Department of Civil Service

EMPLOYEE HEALTH SERVICE
Agency Request for
Mandatory Health Examinations

Reference # _________ EHS-792 (5/2006)

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

PERSON REQUESTING EXAMINATION

Print Name:	Signature:	
Title:	Phone:	Fax:

Agency Name and Address:

Agency Code:	Division:	Preferred Service Location:

Name of Agency Payment Coordinator for exam checked below:	Address:	Phone:

Do you authorize payment for any additional special tests ordered by doctor? ☐ YES ☐ NO

Name of Contact Person to Schedule Appointment:	Phone:

TYPE OF EXAM (PLEASE CHECK APPROPRIATE BOX)

- ☐ State Police (Complete)
- ☐ State Police Diver (Complete/PFT/Tonometry)
- ☐ Crisis Intervention (Complete)
- ☐ Unarmed Defensive Tactics (Complete)
- ☐ Shock Incarceration (Complete)
- ☐ ICC Bus Driver (Complete/Comp. Vision)
- ☐ ICC Tractor Trailer Driver (Complete/Comp. Vision)
- ☐ Other:

PROCESSING REQUIREMENTS

For ***each*** request, please attach a ***separate*** alphabetical listing of the names and social security numbers of employees. Each group of employees should require the same service.

SPECIAL SCHEDULING REQUIREMENTS

☐ A.M. Only ☐ P.M. Only Number to Schedule Each Day: _____

Other Requirements: ____
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PLEASE DO NOT WRITE ON THE REVERSE SIDE OF THIS FORM