MEDICAL ACCESS ORDER (MAO) REQUEST FORM

Date:_____

Region:_____ Area/District Office:_____
Telephone #:_____ Fax #:_____

1. Name of Employer/Company to be Inspected/Evaluated:_____
_____
Address:_____
_____
_____

   a. Contact Person:_____
      Job Title:_____
   b. Type of Company - Product:_____
   c. SIC/NAICS:_____
   d. Number of Employees:_____

2. Purpose of Inspection/Evaluation (Compliance Issues - BBP, Recordkeeping, etc.; VPP Evaluation):_____
_____
_____

3. Basis for Inspection/Evaluation (Complaint, Fatality, etc....; Pre-approval, Merit, Star..):_____
_____
_____

4. Date of Initial Inspection:_____
Preliminary Findings:_____
_____
_____

5. Period requested for Medical Records Access/Review: January 1, _____ to the present date.

6. Inspection - Medical Records Access/Review to Begin (approx.):_____
Be Completed By:_____

7. Other (support information, concerns, unusual circumstances, etc……):_____
_____
_____
_____

8. OSHA Principal Investigator: (Name, Job Title and Location, Telephone #, and E-Mail Address):
_____
_____
_____
_____
_____
_____
_____

9. Inspection Team Members (Name, Job Title and Location):

a. _____
_____
_____

b. _____
_____
_____

c. _____
_____
_____

d. _____
_____
_____