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(assine ao concordar) | | | | | | | | | | | | | | | | | | | | | | **Ass:** | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **EXAMES CLÍNICOS E COMPLEMENTARES (PREENCHER DE ACORDO COM O PCMSO)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | () Exame Médico | | | | | | | | | | | | | | | | | () Hemograma Completo | | | | | | | | | | | | | | | | | | | | | () TGP | | | | | | | | () Audiometria Tonal | | | | | | | | | | | | | | | | | () Espirometria | | | | | | | | | | | | | | | | | | | | | () Gama GT | | | | | | | | () Audiometria Vocal | | | | | | | | | | | | | | | | | () RX Tórax | | | | | | | | | | | | | | | | | | | | | () PPF | | | | | | | | () Acuidade Visual | | | | | | | | | | | | | | | | | () Eletroencefalograma | | | | | | | | | | | | | | | | | | | | | () Coprocultura | | | | | | | | () Avaliação Psicológica | | | | | | | | | | | | | | | | | () Eletrocardiograma | | | | | | | | | | | | | | | | | | | | | () VDRL | | | | | | | | () Toxicológico | | | | | | | | | | | | | | | | | () TGO | | | | | | | | | | | | | | | | | | | | | () Micológico de Unha | | | | | | | | **Caso não tenha o exame descrito preencher abaixo separando cada exame por virgula** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ( | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | |  | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | |  | | | Declaro que os riscos ocupacionais preenchidos nessa guia obedecem ao PPRA e ao PCMSO da empresa. (assine ao concordar) | | | | | | | | | | | | | | | | | | | | | **Ass:** | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **RISCOS OCUPACIONAIS (preencher conforme PPRA e PCMSO)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **() Não há riscos ocupacionais específicos para a atividade**  **() Há riscos ocupacionais para a atividade conforme quadro abaixo (caso haja, favor selecionar)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Físicos** | **Químicos** | **Biológicos** | **Ergonômicos** | **Acidentes** | | () Ruídos | () Poeiras | () Vírus | () Esforço físico intenso | () Arranjo físico inadequado | | () Calor | () Fumos | () Bactérias | () Levantamento de peso | () Eletricidade | | () Vibrações | () Névoas | () Protozoários | () Postura inadequada | () Animais Peçonhentos | | () Umidade | () Neblinas | () Fungos | () Trabalho em turnos e noturno | () Máquinas e equipamentos sem proteção | | () Radiação não-ionizantes | () Gases | () Parasitas | () Monotonia e repetitividade | () Probabilidade de incêndio/explosão | | () Radiação ionizante | () Vapores | () | () Ritmos excessivos | () Outras Situações causadoras de acidentes | | () Frio | () | () | () Controle rígido de produtividade | () Ferramentas inadequadas | | () Pressões anormais | () | () | () | () | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **CAMPO ABAIXO SERÁ PREENCHIDO PELO MÉDICO** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | | | APTO | | | | | | |  |  |  | | | | | | | | | | | | | |  |  | | INAPTO | | | | | | | | | | |  | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | | | TRABALHO EM ALTURA | | | | | | |  |  | ESPAÇO CONFINADO | | | | | | | | | | | | | |  |  | | COM PRODUTOS QUÍMICOS | | | | | | | | | | |  | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | | | | | | | | | | | | | |  | | |  | |  | | | | | | | | | | | | | | | |  | |  |  | | | |  | | |  | Recebi uma via deste Atestado | | | | | | | | | | | | | |  | | |  | |  | | | | | | | | | | | | | | | |  | |  |  | | | |  | | |  |  | | | | | | | | | | | | | |  | | |  | |  | | | | | | | | | | | | | | | |  | |  |  | | | |  | | |  | Assinatura do Funcionário | | | | | | | | | | | | | |  | | |  | | Assinatura e Carimbo Médico Examinador | | | | | | | | | | | | | | | |  | |  | Assinatura do Médico Coordenador | | | |  | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Tel.: (11) 3771-3484 | Tel/Fax: (11) 3772-3194 | www.sso.com.br | comercial@sso.com.br** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Rua Sete de Abril, nº 59 - 8º Andar - República - São Paulo - SP - CEP: 01043-000** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Este documento deve ser arquivado no Departamento Médico da Empresa ou do serviço contratado, na ficha do funcionário. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 1ª Via da Empresa | 2ª Via Funcionário| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |