

OAK RIDGE INSTITUTE FOR SCIENCE AND EDUCATION

CENTER FOR EPIDEMIOLOGIC RESEARCH

Beryllium Worker Medical Surveillance Program  
Informed Consent Statement

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Sponsor: Department of Energy/Office of Occupational Medicine and Medical Surveillance

**PARTICIPANT'S AUTHORIZATION**

I have read: (Check and initial items to indicate you have read them.)

- ÿ \_\_\_ the attached information about the beryllium Lymphocyte Proliferation Test (Be-LPT) and other tests I may be asked to take. I have had the opportunity to discuss any questions that I may have. I understand that I am free to withdraw without penalty or loss of benefits at any time from all or any part of the program for which I am volunteering. I understand that if the results of any test suggest a health problem, whether related to chronic beryllium disease or not, this will be discussed with me by the examining physician.
- ÿ \_\_\_ that the results of any tests, examinations, or analysis of this surveillance program may be published or presented at scientific meetings, but that I will not be identified personally.
- ÿ \_\_\_ that the records of my participation in this program and the results of any tests or examinations that I consent to are private and confidential. This information will become part of the DOE Beryllium Registry that is protected under the provisions of the Privacy Act of 1974.
- ÿ \_\_\_ that if I have additional questions about this program or my participation in it, I can contact Dr. Donna Cagle, ORISE, at (423) 576-2866, Dr. Bill Stange, ORISE, at (303) 966-8373, or the Chair of the ORAU/ORNL Institutional Review Board at (423) 576-1725.
- ÿ \_\_\_ that I will be given a copy of this Consent Form and Fact Sheet after I have signed them.

CONSENT STATEMENTS

I consent to having the following medical evaluations: (Check and initial **ONLY** those items to which you give your consent.)

Blood test called the beryllium lymphocyte proliferation test or Be-LPT with the understanding that if the results are positive on two consecutive tests, I will be offered additional testing to determine whether I have chronic beryllium disease.

Chest x-ray.

Spirometry (a breathing test).

Physical examination concentrating on my lungs and breathing.

Other test(s). Specify

Name of Participant\* SSN\* \_\_\_\_\_  
(Please print)

Signature of Participant Date \_\_\_\_\_ Time \_\_\_\_am  
\_\_\_\_\_pm

\*Neither your name nor your SSN will be included in the beryllium registry.

I have explained and discussed any questions that the above program participant expressed concerning the Be-LPT, physical examination, chest x-ray, and breathing test, and the implications of those tests.

Date \_\_\_\_\_ Time \_\_\_\_am  
\_\_\_\_\_pm

ORISE-Authorized Representative (Signature)

Authorized Representative (Please print)

Consent form approved by the ORAU/ORNL Institutional Review Board (MPA M1394) on July 9, 1999, for a period of up to 12 months.