CMRR Employee/Researcher Screening Form
(Not to be used as a patient/volunteer screening form)
(A new form should be submitted if you have any changes over the course of your tenure at CMRR)

Name________________________________________ x500________________________________________

Department ______________________________________ e mail _________________________________

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind?  □ No  □ Yes
If yes, please indicate date and type of surgery:

Date ____/____/____ Type of surgery_______________________________________________________

Date ____/____/____ Type of surgery_______________________________________________________

Date ____/____/____ Type of surgery_______________________________________________________

2. Have you had an injury to the eye involving a metallic object (e.g., metallic slivers, foreign body)?  □ No  □ Yes
If yes, please describe: ___________________________________________________________________

3. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)?  □ No  □ Yes
If yes, please describe: ________________________________________________________________

4. By signing below you acknowledge that if you are pregnant, suspect that you are pregnant, or become pregnant while working at CMRR that the American College of Radiology guidelines permit work in and around MR scanners throughout all stages of pregnancy but do not recommend being in the scanner room during image acquisition.

Please indicate if you have any of the following:

□ Yes  □ No  Aneurysm clip(s)

□ Yes  □ No  Cardiac pacemaker

□ Yes  □ No  Implanted cardioverter defibrillator (ICD)

□ Yes  □ No  Electronic implant or device

□ Yes  □ No  Magnetically activated implant or device

□ Yes  □ No  Neurostimulation system

□ Yes  □ No  Spinal cord stimulator

□ Yes  □ No  Cochlear implant or implanted hearing aid

□ Yes  □ No  Insulin or infusion pump

□ Yes  □ No  Implanted drug infusion device

□ Yes  □ No  Any type of prosthesis or implant

□ Yes  □ No  Artificial or prosthetic limb

□ Yes  □ No  Any metallic fragment or foreign body

□ Yes  □ No  Any external or internal metallic object

□ Yes  □ No  Hearing aid

( Remove before entering the MR system room)

□ Yes  □ No  Other implant____________________________

If you have any questions or concerns about this form either now or in the future, please do not hesitate to contact the CMRR Safety Officer (ande2445@umn.edu).

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.

Signature of Person Completing Form: ___________________________________________ Date ____/____/____

Form Reviewed by ______________________ Signature ______________________ Date ____/____/____

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