UNIVERSITY OF CALGARY

# Personal Information Consent Form

Send completed form to confidential fax # 403-282-8603

## Staff Wellness – Occupational Health Nurse and Physician Audiometric and Pulmonary Testing

| PERSONAL AND CONTACT INFORMATION | | |
|---|---|---|
| Name: | ID#: | Date of birth: |
| Home phone or cell #: | E-mail address: | |
| Mailing address: | | |

### CONSENT TO COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

TO: The Governors of the University of Calgary (the "**University**")

AND TO: The University's occupational health nurse (the "**OH Nurse**")

AND TO: The University's occupational health physician (the "**OH Physician**")

I understand that the University intends to:

- ☐ provide me with free periodic **Audiometric Testing and Audiometric Testing Questionnaires**, in accordance with the *Occupational Health and Safety Code* (Alberta); and/or
- ☐ provide me with a free **Pulmonary Function Test (Spirometry) and Respiratory Health Questionnaire**, as a reasonably practicable safety measure prior to using a respirator while working at the University, in accordance with the *Occupational Health and Safety Act* (Alberta);

and that such testing and questioning is conducted by the University of Calgary's Staff Wellness Department. I further understand that in order to reduce the risk of hearing loss, and/or adverse health effects arising from the use of respirators, the University will monitor and assess the results of the above testing and questioning ("**Results**") through the OH Nurse and the OH Physician. I acknowledge that I have a responsibility to co-operate with the University for the purposes of protecting my health and safety.

I consent to the following by the OH Nurse and OH Physician:

- The collection of my Results through testing, for the purpose of monitoring and assessing my Results
- The use of my Results, for the purpose of monitoring and assessing my Results
- The exchange of my Results between the OH Nurse and OH Physician, for the purpose of monitoring and assessing my Results
- The disclosure of health and safety recommendations arising from my Results to the University's Staff Wellness Dept. and my department

I understand that the information will be collected, used and disclosed in accordance with applicable laws, including the *Freedom of Information and Protection of Privacy Act* and the University's Privacy Policy. Any questions regarding the gathering or use of this information can be directed to Staff Wellness at (403) 220-2918.

This consent will be valid for the duration of my employment with the University or until revoked by me in writing. A photocopy, electronic scan or other facsimile of this authorization is as valid as the original.

| Employee signature: | Date: |
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