OCCUPATIONAL HEALTH PERMIT

PRIVACY ACT STATEMENT

Information contained on this form is maintained under the systems of records notice OPM/GOVT-2, Employee Performance File System Records (June 19, 2006, 71 FR 35347). **AUTHORITY**: Sections 1104, 3321, 4305, and 5405 of Title 5, U.S. Code, and Executive Order 12107. **PRINCIPLE**: Written recommendations for awards, removals, demotions, denials of within-grade increases, reassignments, training, pay increases, cash bonuses, or other performance-based actions (e.g., nominations of SES employees for Meritorious or Distinguished Executive), including supporting documentation. **PURPOSE**: These records are maintained to ensure that all appropriate records on an employee's performance are retained and are available (1) To agency officials having a need for the information; (2) to employees; (3) to support actions based on the records; (4) for use by the Office in connection with its personnel management evaluation role In the executive branch; and (5) to identify individuals for personnel research. **ROUTINE USE**: To consider and select employees for incentive awards, quality-step increases, merit increases and performance awards, or other pay bonuses, and other honors and to publicize those granted. This may include disclosure to public and private organizations, including news media, which grant or publicize employee awards or honors. **DISCLOSURE**: Mandatory for processing awards in the system.

INSTRUCTIONS

1. Supervisor completes Section I and contacts Occupational Health Clinic to schedule an appointment.
2. Injured/Ill employee takes Occupational Health Permit to Occupational Health Clinic at time of appointment.
3. Upon return to work center, provide the Occupational Health Permit (with Section II completed) to the employee's Supervisor with one copy to CHRO-E and one copy to MCIEAST-MCB CAMLEJ Safety Department.
4. If an Occupational Injury, Form CA-17 with completed "Side A" must also be submitted.

SECTION I TO BE COMPLETED BY SUPERVISOR

TO: Occupational Health Nurse, Occupational Health Clinic, Bldg 65, MCB Camp Lejeune

FROM: (Title of Supervisor, Shop or Office, and Location)

NAME OF EMPLOYEE: (First, Middle, Last)	EMPLOYEE ID NUMBER (MCCS)	DOD ID (EDIPI)
JOB TITLE:	TIME LEFT JOB:	TIME RETURNED:

REASON FOR REFERRAL: INJURY ILLNESS EMPLOYEE REQUEST OTHER (SPECIFY BELOW)

DATE OF INJURY:	TIME OF INJURY:	DATE REFERRED TO CLINIC:	OCCUPATIONAL: YES NO QUESTIONABLE

REMARKS:

NAME OF SUPERVISOR:	SIGNATURE:	PHONE NUMBER:	DATE:

SECTION II TO BE COMPLETED BY MEDICAL PROVIDER

TIME REPORTED:	TIME RELEASED:	OCCUPATIONAL: ☐ YES ☐ NO ☐ QUESTIONABLE

DEGREE OF INJURY:
☐ FIRST AID ☐ DISPENSARY ☐ HOSPITAL ☐ PERSONAL PHYSICIAN ☐ SENT HOME ☐ OTHER

DISPOSITION OF EMPLOYEE

☐ RETURN FOR FURTHER TREATMENT: TIME: DATE:

☐ RETURN TO WORK

☐ DISCHARGED, TREATMENT COMPLETED

☐ RETURN TO LIMITED DUTY AS INDICATED BELOW	☐ DESK JOB ONLY
☐ NO LIFTING, PULLING OR CARRYING IN EXCESS OF LBS	☐ NO DRIVING GOVERNMENT VEHICLE
☐ NO EXCESSIVE WALKING, STANDING OR BENDING	☐ NO WORKING AROUND MOVING MACHINERY
☐ NO EXPOSURE TO SOLVENTS, GREASES, OILS, DETERGENTS, ETC.	☐ NO WORKING ON LADDERS, SCAFFOLDING, ETC.
☐ NO WALKING ON UNEVEN OR SLIPPERY SURFACES	☐ NO OVERHEAD WORK
☐ NO EXPOSURE TO EXTREME TEMPERATURE OR HUMIDITY	☐ OTHER (EXPLAIN IN REMARKS)

REMARKS:

NAME OF MEDICAL PROVIDER:	SIGNATURE OF MEDICAL PROVIDER	DATE: (DD MM YY)