

NAME

Last		First		Middle	SOCIAL SECURITY NO.	OPERATING UNIT & LOCATION	
DATE OF BIRTH		DATE EMPLOYED		JOB ASSIGNMENT			DATE

AUDIOLOGICAL HISTORY

OCCUPATIONAL HISTORY (Beginning with last previous, working back to first job.)				DATES OF SERVICE	NOISE EXPOSURE		EAR PROTECTORS	
	EMPLOYER	CITY	DUTIES		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
1.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MILITARY SERVICE		TIME SERVED	BRANCH (OTHER)		EXPOSURE TO GUNFIRE AND NOISE <input type="checkbox"/> YES <input type="checkbox"/> NO			
			<input type="checkbox"/> ARMY <input type="checkbox"/> NAVY <input type="checkbox"/> MARINES <input type="checkbox"/> AIR FORCE					

CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING:

- ALLERGY
- DIABETES
- MUMPS
- HEARING LOSS IN FAMILY
- MEASLES
- SCARLET FEVER
- WHOOPING COUGH
- HAVE YOU OR ANY MEMBER OF YOUR FAMILY HAD ANY EAR OPERATIONS? YES NO
- MENINGITIS
- ENCEPHALITIS
- HEAD INJURY

HAVE YOU EVER BEEN NOTIFIED THAT YOU HAVE A HEARING LOSS?
DATE _____

SEVERE OR PROLONGED ILLNESS

DESCRIBE: _____

CHECK IF YOU NOW HAVE ANY OF THE FOLLOWING:		
<input type="checkbox"/> PAIN IN EARS	<input type="checkbox"/> EAR DISCHARGE	<input type="checkbox"/> RINGING IN EARS
<input type="checkbox"/> TAKING ANY MEDICATIONS NAME _____		

NON-OCCUPATIONAL NOISE EXPOSURE	YES	NO	HOW OFTEN?
HUNTING OR SHOOTING			
LOUD MUSIC			
SNOWMOBILE			
AIRPLANE			
MOTORCYCLE			
OTHER			
PREVIOUS HEARING TEST	DATE	COMPANY	

IS YOUR HEARING	<input type="checkbox"/> GOOD	<input type="checkbox"/> FAIR	<input type="checkbox"/> POOR
ARE YOU NOW USING EAR PROTECTION?	<input type="checkbox"/> YES, TYPE USED _____		<input type="checkbox"/> NO (IF NO, EXPLAIN BRIEFLY)

A Federal agency may not conduct or sponsor, and a person is not required to respond to, nor shall a person be subject to a penalty for failure to comply with an information collection subject to the requirements of the Paperwork Reduction Act of 1995 unless the information collection has a currently valid OMB Control Number. The approved OMB Control Number for this information collection is 0693-0080. Without this approval, we could not conduct this information collection. Public reporting for this information collection is estimated to be approximately 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the information collection. All responses to this information collection are voluntary. Send comments regarding this burden estimate or any other aspect of this information collection, including suggestions for reducing this burden to the National Institute of Standards and Technology, Attn: Stephen Banovic, stephen.banivc@nist.gov.

Privacy Act Statement

Authority: The collection of this information is authorized under The National Institute of Standards and Technology Act, as amended, 15 U.S.C. 271 et seq. (which includes Title 15 U.S.C. 272) and section 12 of the Stevenson-Wydler Technology Innovation Act of 1980, as amended, 15 U.S.C. 3710a. Includes the following, with all revisions and amendments: 5 U.S.C. 301; 44 U.S.C. 3101; E.O. 12107, E.O. 13164, 41 U.S.C. 433(d); 5 U.S.C. 5379; 5 CFR Part 537; DAO 202-957; E.O. 12656; Federal Preparedness Circular (FPC) 65, July 26, 1999; DAO 210-110; Executive Order 12564; Public Law 100-71, dated July 11, 1987. Executive Orders 12107, 12196, and 12564 and 5 U.S.C. chapters 11, 33, and 63.

Purpose: The Office of Safety, Health, and Environment (OSHE) supports the National Institute for Standards and Technology in carrying out its mission safely and in maintaining safety as an integral core value and vital part of the NIST culture. The NIST Health Unit will use this information to record medical or health information for individuals seeking medical care on NIST campus; for recording of medical or safety equipment or incidents; to refer information required by applicable law to be disclosed to a Federal, State, or local public health service agency, concerning individuals who have contracted certain communicable diseases or conditions. Such information is used to prevent further outbreak of the disease or condition; to disclose information to the appropriate Federal, State, or local agency responsible for investigation of an accident, disease, medical condition, or injury as required by pertinent legal authority; to disclose information, when an individual to whom a record pertains is mentally incompetent or under other legal disability, to any person who is responsible for the care of the individual, to the extent necessary; to disclose to the Office of Workers' Compensation Programs in connection with a claim for benefits filed. Disclosure of this information is also subject to all the published routine uses as identified in the Privacy Act System of Records Notices:

Commerce/DEPT-18: Employees Personnel Files Not Covered by Notices of Other Agencies

OPM/GOVT-10: Employee Medical File System Records

Disclosure: Furnishing this information is voluntary. For Health Unit information collections, individuals have opportunity to decline providing information, however, care may be affected and future retrievability will be impacted. Submitting voluntary information constitutes your consent to the use of the information for the stated purpose. When you submit the form, you are indicating your voluntary consent for NIST to use of the information you submit for the purpose stated.

NIST-426 (REV. 4-2021)