

**Occupational Medicine Department
Health Event Report**

(Ref. WI 02.01.01.01.03, 10 CFR 712)

Employee Section

Privacy/HIPAA information on the back of form.

Circle current status

Employee must complete all entries in this section. (See reverse side for instructions.)

HRP – Yes No

I authorize release of all medical information relevant to this health event to the Pantex Occupational Medicine Department, and/or the Pantex Case Managers, for the purposes of determining my fitness for duty related to my current position and epidemiological tracking.

Employee Name (PRINT)		Employee Signature				Badge No.																									
Department Number	Job Title	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td></td><td>Mon</td><td>Tue</td><td>Wed</td><td>Thurs</td><td>Fri</td><td>Sat</td><td>Sun</td> </tr> <tr> <td style="text-align: center;">DATE</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td style="text-align: center;">HOURS</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>			Mon	Tue	Wed	Thurs	Fri	Sat	Sun	DATE								HOURS								Date(s) and number of hours of sick leave used (for epi/HRP)			
	Mon			Tue	Wed	Thurs	Fri	Sat	Sun																						
DATE																															
HOURS																															
Name of Supervisor		Supervisor's Phone Number																													

Reason report (example: physical exam, dental procedure, cold, fever, new medication, injury, illness, etc.)

List any medications taken as a result of this absence or write "None"

Does your present condition/illness prevent you from performing any requirement of your job safely and reliably?
Mark the appropriate answer.

NO _____ YES _____ If yes, then you must come to Medical for evaluation.

Health Care Provider's Section - - - This section is completed when a visit to a Health Care Provider is made or required.

Health Care Provider please complete all entries in this section.

Diagnosis: _____

Operative Procedure: _____ **Date:** _____

Medications: _____

- will allow the employee to Return to Work as of _____ (date) **without** restrictions.
- will allow the employee to Return to Work as of _____ (date) **with** recommendation/restrictions addressed below, which are expected to last through _____.
- Next Appointment _____

Recommendations/ Restrictions (if any)

(Please consider: posture, motion, lift/carry, vehicles/machinery, and hours)

Health Provider's Name (**Print**)

Time and Date of Visit

Health Provider's Signature / Title

Area Code

Phone Number

**Occupational Medicine Department Pantex Plant
P.O. Box 30020, Bldg. 12-2
Amarillo, TX 79120-0020
806-477-3049(Case Managers), -3033 (OMD- reception)**

Instructions to Employee:

This form is to be used **any time** a health event happens as listed in WI 02.01.01.01.03 Step 12 and/or 10 CFR 712.14. ❖ Bargaining personnel are also governed by their respective contracts.

The employee must complete **all** entries in the section labeled "Employee Section".

When you see a Health Care Provider, make sure that they complete **all** entries in the section labeled "Health Care Provider Section".

Note: Failure to comply with HRP requirements as noted above may jeopardize your HRP status, if applicable. Loss of HRP status may affect your ability to perform assigned job duties, and ultimately may adversely affect your employment with BWXT Pantex.

You are responsible to fax or personally deliver this form to the

Case Management - Occupational Medicine Dept. Bldg. 12-2;
Fax (806) 477-5188,

PRIVACY/HIPAA INFORMATION

By signing this form the listed employee authorizes his/her health care provider to disclose health information, as listed on the front of this form, to the Pantex Occupational Medicine Department. Disclosure of this information is protected by applicable federal and state laws, DOE orders, and plant standards. This information is for the purposes of determining the employee's fitness for duty as related to their current position, epidemiological tracking, and for determining approval of benefits. Treatment and payment of health care services are not affected by not signing this form. Any other use of this information without the written consent of the employee is prohibited. This consent may be revoked (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 180 days after the latest date listed on the front of this form unless otherwise specified in writing.