New Jersey Department of Health
Consumer, Environmental and Occupational Health Service
PO Box 369
Trenton, NJ 08625-0369

OCCUPATIONAL AND ENVIRONMENTAL DISEASE, INJURY, OR POISONING REPORT BY HEALTH CARE PROVIDER

*INSTRUCTIONS: N.J.A.C. 8:58-1.5 requires a health care provider who diagnoses a person as having a disease, injury or poisoning listed therein to complete the Occupational and Environmental Disease, Injury, or Poisoning Report by Health Care Provider form with respect to the patient and submit the completed form to the Occupational Health Surveillance Unit within **30 days** of making the diagnosis. All information **MUST** be completed. Mail **complete** report to above address or fax to (609) 292-5677. See Additional Information sheet for clarification.*

Date of Report
____ / ____ / _____

SECTION I - PATIENT INFORMATION

Name of Patient *(Print)*

Date of Birth
____ / ____ / _____

Street Address

Age (If DOB Unavailable)

City | State | Zip Code

Home Telephone Number
( )

Sex
☐Male ☐Female

Race
☐ White ☐ American Indian/Alaskan Native ☐ Other
☐ Black ☐ Asian/Pacific Islander

Hispanic Origin
☐Yes ☐No ☐Unknown

SECTION II - DIAGNOSTIC INFORMATION

Date of Onset of Disease, Injury, or Poisoning
____/____/_____

Date of First Diagnosis
____/____/_____

Diagnosis
- ☐ Asbestosis
- ☐ Asthma, Suspected, Work-Related
- ☐ Asthma, Confirmed, Work-Related
- ☐ Hypersensitivity Pneumonitis
- ☐ Silicosis
- ☐ Unspecified/Other Pneumoconiosis
- ☐ Other Occupational Disease, Specify: _____

Work-Related:
- ☐ Carpal Tunnel Syndrome
- ☐ Fatal Injury
- ☐ Injury in Minors (Under Age 18)
- ☐ Unspecified Contact Dermatitis (Occupational)

Poisonings:
- ☐ Arsenic *(Complete Section III)*
- ☐ Cadmium *(Complete Section III)*
- ☐ Lead *(Complete Section III)*
- ☐ Mercury *(Complete Section III)*
- ☐ Pesticide
- ☐ Other Substance or Toxin Unspecified, Work-Related

SECTION III - HEAVY METAL TOXICITY

SAMPLE TYPE	ARSENIC		CADMIUM		LEAD *(16 Years of Age or Older)*		MERCURY	
	Reportable Level	Value (with Unit)	Reportable Level	Value (with Unit)	Reportable Level	Value (with Unit)	Reportable Level	Value (with Unit)
BLOOD	≥ .07 μg/mL		≥ 5 μg/L Whole Blood		≥ 5 μg/dL		≥ 2.8 μg/dL	
URINE	≥ 100 μg/L		≥ 3 μg/gram creatinine		≥ 32 μg/L		≥ 20 μg/L	

Name of Testing Laboratory, if Applicable

Telephone Number
( )

Street Address

Date Sample Taken
____ / ____ / _____

City | State | Zip Code

Date Sample Analyzed
____ / ____ / _____

SECTION IV - PLACE OF EXPOSURE / INJURY / ILLNESS

Workplace at which Exposure, Injury or Illness Occurred

Street Address | City | State | Zip Code

Job Title or Type of Work Performed by Patient

Dates of Employment
From: To:

Patient-Reported Cause of Symptoms

Is Patient still employed at workplace?
☐ Yes ☐ No ☐ Unknown

SECTION V - HEALTH CARE PROVIDER INFORMATION

Name of Health Care Provider (Print)

Telephone Number
( )

Facility Name

Facility Address | City | State | Zip Code

Comments by Health Care Provider (if any)