



NYS Department of Civil Service
Employee Health Service
55 Mohawk Street – Suite 201
Cohoes, NY 12047

Agency Request for Mandatory Health Examinations

Reference # _____

EHS-792 (5/06)

(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? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Name of Contact Person to Schedule Appointment:			Phone:

TYPE OF EXAM (PLEASE CHECK APPROPRIATE BOX)

<input type="checkbox"/> State Police (Complete)	<input type="checkbox"/> Shock Incarceration (Complete)
<input type="checkbox"/> State Police Diver (Complete/PFT/Tonometry)	<input type="checkbox"/> ICC Bus Driver (Complete/Comp. Vision)
<input type="checkbox"/> Crisis Intervention (Complete)	<input type="checkbox"/> ICC Tractor Trailer Driver (Complete/Comp. Vision)
<input type="checkbox"/> Unarmed Defensive Tactics (Complete)	<input type="checkbox"/> 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

<input type="checkbox"/> A.M. Only	<input type="checkbox"/> P.M. Only	Number to Schedule Each Day: _____
Other Requirements: _____		

PLEASE DO NOT WRITE ON THE REVERSE SIDE OF THIS FORM