



**Department of  
Civil Service**

**EMPLOYEE HEALTH SERVICE**

Agency Request for  
Occupational/Mandatory Health Examinations

Reference # \_\_\_\_\_

EHS-699 (2/2011)

(518) 233-3100 General Information

(518) 233-3131 Fax

**PERSON REQUESTING EXAMINATION**

<b>Print Name:</b>		<b>Signature:</b>	
<b>Title:</b>		<b>Telephone #:</b>	<b>Fax #</b>
<b>Agency Name and Address:</b>			
<b>Agency Code</b>	<b>Cost Center</b>	<b>Division</b>	<b>Preferred Service Location</b>
<b>Agency Payment Coordinator's Name &amp; Address</b>			<b>Telephone #</b>
			<b>E-mail Address</b>
<b>Do you authorize payment for any additional special tests ordered by doctor?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>			
<b>Name of Scheduling Person</b>		<b>Telephone #</b>	<b>E-mail Address</b>

<b>Exposures</b>	<b>Exams For</b>	<b>Respirator Type</b>
<input type="checkbox"/> Solvents	<input type="checkbox"/> CERT/CCSERT/SORT	<input type="checkbox"/> Particulate Filter Respirator (Dust Mask)
<input type="checkbox"/> PCBs	<input type="checkbox"/> Firefighting	<input type="checkbox"/> Cartridge/Canister Filter Respirator (including M-17 and Avon C50)
<input type="checkbox"/> Asbestos	<input type="checkbox"/> Weapons Officer	<input type="checkbox"/> PAPR
<input type="checkbox"/> Lead	<input type="checkbox"/> Confined Space	<input type="checkbox"/> Supplied Air Respirator
<input type="checkbox"/> Pesticides/Herbicides	<input type="checkbox"/> SCUBA Diving	<input type="checkbox"/> SCBA
<input type="checkbox"/> Heavy Metals	<input type="checkbox"/> CDL Truck Driver	<input type="checkbox"/> All of the Above
<input type="checkbox"/> Noise	<input type="checkbox"/> Article 19A Bus Driver	
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	

**PROCESSING REQUIREMENTS**

**FOR EACH REQUEST:** Please provide the names and EHS account numbers for all employees using page 2 of this form. This form may be used to request services for multiple employees at the same location. Each group of employees should have the same **EXPOSURES** and/or **SERVICES** and/or **RESPIRATOR TYPE**.

**SPECIAL SCHEDULING REQUIREMENTS**

AM Only     PM Only    How many would you like scheduled each day?

**EHS INTERNAL USE ONLY**

<b>To Be Seen:</b>	<b>Services:</b>	<b>B-Read CXR/Asbestos Qu.</b>
<input type="checkbox"/> Cohoes Clinic	<input type="checkbox"/> Vital Signs	<input type="checkbox"/> CXR:PA and Lateral
<input type="checkbox"/> Hauppauge Clinic	<input type="checkbox"/> Vision (Binocular)	<input type="checkbox"/> ECG (age ≥ 40)
<input type="checkbox"/> Buffalo Clinic	<input type="checkbox"/> Vision (Complete)	<input type="checkbox"/> ECG (all)
<input type="checkbox"/> Syracuse Clinic	<input type="checkbox"/> Routine Bloodwork	<input type="checkbox"/> ECG Stress Test
<input type="checkbox"/> Binghamton Clinic	<input type="checkbox"/> PCB Levels	<input type="checkbox"/> MD/PA
<input type="checkbox"/> Brooklyn Clinic	<input type="checkbox"/> Lead/ZPP	<input type="checkbox"/> Bus Driver Article 19A Forms
<input type="checkbox"/> Utica Clinic	<input type="checkbox"/> RBC/Plasma Cholinesterase	<input type="checkbox"/> Truck Driver (CDL) Forms
	<input type="checkbox"/> Audiogram (STS Calculation)	<input type="checkbox"/> Other _____
No. of Exams _____	<input type="checkbox"/> Audiogram	
Notified _____	<input type="checkbox"/> PFT	

Reference # \_\_\_\_\_

Instructions: Please alphabetically list the last and first name of employee. Each person's EHS chart number must also be provided. If you don't know the EHS chart number, please provide the Social Security number. By contacting EHS at (518) 233-3105 a complete listing of EHS chart numbers for your agency's employees can be obtained.

LAST NAME	FIRST NAME	EHS CHART NUMBER	SOCIAL SECURITY NUMBER