

Northwestern University Clinical Passport

Please print clearly.

EMPLOYEE'S INFORMATION

Last Name	First Name	MI	ID Number	Birth Date	Email

Street Address	City	State	Zip	Personal Phone	CCM Employee?
					<input type="checkbox"/> YES <input type="checkbox"/> NO

DEPARTMENT INFORMATION

Department/Lab	Manager / PI's Name	Manager / PI's Phone	Manager / PI's Signature

Department Address	City	State	Zip

SERVICE REQUESTED

- | | |
|--|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Titer for Immunity <ul style="list-style-type: none"> <input type="radio"/> Rubella <input type="radio"/> Rubeola <input type="radio"/> Mumps <input type="radio"/> Varicella <input type="radio"/> Hepatitis B <input type="checkbox"/> Hepatitis B Vaccine Series <input type="checkbox"/> TB Screening <ul style="list-style-type: none"> <input type="radio"/> Skin Test <input type="radio"/> Quantiferon <input type="checkbox"/> Mumps, Rubeola, Rubella (MMR) Vaccine Series <input type="checkbox"/> Annual TB Testing (ongoing) <input type="checkbox"/> Chest X-Ray (Two View) <input type="checkbox"/> CBC with Differential | <ul style="list-style-type: none"> <input type="checkbox"/> Chemistry Panel <input type="checkbox"/> Lab Animal Questionnaire Review / Physical <input type="checkbox"/> Injury Care for Work Related Incident <input type="checkbox"/> Pre-Employment Urine Drug Screen <ul style="list-style-type: none"> <input type="radio"/> 5 Panel <input type="radio"/> 10 Panel <input type="checkbox"/> Pre-Employment DOT Exam & Drug Test <input type="checkbox"/> Bi-Annual DOT Exam <input type="checkbox"/> Tetanus / Diphtheria Vaccine <input type="checkbox"/> Respiratory Physical <input type="checkbox"/> Audio Surveillance: Audiogram <input type="checkbox"/> Fitness for Duty Evaluation <input type="checkbox"/> Influenza Vaccine <input type="checkbox"/> Other: _____ |
|--|---|

Date of Injury/Exposure (if applicable): _____

NU CCM Protocol:
 TST or QFT once per year, or chest x-ray once every 3 years

AUTHORIZING SIGNATURE (Must be Signed with ChartString Account)

ChartString Account: _____

NU Director/Authorizing Person's Signature: _____ Date: _____

As an authorized signing agent for my organization, I guarantee payment in full for all services rendered by NMPG Corporate Health.

EMPLOYEE'S SIGNATURE

Employee's Signature: _____ Date: _____

By signing this form, I understand that the above requested services are being provided to me as an employee of Northwestern University and that the proof of completion and/or results of these services will be reported to and maintained by my employer in accordance with Federal, State, and local regulations.