a representative. Please ensure paperwork is received by **April 25th, 2025**.

➤ **Forms to complete if you are a Medical College of Wisconsin graduate:**

- ☐ **Health and Communicable Disease Record**- please have this completed by a physician, NP, or PA, dated within 90 days prior to start (**after April 1st, 2025**).
- ☐ **Authorization to Release Medical Records**
- ☐ **Respirator Medical Evaluation Questionnaire**
- ☐ **Immunization and Tuberculosis (TB) Surveillance Form**- Please send a copy of your CastleBranch records to determine if your immunizations and TB surveillance are up to date

➤ **Forms to complete if you graduated from another medical college system:**

- ☐ **Immunization and Tuberculosis (TB) Surveillance Form** with copies of all testing, vaccinations/titers attached
- ☐ **Health and Communicable Disease Record** completed by a physician, NP, or PA, dated within 90 days prior to start (**after April 1st, 2025**)
- ☐ **Authorization to Release Medical Records**
- ☐ **Respirator Medical Evaluation Questionnaire**

If you need assistance with meeting these health requirements, or have any questions, please call our office at (414)805-7997.

Immunization and Tuberculosis (TB) Surveillance Form



****Supporting documentation must accompany this form****

Please print legibly

Last Name:	First Name:	Middle Initial:
Address:		
Phone:	Primary Email:	
Date of Birth:	Last 4 SS#:	

MMR (Measles, Mumps, Rubella) – 2 doses of MMR vaccine or two (2) doses of Measles, two (2) doses of Mumps and one (1) dose of Rubella; OR serologic proof of immunity for Measles, Mumps, and/or Rubella

Option 1	Vaccine	Date	Copies Must Be Attached
MMR 2 doses of MMR vaccine	MMR Dose #1	___ / ___ / ___	<input type="checkbox"/> Copy Attached
	MMR Dose #2	___ / ___ / ___	<input type="checkbox"/> Copy Attached
Option 2	Vaccine or Test	Date	
Measles 2 doses of vaccine or positive serology	Measles Vaccine Dose #1	___ / ___ / ___	<input type="checkbox"/> Copy Attached
	Measles Vaccine Dose #2	___ / ___ / ___	<input type="checkbox"/> Copy Attached
	Serologic Immunity (IgG, antibodies, titer)	___ / ___ / ___	<input type="checkbox"/> Copy Attached
Mumps 2 doses of vaccine or positive serology	Mumps Vaccine Dose #1	___ / ___ / ___	<input type="checkbox"/> Copy Attached
	Mumps Vaccine Dose #2	___ / ___ / ___	<input type="checkbox"/> Copy Attached
	Serologic Immunity (IgG, antibodies, titer)	___ / ___ / ___	<input type="checkbox"/> Copy Attached
Rubella 1 dose of vaccine or positive serology	Rubella vaccine	___ / ___ / ___	<input type="checkbox"/> Copy Attached
	Serologic Immunity (IgG, antibodies, titer)	___ / ___ / ___	<input type="checkbox"/> Copy Attached

Hepatitis B Vaccination – 3 doses of vaccine follow by a **QUANTITATIVE** Hepatitis B Surface Antibody (titer) preferably drawn 4-8 weeks after 3rd dose. If negative, give 4th (booster vaccine) and recheck Hepatitis B Surface Antibody (titer). If titer continues to be negative, complete second series (doses 5 and 6), and recheck Hepatitis B Surface Antibody (titer) again. If Hepatitis B Surface Antibody is negative after completing a second series (total of 6 doses of vaccine), considered as non-responder.

		Date	
Primary Hepatitis B Series	Hepatitis B Vaccine Dose #1	___ / ___ / ___	<input type="checkbox"/> Copy Attached
	Hepatitis B Vaccine Dose #1	___ / ___ / ___	<input type="checkbox"/> Copy Attached
	Hepatitis B Vaccine Dose #1	___ / ___ / ___	<input type="checkbox"/> Copy Attached
	QUANTITATIVE Hepatitis B Surface Antibody	___ / ___ / ___	Result: ___ mIU/mL <input type="checkbox"/> Copy Attached
Booster Dose of Vaccine (if no response to primary series)	Hepatitis B Vaccine Dose #4	___ / ___ / ___	<input type="checkbox"/> Copy Attached
	QUANTITATIVE Hepatitis B Surface Antibody	___ / ___ / ___	Result: ___ mIU/mL <input type="checkbox"/> Copy Attached
Completion of Second Series (if no response to Booster Dose)	Hepatitis B Vaccine Dose #5	___ / ___ / ___	<input type="checkbox"/> Copy Attached
	Hepatitis B Vaccine Dose #6	___ / ___ / ___	<input type="checkbox"/> Copy Attached
	QUANTITATIVE Hepatitis B Surface Antibody	___ / ___ / ___	Result: ___ mIU/mL <input type="checkbox"/> Copy Attached

Tetanus diphtheria pertussis (Tdap) vaccine – 1 (one) dose of adult Tdap. If last Tdap is more than 10 years ago, also provide date of last Tetanus diphtheria vaccine (Td)

		Date	
	Tetanus diphtheria pertussis (Tdap) Vaccine	____ / ____ / ____	<input type="checkbox"/> Copy Attached
	Tetanus diphtheria vaccine (Td) - if Tdap given more than 10 years ago	____ / ____ / ____	<input type="checkbox"/> Copy Attached

Varicella Vaccination – 2 doses of vaccine or positive serology

		Date	
Option 1	Varicella Vaccine #1	____ / ____ / ____	<input type="checkbox"/> Copy Attached
	Varicella Vaccine #2	____ / ____ / ____	<input type="checkbox"/> Copy Attached
Option 2	Serologic Immunity (IgG, antibodies, titer)	____ / ____ / ____	<input type="checkbox"/> Copy Attached

Covid Vaccination- Completed Series Required

		Date	
Option 1 Pfizer/Moderna	Dose 1:	____ / ____ / ____	<input type="checkbox"/> Copy Attached
	Dose 2:	____ / ____ / ____	<input type="checkbox"/> Copy Attached
Option 2 Single Dose	Manufacturer:	____ / ____ / ____	<input type="checkbox"/> Copy Attached
Covid Vaccine Booster	Manufacturer:	____ / ____ / ____	<input type="checkbox"/> Copy Attached
Covid Vaccine Booster	Manufacturer:	____ / ____ / ____	<input type="checkbox"/> Copy Attached
Covid Vaccine Booster	Manufacturer:	____ / ____ / ____	<input type="checkbox"/> Copy Attached

Tuberculosis Surveillance – Complete Section A, B, OR C

SECTION A: Negative Skin or Blood Test History - Last two skin tests or one IGRA required

Option 1	Tuberculin Skin Test #1 (dated within 12 months of program start)	Date Placed	Date Read	Result: _____ mm <input type="checkbox"/> Copy Attached
	Tuberculin Skin Test #2 (dated within 90 days of program start)	Date Placed	Date Read	Result: _____ mm <input type="checkbox"/> Copy Attached
Option 2	Interferon gamma releasing assay (IGRA) Blood Test (dated within 90 days of program start)	Date		Result: _____ <input type="checkbox"/> Copy Attached

SECTION B: History of Latent Tuberculosis, Positive Skin Test or Positive Blood Test

Option 1	Positive Tuberculin Skin Test	Date Placed	Date Read	Result: _____ mm
Option 2	Positive IGRA Blood Test	Date: ____ / ____ / ____		Result: _____ <input type="checkbox"/> Copy Attached
	Chest X-ray (dated within 6 months of program start)	Date: ____ / ____ / ____		Result: _____ <input type="checkbox"/> Copy Attached
	Written symptoms questionnaire (dated within 90 days of program start) – Form may be obtained from Internal Occupational Health	Date: ____ / ____ / ____		<input type="checkbox"/> Copy Attached
	Was prophylactic medication taken for latent TB?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	If prophylactic medication was taken, total duration of prophylaxis	_____ Months		

SECTION C: History of Active Tuberculosis

	Date of Diagnosis:	
	Date Treatment Completed:	

	Chest X-ray (dated within 6 months of program start)	Date: ____ / ____ / ____	Result: _____ <input type="checkbox"/> Copy Attached
History of Active Tuberculosis continued:	Written symptoms questionnaire (dated within 90 days of program start) – Form may be obtained from Internal Occupational Health	Date: ____ / ____ / ____	<input type="checkbox"/> Copy Attached

<p>I hereby declare that all statements included in this Surveillance Form are true and correct to the best of my knowledge.</p>	
<p>_____ Signature of Patient</p>	<p>_____ Date</p>

Respirator Medical Evaluation Questionnaire

Can you read? Yes ☐ No ☐

Would you like assistance in completing this questionnaire? Yes ☐ No ☐

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Part A. Section 1. (Mandatory) The following information must be provided by every person who has been selected to use any type of respirator (please print).

1. Today's date:	2. Your name:
3. Your age (to nearest year):	4. Sex (circle one): Male Female
5. Your height: _____ feet _____ inches	6. Your weight: _____ lbs.
7. Do you have a full facial beard? Yes <input type="checkbox"/> No <input type="checkbox"/>	
8. Your department and job title:	
9. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the area code):	
10. The best time to phone you at this number:	
11. Has your employer told you how to contact the health care professional who will review this questionnaire? Yes <input type="checkbox"/> No <input type="checkbox"/>	
12. Check the type of respirator you will use. (You may check more than one category.) a. <input type="checkbox"/> N (Non-Oil), R (Oil Resistant), or P (Oil Proof) disposable respirator (i.e., filter-mask/N95, non-cartridge type only.) b. <input type="checkbox"/> Other type (i.e., half or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus.) <input type="checkbox"/> Powered Air Purifying Respirator (PAPR) <input type="checkbox"/> Half Face Piece <input type="checkbox"/> Other: _____ <i>(This question is answered for you since N95 respirators are those commonly worn in isolation rooms.)</i>	
13. Have you worn a respirator? Yes <input type="checkbox"/> No <input type="checkbox"/> If "yes", what type(s): _____	

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every person who has been selected to use any type of respirator (please indicate "yes" or "no").

	Yes	No
1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? If yes: At what age did you start smoking? _____ How long ago did you quit smoking? _____ How many packs per day did or do you smoke? _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever had any of the following conditions?	Yes	No
a. Seizures (fits) Type _____ Date of last seizure _____	<input type="checkbox"/>	<input type="checkbox"/>
b. Diabetes (sugar disease) Have you ever lost consciousness or had a change in level of consciousness? If yes, when? _____	<input type="checkbox"/>	<input type="checkbox"/>
c. Allergic reactions that interfere with your breathing?	<input type="checkbox"/>	<input type="checkbox"/>

If yes, when? _____
 If yes, describe: _____

☐ ☐

d. Claustrophobia (fear of closed-in places)

☐ ☐

e. Trouble smelling odor

☐ ☐

3. Have you **ever had** any of the following pulmonary or lung problems?

Yes **No**

a. Asbestosis

☐ ☐

b. Asthma

☐ ☐

c. Chronic bronchitis

☐ ☐

d. Emphysema

☐ ☐

e. Pneumonia

☐ ☐

f. Tuberculosis

☐ ☐

g. Silicosis

☐ ☐

h. Pneumothorax

☐ ☐

i. Lung cancer

☐ ☐

j. Broken rib

☐ ☐

k. Any chest injuries or surgeries

☐ ☐

l. Any other lung problem that you've been told about?

☐ ☐

If yes to any of the above, please describe, including when: _____

4. Do you **currently** have any of the following symptoms of pulmonary or lung illness?

Yes **No**

a. Shortness of breath

☐ ☐

b. Shortness of breath when walking fast on level ground or up a slight hill or incline

☐ ☐

c. Shortness of breath when walking with others at an ordinary pace on level ground

☐ ☐

d. Have to stop for breath when walking at your own pace on level ground

☐ ☐

e. Shortness of breath when washing or dressing yourself

☐ ☐

f. Shortness of breath that interferes with your job

☐ ☐

g. Coughing that produces phlegm (thick sputum)

☐ ☐

h. Coughing that wakes you early in the morning

☐ ☐

i. Coughing that occurs mostly when you are lying down

☐ ☐

j. Coughing up blood in the last month

☐ ☐

k. Wheezing

☐ ☐

l. Wheezing that interferes with your job

☐ ☐

m. Chest pain when you breathe deeply

☐ ☐

n. Any other symptoms that you think may be related to lung problems

☐ ☐

If yes to any of the above, please describe: _____

5. Have you **ever had** any of the following cardiovascular or heart problems?

Yes **No**

a. Heart attack

☐ ☐

b. Stroke

☐ ☐

c. Angina

☐ ☐

d. Heart failure

☐ ☐

e. Swelling in your legs or feet (not caused by walking)

☐ ☐

f. Heart arrhythmia (heart beating irregularly)

☐ ☐

g. High blood pressure

If yes, is it under control?

☐ ☐

☐ ☐

h. Any other heart problem that you've been told about

If yes, to any of the above, please describe, including when: _____

☐ ☐

6. Have you **ever had** any of the following cardiovascular or heart symptoms?

Yes **No**

a. Frequent pain or tightness in your chest

☐ ☐

b. Pain or tightness in your chest during physical activity

☐ ☐

c. Pain or tightness in your chest that interferes with your job

☐ ☐

d. In the past two years, have you noticed your heart skipping or missing a beat

☐ ☐

e. Heartburn or indigestion that is not related to eating

☐ ☐

f. Any other symptoms that you think may be related to heart or circulation problems

If yes to any of the above, please describe, including when: _____

☐ ☐

7. Do you **currently** take medication for any of the following problems?

Yes **No**

a. Breathing or lung problems

☐ ☐

b. Heart trouble

☐ ☐

c. Blood pressure

☐ ☐

d. Seizures (fits)

☐ ☐

8. If you've used a respirator, have you **ever had** any of the following problems during respirator use? (If you've never used a respirator, check the following box and go to question number 9): ☐

Yes **No**

a. Eye irritation

☐ ☐

b. Skin allergies or rashes

☐ ☐

c. Anxiety

☐ ☐

d. General weakness or fatigue

☐ ☐

e. Any other problem that interferes with your use of a respirator

If yes to any of the above, please describe: _____

☐ ☐

9. Are you currently taking any medications? If yes, please list here: _____ ☐ ☐

10. Would you like to talk to the health care professional that reviews this questionnaire about your answers to this questionnaire? ☐ ☐

For any “Yes” answers in section 2 (questions 1-9 above), does this condition interfere with your ability to wear a respirator? ☐ ☐

Comment: _____

Signature: _____ **Date:** _____

Internal Occupational Health Department Use Only

- ☐ Approved
- ☐ Approved with restrictions: _____
- ☐ Pulmonary function test and follow-up medical evaluation indicated
- ☐ Denied
- ☐ More information needed

Remarks: _____

Signature: _____ **Date:** _____

HEALTH AND COMMUNICABLE DISEASE RECORD

The information you are being asked to provide is being requested for two purposes. It will assist in evaluating your physical and mental capacity to perform healthcare worker functions and to ascertain whether you are free from communicable disease.

This information will be maintained in your health record and is **confidential** unless Internal Occupational Health is authorized to disclose it.

This review, with signed health practitioner statement, must be done within 90 days of program and/or employment start.

Name: _____

Date of Birth: _____

Home Address: _____

Gender: _____

City: _____ State: _____

Social Security Number: _____

Zip Code: _____ Phone (Cell): _____

Phone (Home): _____

Have you ever worked or volunteered at a Froedtert or Medical College of Wisconsin facility? Yes ☐ No ☐

If yes, please indicate when and where:

PERSONAL HISTORY (To be completed by patient)

Allergies

Drug(s): _____

Reaction(s): _____

Food: _____

Reaction(s): _____

Latex: _____

Reaction(s): _____

Environmental : _____

Reaction(s): _____

Medications

Please list all nonprescription (over – the – counter) medications that you regularly use, including vitamins, herbal supplements, laxatives, aspirins, and weight-reducing aids:

Please list all prescription medicines that you are currently taking:

Hospitalizations / Surgeries / Childbirth Within the Last Five Years

Year	Reason(s)
_____	_____
_____	_____
_____	_____

Have you had or do you now have: (Please comment on "yes" answers as needed.)					
	Yes	No		Yes	No
Heart / Blood			Musculoskeletal		
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain / Neck Injury	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain / Back Injury	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Spine or Joint Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Inability to Lift / Lifting Restrictions	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			Dislocation of Any Joint	<input type="checkbox"/>	<input type="checkbox"/>
			Bone, Joint, or Other Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory / Lungs			Fractured / Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>
Breathing Problems	<input type="checkbox"/>	<input type="checkbox"/>	Joints That "Lock" or Give Out	<input type="checkbox"/>	<input type="checkbox"/>
Coughed Up Blood	<input type="checkbox"/>	<input type="checkbox"/>	Swollen / Painful Joint(s)	<input type="checkbox"/>	<input type="checkbox"/>
Cough Over 2 weeks Duration	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Tendonitis	<input type="checkbox"/>	<input type="checkbox"/>
Positive TB Skin Test	<input type="checkbox"/>	<input type="checkbox"/>	Bursitis	<input type="checkbox"/>	<input type="checkbox"/>
Year:	<input type="checkbox"/>	<input type="checkbox"/>	Carpal Tunnel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Date of Chest X-ray:			Hernia	<input type="checkbox"/>	<input type="checkbox"/>
INH Treatment?	<input type="checkbox"/>	<input type="checkbox"/>	Need to use a mobility aid (i.e., walker, cane, wheelchair, scooter)	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			Comments:		
Head			Nerve / Muscle		
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness / Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Headaches, Frequent or Severe	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
			Unusual Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Skin			Numbness / Tingling	<input type="checkbox"/>	<input type="checkbox"/>
Skin Problems	<input type="checkbox"/>	<input type="checkbox"/>	Seizures / Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			Comments:		
	Yes	No		Yes	No
Eyes / Ears / Nose / Throat			Gastrointestinal		
Wear Glasses	<input type="checkbox"/>	<input type="checkbox"/>	Stomach or Bowel Problems	<input type="checkbox"/>	<input type="checkbox"/>
Contacts (type):	<input type="checkbox"/>	<input type="checkbox"/>	Comments:		
Vision: Nearsighted	<input type="checkbox"/>	<input type="checkbox"/>			
Farsighted	<input type="checkbox"/>	<input type="checkbox"/>	Immune System		
Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>	Lymph Gland Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Aid	<input type="checkbox"/>	<input type="checkbox"/>	Organ Transplant	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			Immunocompromised	<input type="checkbox"/>	<input type="checkbox"/>
			Comments:		
Mental Health					
Anxiety / Panic Attacks	<input type="checkbox"/>	<input type="checkbox"/>	Other Health Problems		
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Cancer:	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol / Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Radiation	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Comments:			Comments:		
Any other physical or psychological problem(s) not listed above:					

Have you lived or traveled outside of the United States for longer than a month? Yes ☐ No ☐ If yes, when and where?

Have you had an injury to the eye involving metallic fragments, an implanted device placed (i.e., aneurysm clips, cochlear implants, pace maker, spinal cord stimulator, etc.), an injury by a metallic object (i.e., bullet, BB, shrapnel, etc.), or any other implanted metallic object? Yes ☐ No ☐ If yes, please comment:

Do you have any permanent physical, mental, or learning disabilities? Yes ☐ No ☐ If yes, what are they? _____

I hereby declare that all statements included in this Health and Communicable Disease Record are true and correct to the best of my knowledge.

Signature of Patient

Date

HEALTHCARE PRACTITIONER STATEMENT

☐ This patient is free of clinically apparent communicable disease.

This patient may participate in direct patient care:

☐ Without restrictions.

☐ With the following restrictions: _____

☐ May not participate at this time

Physician, Nurse Practitioner, or Physician Assistant's name (Please print.)

Street Address

City, State, Zip

Telephone

Signature of Physician, Nurse Practitioner, or Physician Assistant

Date

Authorization to Release Medical Records

For the Purpose of Occupational Health Information Requirements Only

I hereby authorize and request Froedtert & the Medical College of Wisconsin Internal Occupational Health Services to release the following occupational health records to any healthcare facilities I may rotate through as a student of the Medical College of Wisconsin and/or employee of Medical College of Wisconsin Affiliated Hospitals.

- ✓ Immunization records including Influenza; Varicella; Hepatitis B; Measles, Mumps, Rubella (MMR); Tetanus diphtheria (Td); Tetanus diphtheria pertussis (Tdap); Polio; Yellow Fever; Hepatitis A; Typhoid; Meningococcal; Japanese Encephalitis; Rabies
- ✓ Tuberculosis surveillance records including Mantoux tuberculin skin testing, interferon-gamma release assay (IGRA) testing and / or chest X-ray results
- ✓ Laboratory reports including Rubeola (Measles), Mumps, Rubella, Varicella, Hepatitis B titers
- ✓ Any other medical documentation needed to meet the occupational health requirements of the healthcare organization

This authorization for disclosure is effective until completion of my training with the Medical College of Wisconsin and/or termination of employment with Medical College of Wisconsin Affiliated Hospitals.

This information is for use by the recipient named below only. Records may not be released to any other individual or agency without written authorization. The party signing this release is entitled to receive a copy upon request. I understand that I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present my written revocation to the Froedtert & Medical College of Wisconsin Internal Occupational Health Department. I understand that the revocation will not apply to information that has already been released. I understand that if the persons or organizations I authorize to receive and/or use the protected health information described in this form are not health plans, covered health care providers or health care clearinghouses subject to the federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health law. I understand that I may refuse to sign this authorization, and that my refusal will not affect my ability to practice. I understand that my health information may be transmitted electronically.

Name (please print legibly):		Signature:	
Date:	Birth month and day:	Last four digits of SS number:	