## **Employee Occupational Health Medical Form**

## **Employee Information** Name Employee ID Department Position/Title Date of Birth **Medical Information** Relevant Medical History **Current Medications** Known Allergies Immunization Status **Occupational Health Assessment** Workplace Exposure Risks

Personal Protective Equipment Needed

Fitness for Work	
	_
Recommended Adjustments	
Healthcare Provider	
Name of Healthcare Provider	
Signature	
Dete	
Date	