This protocol was developed 6/01 to comply with BNL's requirement for medical review of personnel who are exposed to Static Magnetic Fields. Rev 2/14 - Form will be used for employees and non-employees.

Employees are identified to be included in this medical protocol by their supervisor by checking "Static Magnetic Fields" on the OMC Job Assessment Form. This is a required medical protocol for identified employees. Status will be recorded on the BNL Training Database (Completed/Qualified or Other/Pending).

Approval for work in Static Magnetic Field areas will be in effect for twelve months or until the last physical examination at the OMC, whichever occurs first. Employees or their supervisors may request a re-evaluation of approval status if there is a change in an employee's health status.

Employees will need to complete the attached form, which will then be reviewed by the examining OMC physician. Any restrictions or limitations on work in Static Magnetic Field areas should be reviewed with the Manager or Deputy Manager of OMC before issuance of written restrictions or limitations. Permanent limitation recommendations must be approved by OMC Manager or Deputy Manager.

Reference MRISafety.com to look up safety of implanted metal.

Actions for This protocol:

Protocol completed at time of OMC physical examination
Re-evaluation as needed at supervisor's or employee's request

OMC physician should complete and sign:

_____ Protocol Completed/Qualified
_____ Protocol Not Qualified
_____ Protocol Other/Pending (includes Not Qualified)

Employees not cleared for work in Static Magnetic Field areas should be so advised. Supervisor notification is required.

_____ Restricted duty form sent (temporary; establish date for follow-up)
_____ Permanent Limitation recommended (Approved by OMC Manager)

OMC Physician Signature ___________________________ Date _____________
This form to be completed by anyone working in a static magnetic field area. The purpose of this questionnaire is the detection of medical devices, conditions or procedures that may result in adverse effects in a magnetic field.

Please check any of the following items relevant to your health. These will be discussed with you and clarified by the OMC physicians at the time of your routine examination at the OMC. You may use the space at the bottom of this form to write in details.

Have you had any surgery other than dental surgery? ___ Yes ___ No (If yes, date and type of surgery):

Have you had a diagnostic MRI in the past year? Y/N (If yes, date ________ reason _________________________________.)

Have you served as an experimental subject at a BNL MRI in the past year? Y/N

Have you ever entered the MRI ring as an employee (non-subject)? Y/N

If yes, approximate date(s) (month/year) __________________________

Have you experienced the following: dizziness/vertigo, metallic taste, nausea or flashing lights (visuals), when exposed to static magnetic fields? Y/N (If yes, explain _________________________________.)

Please check any that may apply to you:

_____ Cardiac Pacemaker/Defibrillator                 _____ Insulin Pump
_____ Surgical clips (aneurysm, brain, cardiac, vascular, other)  _____ Neurostimulators (Tens Unit)
_____ Joint replacement, joint prosthesis, or fractured bones treated with metal rods, metal plates, pins, screws nails or plates  _____ Body Piercings/Tattoos
_____ Spinal fusion performed using metal rods, metal plates, pins, screws or other metallic instrumentation  _____ Shrapnel injury
_____ Surgery involving insertion of a metal mesh  _____ Work grinding metal slivers or fragments
_____ Eye surgery or metal chips in the eye  _____ Shunts
_____ Cochlear implantation surgery  _____ Heart Valve
_____ Hearing aid  _____ Other ferromagnetic implants or other internal devices (explain below)
_____ IUD (Intrauterine Device)  _____ Diagnostic medical MRI studies in the past

Signature of employee: ________________________ Date: ________________

Reviewed by OMC Physician:

Signature: ________________________ Date: ________________