

## AUTHORISATION FORM - OCCUPATIONAL HEALTH SERVICES IN NUS

1. Each staff/student requesting OH services is to submit an authorisation form to their PI or Lab Supervisor or HOD for approval.
2. The staff/student should make an appointment with the Occupational Health Clinic. For vaccinations and form submission, there is no need to make any appointment.
3. Please inform the Occupational Health Clinic if you cannot make it for your appointment. Repeat defaults will be recorded.
4. On the day of the appointment, the staff/student should bring the signed Authorisation Form and any other relevant documents e.g. Safety Data Sheets.
5. Staff/Student is required to report the work-related injury/illness/exposure online within 24 hours. Please refer to Accident and Incident Management System (AIMS) at [https://inetapps.nus.edu.sg/osh/portal/eServices/ehs360\\_aims.html](https://inetapps.nus.edu.sg/osh/portal/eServices/ehs360_aims.html)

### Our Address

**The Occupational and Diving Medicine Centre (OH Clinic)**  
Basement of University Health Centre (Next to Dental Clinic)  
20 Lower Kent Ridge Road Singapore 119080.

### Clinic Operating Hours

Mon – Fri 8.30am – 12.30pm, 2pm – 5.30pm  
**Physician consultations will be by appointment basis.**

### Queries/Appointments

Ms Goh Sha Wee @ [goh.shawee@nus.edu.sg](mailto:goh.shawee@nus.edu.sg) DID: 6601 1781  
Nurse Kim @ [nursekim@nus.edu.sg](mailto:nursekim@nus.edu.sg) DID: 6516 7333

### Particulars of Staff/Student (Please use separate sheet for names if insufficient space)

Department: \_\_\_\_\_ Faculty/School/Research Institution or Centre: \_\_\_\_\_  
Name of Staff/Student: \_\_\_\_\_ NRIC/FIN: \_\_\_\_\_ DOB (dd/mm/yy): \_\_\_\_\_  
NUS Staff no. / Matric no.: \_\_\_\_\_ NUS Email Address: \_\_\_\_\_  
Declaration: I declare the OH Services requested below is resulting from my research/work-related/education activities (Signature): \_\_\_\_\_

### Medical assessment or treatment required:

- |  |  |
|--|--|
| <input type="checkbox"/> Work-related injury, illness or exposures<br><input type="checkbox"/> Fitness to Work Medical Evaluation<br><input type="checkbox"/> WHMQ (Work Health Medical Questionnaire) Evaluation<br><input type="checkbox"/> Statutory Medical Evaluation (please specify health hazard): _____<br><input type="checkbox"/> Respirator Fit test, Spirometry, ECG and Fitness Evaluation<br><input type="checkbox"/> Investigations eg. TB testing, allergy test (please specify): _____<br><input type="checkbox"/> Medical evaluation & investigations/vaccinations (if required) – BSL3 / Animal Husbandry / Animal Research / BSL2 Work / SDE / Chemotherapeutic drugs / Others: _____ | <input type="checkbox"/> Hepatitis B screening / Vaccinations / Post screening<br><input type="checkbox"/> Tetanus Vaccination<br><input type="checkbox"/> Other vaccination (please specify): _____<br><input type="checkbox"/> Diving Medical Evaluation<br><input type="checkbox"/> Medical examination for Ionizing radiation license application. Please download form from <a href="http://www.nea.gov.sg/services-forms/licences-permits-building-plan-clearances/radiation">http://www.nea.gov.sg/services-forms/licences-permits-building-plan-clearances/radiation</a><br><input type="checkbox"/> Medical examination for laser license application. Please download form from <a href="http://www.nea.gov.sg/services-forms/licences-permits-building-plan-clearances/radiation">http://www.nea.gov.sg/services-forms/licences-permits-building-plan-clearances/radiation</a><br><input type="checkbox"/> Others (please specify): _____ |
|--|--|

### Approval by PI/Safety Officer/Department

#### ^ Name of Safety & Health Officer:

The request for the above medical assessment/management is  Supported  Not Supported (Reason: \_\_\_\_\_)

^ - Please seek the Safety & Health Officer's support if it is mandatory by the respective Deans.

Name of PI / Supervisor: \_\_\_\_\_ Department : \_\_\_\_\_  
Faculty/School/Research Institution or Centre (where research fund is managed) : \_\_\_\_\_  
WBS Number of research grant (provide Faculty/School/Research Institute or Centre for rebilling if applicable): \_\_\_\_\_  
PI / Supervisor Contact no: \_\_\_\_\_ PI NUS Email Address: \_\_\_\_\_  
The request for the above OH services is  Verified & Approved\*  Not Approved

\_\_\_\_\_  
Signature of PI or Supervisor or Authorised Person

\_\_\_\_\_  
Date

\*it is needed to fulfil the requirements as stipulated in the NUS OH Programme ( <https://inetapps.nus.edu.sg/osh/portal/oh/intro.html> )

**Billing Process: University Health Clinic will bill Faculty/School/Research Institute or Centre on a monthly basis. Faculty/School/Research Institute or Centre may subsequently cost recover from the PI's research grant.**