UNIVERSITÀ DEGLI STUDI FIRENZE
DIPARTIMENTO DI FISICA E ASTRONOMIA

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.) _____

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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

_____