



To the *Servizio Prevenzione e Protezione* of  
the *Università degli Studi di Firenze*

To the Resident Physician of  
the *Università degli Studi di Firenze*

**Form for Access to the Department**

**Personal details**

Name

Surname

**Type of contract:**

**- Permanent contract**

- Technical
- Research
- Faculty
- Other.....

**- Temporary contract**

- Specialization (*Specializzazione*)
- Doctorate
- Graduate Fellowship
- Scholarship
- Teaching
- Internship
- Other.....

**Term of office (only for terminable contract):** from \_\_\_\_\_ to \_\_\_\_\_

**The above mentioned employment/study relationship is established with:**

- the Università degli Studi di Firenze
- another entity (please specify) \_\_\_\_\_

**Address** \_\_\_\_\_

**Telephone number** (preferably a mobile) \_\_\_\_\_

**E-mail:** \_\_\_\_\_

**Research Unit** (please indicate the research coordinator) \_\_\_\_\_

**Research Project** \_\_\_\_\_

**Vaccinations**

Tetanus vaccine  yes  no

Please specify the date of the vaccine or last booster: \_\_\_\_\_

Hepatitis B Vaccine  yes  no

Please specify the date of the vaccine or last booster: \_\_\_\_\_



Other vaccinations: \_\_\_\_\_

**Allergies** \_\_\_\_\_

**Medical surveillance**

You are currently under the medical surveillance of:

- this University.
- another entity (please specify): \_\_\_\_\_.
- I am currently under no medical surveillance.

**Occupational hazards**

Please tick the risks you are exposed to during your activities at the Department.

**VDT** (use of a video terminal for at least 20 hours per week)

- yes                       no

**Chemical**

- yes                       no

**Biological**

- yes                       no

If yes, please specify whether samples of human origin are being used:  yes                       no

**MOGM (genetically modified microorganisms)**

- yes                       no

**Carcinogens and Mutagens**

- yes                       no

If yes, please specify:

1) Type of substance or preparation \_\_\_\_\_

2) Quantity used \_\_\_\_\_

3) Duration of exposure \_\_\_\_\_

**Noise**

- yes                       no

**Manual labor moving heavy loads**

- yes                       no

**Artificial optical radiation**

- yes                       no

If yes, please specify (e.g. laser, UVA, UVB, etc.) \_\_\_\_\_



**Electromagnetic fields**

yes  no

**Vibrations**

yes  no

**Asbestos**

yes  no

**Ionizing radiations**

yes  no

If yes, please specify which legal entity provides radioprotection:

Università degli Studi di Firenze

I.N.F.N.

other (please specify) \_\_\_\_\_

**Date:** \_\_\_\_\_

Signature of worker

\_\_\_\_\_

Signature of the Director of the Department/  
Signature of the research coordinator

\_\_\_\_\_

I, the undersigned, \_\_\_\_\_, declare that I am informed that the data furnished in submitting this access form will be employed for the purposes of Medical Surveillance as per University regulations, in application of the code protecting personal information promulgated by the *Rettore* with his decree no. 449 (33210) of 7 July, 2004 and modified by his Decree no. 1177 (79382) of 29 December, 2005; and as per the University Regulation governing the use of sensitive and judiciary data, in application of the National Decree 196/2003, promulgated by the *Rettore* with his Decree no. 337 (25798) of 15 M y, 2006.

Signature of worker

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