*To be returned to the Medical Department of SCK CEN at the latest 5 working days before accessing the technical site of SCK CEN !*

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| *By mail to:* |  | **The Medical Department****SCK CEN****Nuclear Research Centre****Boeretang 200****B-2400 MOL** |
| *E-mail :**Fax :****Telephone number :*** |  | medical@sckcen.be+ 32 14 32 10 40**+ 32 14 33 28 09** |

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| **A. Identification of the Internal/External Prevention Service - Medical Surveillance :** |
| Name : |   |
| Address : |   |
| Phone : |   |
| Fax : |   |
| Responsible physician : |   |

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| **B. Identification of the employee/employer :** |
| Surname and name (employee): : |   |
| Place and date of birth:  |   |
| Nationality: |   |
| Name and address (employer): compa: |   |
| Phone:  |   |
| Fax: |   |

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| **C. Medical history :** |
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| **D. Surgical interventions :** |
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| **E. Occupational accidents/accidental irradiations and radioactive contaminations, if any :** |
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| **F. Medical examinations and treatments using ionizing radiations :** |
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| **G. Professional history regarding exposure to ionizing radiations :** |
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| **H. Medical examination :** |
| Date of last examination : |   |
| * Summary of conclusions :
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|   |
| * Possible restrictions concerning aptitude :
 |
| * for using pressure suits or other (respiratory) protection equipment :
 |
| * for performing safety-related duties :
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| **I. Pregnancy and breast feeding :** |
| Female employees need to be informed about restrictions regarding pregnancy and breast feeding, in which case the Occupational Health Department of SCK CEN must be contacted. |

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| **J. Last Blood Analysis** (enclose protocol as annex) **:** |
| NOTE: WHEN EMPLOYED IN CONTROLLED AREAS, THE VALIDITY OF THE BLOOD ANALYSIS IS RESTRICTED TO A PERIOD OF 6 MONTHS ! |
| Date : |       | Hb : |   | g % |
|  |  | RBC : |   | /mm³ |
|  |  | Trombocytes : |   | /mm³ |
|  |  | Reticulocytes : |   | ‰ |
| Leucocytes : |   | /mm³ |  |  |
| Formula leucocytes | Neutr : |   | % |
|  | Ly : |   | % |
|  | Eo : |   | % |
|  | Baso : |   | % |
|  | Mono : |   | % |

|  |  |  |
| --- | --- | --- |
| Name physician | Date | Signature and stamp |
|   |   |  |
|  |  |  |