

UCSF OCCUPATIONAL HEALTH SERVICES

REQUEST FOR RECORDS

PHONE: 415.885.7580

ohs@ucsf.edu

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DATE: _____

NAME: _____
(PLEASE PRINT)

DATE OF BIRTH OR EMPLOYEE ID #: _____

SIGNATURE (required): _____ **CONTACT #:** _____

I am requesting:

Immunization records and TB tests/symptom review results

Other—Please let us know what you are requesting:

WHERE/HOW YOU WANT THE RECORDS SENT:

We are able to email immunization/TB results to your active UCSF mailbox only. We cannot email results to non-UCSF addresses.

UCSF email address: _____

FAX: _____

MAILING ADDRESS:
