

UNITED STATES DEPARTMENT OF AGRICULTURE  
AGRICULTURAL RESEARCH SERVICE

**OCCUPATIONAL MEDICAL SURVEILLANCE PROGRAM**  
**OCCUPATIONAL EXPOSURES**

(Please print all information)

**SECTION A (To be completed by employee)**

Name (Last, First, Middle Initial)		Social Security Number	Work Address (Include Laboratory, Building and Room)
Date of Birth	Title, Series, Grade		
Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Telephone Number	Mode Code (Levels 4-6) - -	

**SECTION B (To be completed by employee)**

Are you a respirator user? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what type? (Check all that apply) <input type="checkbox"/> Negative Pressure <input type="checkbox"/> PAPR <input type="checkbox"/> SCBA			Pesticide Applicator <input type="checkbox"/> Yes <input type="checkbox"/> No						
Name of Occupational Exposure (List all actual/potential occupational exposures with which you work. Use continuation sheet, if necessary)	CAS or EPA Number	Work Use (Note 1)	Route of Entry S, I, R (Note 2)	Frequency 1F 2F 3F 4F (Note 3)				Duration 1D 2D 3D (Note 4)		

Specify other work use:

Note 1 (Work Use): FM-Fume Hood, BT-Bench Top, BS-Back Sprayer, T-Tractor, BSC-Biological Safety Cabinet, O-Outdoors, Other; Note 2 (Route of Entry): S-Skin, I-Ingestion, R-Respiratory; Note 3 (Frequency): 1F-Daily, 2F-Weekly, 3F-Monthly, 4F-Seasonally; and Note 4 (Duration): 1D-Less than 1 hour, 2D-1 to 8 hours, 3D-More than 8 hours.

**SECTION C (To be completed by employee)**

<input type="checkbox"/> I wish to be voluntarily enrolled in the recommended participation program.	Signature	Date
<input type="checkbox"/> I wish to continue voluntary enrollment.		
<input type="checkbox"/> No, I do not want to be enrolled.		

**SECTION D (To be completed by employee's supervisor)**

I have reviewed the information provided by the employee and certify that it is accurate to the best of my knowledge.

Recommended Participation <input type="checkbox"/> Yes <input type="checkbox"/> No		
Address	Signature	Telephone Number
		Date

[illegible]

Form ARS-182A/B (Rev. 9/2001)  
Previous edition not usable

## INSTRUCTIONS FOR COMPLETING ARS-182A/B, OCCUPATIONAL MEDICAL SURVEILLANCE PROGRAM - OCCUPATIONAL EXPOSURES

**Employee.** Please print or type all information requested. If you have more than 10 items to list in Section B, use the ARS-182 A/B Continuation Sheet, as needed. On the Continuation Sheet, please fill in your "Name, Social Security Number, Telephone Number and the Date."

### SECTION A

If you can not answer a question, please contact your supervisor, Occupational Medical Surveillance (OMS) Coordinator or Location Administrative Officer (LAO) for assistance. Some information may have already been completed for you. For example: Mode Code.

### SECTION B

Provide as much information as possible. List actual/potential exposures to: Chemical Hazards (e.g., pesticides, solvents, etc.); Other Hazards (e.g., asbestos and any other respiratory hazards); Physical Hazards (e.g., noise, lasers, radiation, etc.); Biological Hazards (e.g., rabies, human blood and body fluids, etiologic agents, exposure to animals, etc.); and any exposures to chemicals where an alteration of health status may occur. Do not give general descriptions such as pesticides, chemicals, dust, or noise. Please give as detailed a description as possible. Samples are as follows:

General Descriptions	Detailed Information
Pesticide	Admire 2F
Chemicals	MethylAlcohol
Dust	Cotton Dust
Noise	Work with a Kalamazoo Band Saw that is labeled as noise hazardous.

Chemical names should be obtained from the Material Safety Data Sheet (MSDS) for the product. The MSDS also provides the CAS number, etc. Names of pesticides are provided on the label and the MSDS. If pesticides are registered, they will have a number assigned by EPA.

**Chemical Abstract Serial Number or Environmental Protection Agency Number (CAS or EPA Number).** If the product is a laboratory chemical, it should have a CAS number unless it is a compound comprised of two or more chemicals or a CAS number has not been assigned. For all registered pesticides, there is an EPA number assigned. Refer to the MSDS or labeling information for these numbers.

**Work Use.** Use one or more of the following: FM-Fume Hood, BT-Bench Top, BS-Back Sprayer, T-Tractor, BSC-Biological Safety Cabinet, O-Outdoors or Other designation to describe how you use the item listed. Please be as specific as possible.

**Route of Entry.** Use one or more of the following: S-Skin Exposure, I-Ingestion Exposure or R-Respiratory exposure. Please use combinations of these three main routes to better describe your specific situation.

**Frequency.** Use one of the following: F1-Daily, F2-Weekly, F3-Monthly or F4-Seasonally.

**Duration** (of possible exposure per day). Use one of the following: 1D-less than 1 hour, 2D-less than 8 hours, 3D-greater than 8 hours. Do not use < and > signs.

**NOTE:** For potential or actual exposures due to spills, equipment failures, etc., attach any available documentation showing the date and the amount of spill or accidental exposure.

### SECTION C

Indicate your interest in participating in the OMSP Recommended Participation Program.

- If you are new to the OMSP, check "I wish to be voluntarily enrolled in the Recommended Participation Program."
- If you are already enrolled in the OSMP, check "I wish to continue voluntary enrollment."
- If you do not want to participate, check "No, I do not want to be enrolled."

### SECTION D

Review the information provided on this form with your employee. Make corrections, as necessary. Have employee initial any changes. Determine if recommended participation is appropriate. Sign, complete address, telephone number, and date in area provided in this section. If you have any questions, contact your LAO or Safety Personnel.

**Required Examinations.** Some employees may be initially required to take a physical examination due to their work environment as covered by Occupational Safety and Health Administration (OSHA) or other regulatory standards. For example, OSHA requires a physical examination if employees must use a respirator when performing their duties.

**Recommended Participation.** If you decide to enroll and later decide to withdraw at some later date, there will be no effect on your job status or rights.

## PRIVACY ACT NOTIFICATION

**Authority:** The Medical Review Officer (FOH/DHHS) is authorized by the Occupational Safety and Health Act of 1970 and by 5 USC 301 to obtain personal medical information from ARS employees.

**Purpose:** The program is designed to protect Agency employees from actual or potential occupational exposures in their work environment and to reduce these actual/potential exposures. The medical information collected is necessary in making accurate medical determinations and conclusions about the impact on employees of actual or potential exposure to possible biological, chemical, and physical threats. Medical records maintained will document health status, changes in physical conditions through the years, and provide an account of any care rendered, advice given, and consultations recommended. The physical examination and laboratory tests provided by this program are not intended to substitute for the care provided by a personal physician.

**Routine Uses:** The information may be disclosed to authorized medical professionals to determine unusual susceptibility to illness or injury from exposures in the work environment, to determine medical suitability of assignments, to permit identification of potentially harmful effects of toxicants used, and to provide medical treatment and advice. It may be disclosed to appropriate public health agencies to conduct epidemiologic studies and research.

**Effects of non-enrollment:** If you choose not to enroll or if you decide to withdraw at some later date, there will be no effect on your job status or rights. Failure to take a physical examination required by OSHA regulations will result in appropriate administrative action (see Section D, Required Examinations, above).