Health Care
University of Missouri Health System

Please circle your employer:

University of Missouri Hospital & Clinics
School of Medicine
School of Nursing
School of Health Related Professions
Contract Employer _____
Other: _____

Please circle your worksite location:

University of Missouri Hospital & Clinics
Women's & Children's Hospital

Previous Employee? Yes ○ No ○

Full LEGAL Name (First, Middle, Last): _____

Home Address: _____

City: _____

State: _____

Zip Code: _____

Gender (check one): Male ○ Female ○ Other ○

Date of Birth: _____ **Social Security # (last 4 only)** _____

Phone number: _____

Email Address (primary): _____

Employee ID # or MU student ID# (if known): _____

Start Date/Orientation Date: _____

Job Title (if known): _____

Department (if known): _____

Authorization for Release of Information:

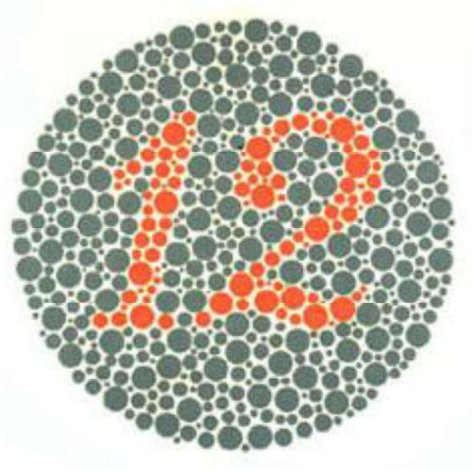
I authorize University of Missouri, Staff Health Services to release or obtain my information regarding my present condition of health as it relates solely to my immunization status, TB skin test result, and/or chest x-ray result. This release is voluntary, may be revoked at any time, and will be valid no longer than is reasonably necessary to accomplish the purpose for which it is given.

Signature: _____ **Date:** _____

Please complete all documents and return to umhshrstaffhealth@health.missouri.edu as soon as possible.

Ishihara's Test for Colour Deficiency
Concise Edition-Email

Type or write the number that you see inside each circle on the line to the right.
Submit to muhshrstaffhealth@health.missouri.edu when complete.



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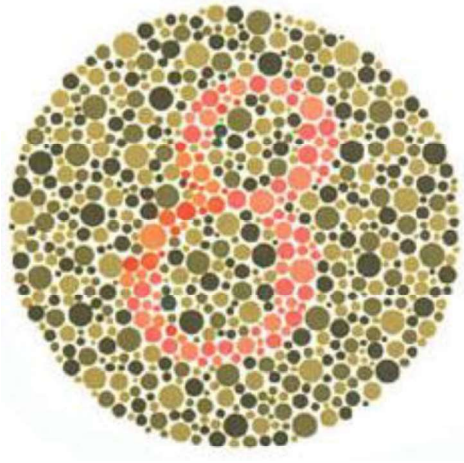

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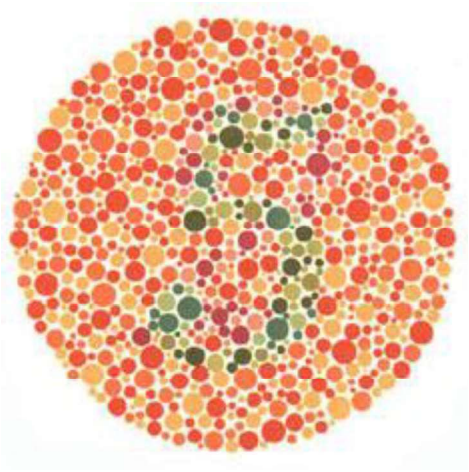

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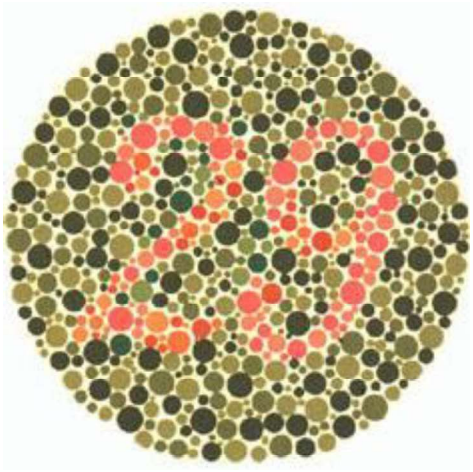

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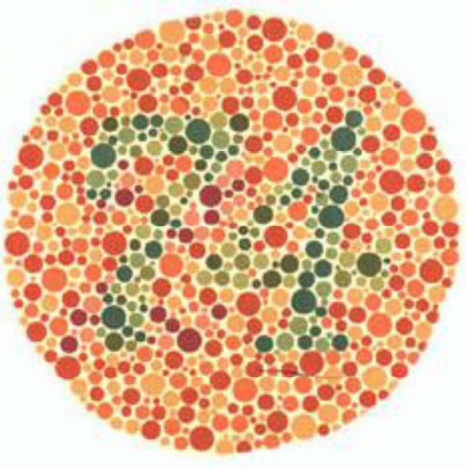

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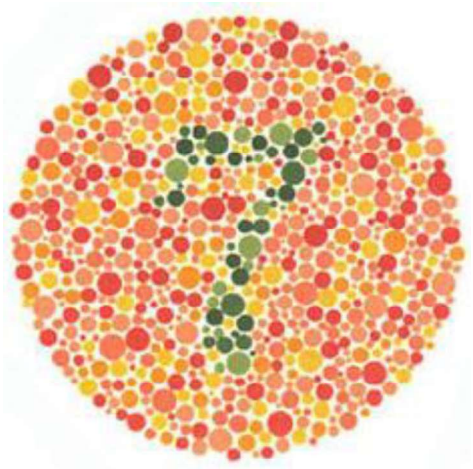

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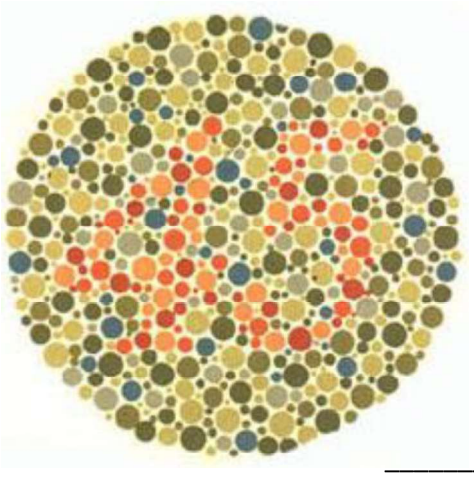
Ishihara's Test for Colour Deficiency

Concise Edition-Email



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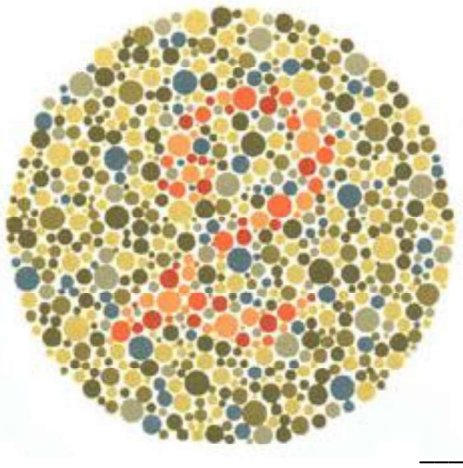

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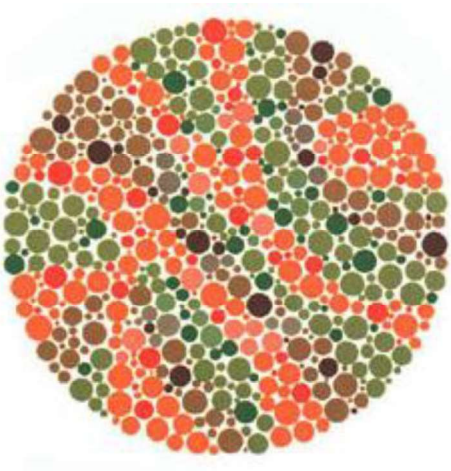

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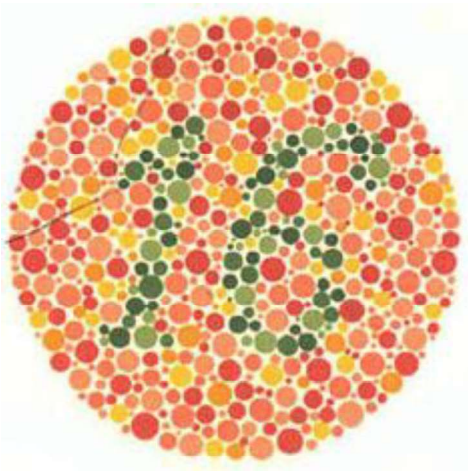

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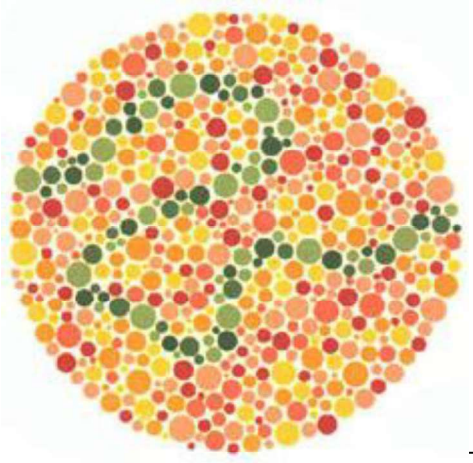

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By signing below, I attest that all answers given are accurate and true to the best of my ability. I completed this color vision screening on my own, with no assistance.

Name: _____

Date: _____