NEW YORK STATE | **Department of Civil Service**

EMPLOYEE HEALTH SERVICE
Agency Request for
Occupational/Mandatory Health Examinations

Reference #_____ EHS-699 (1/2025)

(518) 233-3100 General Information **(518) 233-3131 Fax**

AGENCY REPRESENTATIVE REQUESTING EXAMINATION

Print Name:		**Signature:**	
Title:			**Phone Number:** ( ) -
Agency Name and Address:			**E-mail Address:**
Agency Code:	**Cost Center**	**Division:**	**Preferred Service Location:**
Agency Scheduler Name:		**Phone Number:** ( ) -	**E-mail Address:**
Agency Payment Coordinator Name:		**Phone Number:** ( ) -	**E-mail Address:**
Do you authorize payment for any additional special tests ordered by doctor?		***Yes*** ☐	***No*** ☐
Agency Representative to Receive Results:		**Phone Number:** ( ) -	**E-mail Address:**

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

To Be Seen:
__ Cohoes Clinic
__ Hauppauge Clinic
__ Buffalo Clinic
__ Syracuse Clinic
__ Brooklyn Clinic
__ Utica Clinic
__ EHS Consultants
__ Wende CF
__ Green Haven CF
__ Ogdensburg CF
__ Upstate CF
__ Shawangunk CF
__ Other_____

No. of Exams ____ Notified _____

Services:
__ Vital Signs
__ Vision (Binocular)
__ Vision (Complete)
__ Routine Bloodwork
__ PCB Levels
__ Lead/ZPP
__ RBC/Plasma Cholinesterase
__ Audiogram (STS Calculation)
__ Audiogram
__ PFT
__ B-Read CXR/Asbestos Qu.
__ CXR:PA and Lateral
__ ECG (age ≥ 40)
__ ECG (all)
__ ECG Stress Test
__ MD/PA
__ Bus Driver Article 19A Forms
__ Truck Driver (CDL) Forms
__ Other _____

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	DATE OF BIRTH	SOCIAL SECURITY NUMBER