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U.S. DEPARTMENT OF ENERGY

10 CFR PART 850 — APPENDIX A
CHRONIC BERYLLIUM DISEASE PREVENTION PROGRAM INFORMED CONSENT FORM

OMB Burden Disclosure Statement

I, _____ have carefully read and understand the attached information about the Be-LPT and other medical tests. I have had the opportunity to ask any questions that I may have had concerning these tests.

I understand that this program is voluntary and I am free to withdraw at any time from all or any part of the medical surveillance program. I understand that the tests are confidential, but not anonymous. I understand that if the results of any test suggest a health problem, the examining physician will discuss the matter with me, whether or not the result is related to my work with beryllium. I understand that my employer will be notified of my diagnosis only if I have a beryllium sensitization or chronic beryllium disease. My employer will not receive the results or diagnosis of any health conditions not related to beryllium exposure.

I understand that, if the results of one or more of these tests indicate that I have a health problem that is related to beryllium, additional examinations will be recommended. If additional tests indicate I do have a beryllium sensitization or CBD, the Site Occupational Medical Director may recommend that I be removed from working with beryllium. If I agree to be removed, I understand that I may be transferred to another job for which I am qualified (or can be trained for in a short period) and where my beryllium exposures will be as low as possible, but in no case above the action level. I will maintain my total earnings, seniority, and other benefits for up to two years if I agree to be permanently removed.

I understand that if I apply for another job or for insurance, I may be requested to release my medical records to a future employer or an insurance company.

I understand that my employer will maintain all medical information relative to the tests performed on me in segregated medical files separate from my personnel files, treated as confidential medical records, and used or disclosed only as provided by the Americans with Disability Act, the Privacy Act of 1974, or as required by a court order or under other law.

I understand that the results of my medical tests for beryllium will be included in the Beryllium Registry maintained by DOE, and that a unique identifier will be used to maintain the confidentiality of my medical information. Personal identifiers will not be included in any reports generated form the DOE Beryllium Registry. I understand that the results of my tests and examinations may be published in reports or presented at meetings, but that I will not be identified.

I consent to having the following medical evaluations:

/ / Physical examination concentrating on my lungs and breathing

/ / Chest X-ray

/ / Spirometry (a breathing test)

/ / Blood test called the beryllium-induced lymphocyte proliferation test or Be-LPT

/ / Other test(s). Specify: _____

Signature of Participant _____ Date _____

I have explained and discussed any questions that the employee expressed concerning the Be-LPT, physical examination, and other medical testing as well as the implications of those test.

Name of Examining Physician: _____

Signature of Examining Physician: _____

Date: _____