

## Request for Services for Postdoctoral Appointees

Name of Postdoctoral Appointee \_\_\_\_\_

School  GSBS  NJMS  SDM  SHP  SN  SPH  Other \_\_\_\_\_

Department \_\_\_\_\_

Cornerstone/PeopleSoft Codes: \_\_\_\_\_ Employee Number \_\_\_\_\_

Full Combo |\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_|

Location |\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_| Fund Type |\_\_\_\_|\_\_\_\_|\_\_\_\_| Business Line |\_\_\_\_|\_\_\_\_|\_\_\_\_|

Natural Account |\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_| Project |\_\_\_\_|\_\_\_\_|\_\_\_\_|\_\_\_\_| Task |\_\_\_\_|\_\_\_\_|\_\_\_\_|

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Dept Head/Principal Investigator)

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

Tel No: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

### Please Select Requested Services:

#### Preplacement Medical Evaluations\*:

\* Based on risk factors and potential exposures

Preplacement evaluation – History and animal contact evaluation (if applicable).

√ **NO** potential exposure to bloodborne pathogens AND

√ **NO** patient contact AND

√ **NO** tuberculosis exposure

Preplacement evaluation – History, physical, tuberculosis, and hepatitis B evaluation. Measles, mumps, rubella, varicella, and animal contact evaluation (if applicable).

√ Potential exposure to **bloodborne and/or airborne pathogens** (includes tuberculosis, hepatitis B, measles, mumps rubella, varicella) AND/OR

√ **Potential patient contact**

#### Other Available Services:

Post-needlestick or potential bloodborne pathogens exposure exam

Tuberculosis surveillance evaluation (including chest radiograph if indicated)

Hepatitis B vaccination (1 booster dose) and follow-up hepatitis B surface antibody

Hepatitis B vaccine series (3 doses) and follow-up hepatitis B surface antibody

Influenza vaccination

MMR vaccination

Varicella vaccination

Tetanus-diphtheria pertussis (Tdap)

Serologic titer (specify) \_\_\_\_\_

Other \_\_\_\_\_

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To be completed by NJMS Occupational Medicine Service:

Services Completed Charge: \$ \_\_\_\_\_

\_\_\_\_\_  
OMS Provider