To: PI’s and Protocol Associates Working with Animals

From: IACUC Compliance Specialist
(251)-460-6863

Subject: **Enrollment in Occupational Health Program**

According to IACUC records, you are a Principal Investigator or Protocol Associate in a study in which you work, or come in contact with, animals. As part of the approval and monitoring process, all individuals in contact with animals must enroll in the Occupational Health Program. The process is for your safety in determining if you are healthy enough to assume risks associated with animal research.

The enrollment is mandatory, but is only required once in most cases. We have assembled a package of all the materials which you may need to complete enrollment.

If utilizing USA Urgent Care the employee need only to complete and fax the OHP Questionnaire and the Billing Memorandum to the USA Urgent Care Clinic on the main campus (Fax #414-8227, the fax number is also provided on the form). Once the form is faxed, please call Urgent Care (414-8101) and schedule an appointment.

If you prefer to see your own physician, I have attached all the forms which will need to be completed. These forms can be filled out electronically and saved or may be printed and manually filled out. The Physicians Statement and OHP Questionnaire will need to be faxed to Urgent Care at: 414-8227.

Please complete enrollment as soon as possible, and feel free to contact me with any questions.
The Occupational Health Program is a risk assessment program provided free of charge to the University community for its members who have workplace exposure to animals. An important element of the Occupational Health Program is preventive medicine and medical evaluation combined with health history to provide a foundation in the event of care.

To better protect your health under OHP, answer questions truthfully and completely.

- Everyone completes Part A and B; mark all answers that apply.
  - Note: primate handlers complete Parts A through C; DCM staff complete Parts A through D.
  - Be sure that both you and your supervisor sign and date.
- Fax completed signed form to USA Urgent Care at 414-8227; location: TRP Bldg. III Rm. 1175

PART A: OCCUPATIONAL/ENVIRONMENTAL HISTORY

LABORATORY ANIMAL CONTACT

- MICE/RATS
- AMPHIBIANS
- CATS
- DOGS
- FISH
- MACAQUES
- PIGS (SWINE)
- RABBITS
- REPTILES
- SQUIRREL MONKEYS
- OTHER SPECIES:

EXPOSURE FREQUENCY:

Using the following frequencies please indicate the amount of exposure you anticipate for each category:

- NO EXPOSURE
- INFREQUENT EXPOSURE
- 1-3 Xs MONTH
- 1-3 Xs WEEK
- EVERYDAY

1. ANIMAL/ANIMAL PRODUCTS:
   (BLOOD, TISSUE, WASTE, BODILY FLUIDS)
2. HUMAN PRODUCTS:
   (BLOOD, TISSUE, WASTE, BODILY FLUIDS)
3. BIOLOGICAL HAZARDS:
4. CHEMICAL CARCINOGENS:
5. RADIATION:

IACUC COMMUNITY MEMBERS

DCM STAFF AND ANIMAL FACILITY SUPPORT AND MAINTENANCE STAFF

PLEASE DESCRIBE DUTIES
PART B: PERSONAL HEALTH

+ Have you been immunized?
  - Tetanus vaccine
    - Yes
    - No
    - Don’t Know
    - If yes, indicate the year of vaccination:
  - Hepatitis B (series of 3 shots)
    - Yes
    - No
    - Don’t Know
    - If yes, indicate the year of vaccination:
  - Rabies (series of 3 shots)
    - Yes
    - No
    - Don’t Know
    - If yes, indicate the year of vaccination:

+ Infection history
  (such as: salmonella, shigellosis, hepatitis, tuberculosis, etc.)

+ Do you have allergies?
  - Yes
  - No
  - Don’t Know
  - If yes, cause of allergies if known:
  - If yes, symptoms of allergies:
  - If yes, treatment for allergies:

+ Do you have asthma?
  - Yes
  - No
  - Don’t Know
  - If yes, cause of asthma if known:
  - Do you have allergy symptoms or asthma specifically related to animals you currently work with?
  - Do you experience shortness of breath at work?
  - Do you have any current skin problems related to work (i.e.-reactions to latex, cracked/dry skin, rashes)

+ Medical history
  - Have you ever been diagnosed with a condition that weakens your immune system?
  - Are you currently taking medications that may weaken your immune system?
  - Have you ever been diagnosed with a valvular or congenital heart condition?

+ OTHER INFORMATION
  - Are there any health/workplace concerns not covered by this questionnaire that you would like to discuss with a physician?

PART C: FOR INDIVIDUALS WORKING WITH NON-HUMAN PRIMATES ONLY

- Have you ever had measles (rubeola)?
  - Yes
  - No
  - Don’t Know
  - If yes, please list:

- Have you ever lived in countries outside the U.S.?
  - Yes
  - No
  - Don’t Know
  - If yes, please list:

- Have you ever had active tuberculosis (TB)?
  - Yes
  - No
  - Don’t Know
  - If yes, please list year and TB treatment received:

- Have you ever had a positive reaction to a TB skin test?
  - Yes
  - No
  - Don’t Know
  - If yes, please list the date of the last chest X-ray?

- Have you ever received the TB vaccine Bacillus Calmette Guerin (BCG)?
  - Yes
  - No
  - Don’t Know

PART D: FOR COMPARATIVE MEDICINE EMPLOYEES ONLY!

- Mark if you use any of the following personal protective equipment (PPE) when working with animals:
  - Lab coat
  - Mask/respirator
  - Protective eyewear

- Will you be required to lift animals, supplies, or equipment exceeding 50 pounds?
  - Yes
  - No
  - Don’t Know

- Are or will you be engaged in a repetitive movement activity?
  - Yes
  - No
  - Don’t Know

Remember to sign, date, and fax this form to USA Urgent Care at 251-414-8227
DATE:

TO: URGENT CARE
   307 UNIVERSITY BLVD N.
   TRP III, SUITE 1175
   MOBILE, AL. 36688

ONCE THE OHP QUESTIONNAIRE IS FAXED TO USA URGENT CARE, PLEASE CALL THEM AND SCHEDULE YOUR APPOINTMENT TO REVIEW THE QUESTIONNAIRE AND ANSWER QUESTIONS.

BE SURE TO COME TO THE URGENT CARE SUITE 1175. DO NOT COME TO STUDENT HEALTH.

NAME: ___________________________  J#  ___________________________  DOB  ___________________________

DEPARTMENT: ___________________________  HOME PHONE #:  ___________________________

☐ HEP B (VACCINATION, APPENDIX 2, REQUIRED)--BILL to "OHP-BIOSAFETY"

☐ HEP B / HEP A COMBO (VACCINATION, APPENDIX 2, REQUIRED)--BILL to "OHP-BIOSAFETY"

☐ TITER--BILL to "OHP-BIOSAFETY"

☐ EXPOSURE INCIDENT CARE--BILL to "OHP" or "OHP-MCI"*

☐ HEALTH ASSESSMENT (OHP QUESTIONNAIRE NEEDED--BILL to "OHP" or "OHP-MCI"*

* If the department above is MCI, the lower two options should be billed to "OHP-MCI"; if not, please bill them to "OHP"

BILL ACCORDING TO THE SELECTIONS AND DEPARTMENT ABOVE.

DUSTY LAYTON
CSAB 120

__________________________
SUPERVISOR NAME

__________________________
SUPERVISOR SIGNATURE
UNIVERSITY OF SOUTH ALABAMA
OCCUPATIONAL HEALTH PROGRAM (OHP)

PHYSICIAN’S STATEMENT
HEALTH ASSESSMENT FOR ANIMAL HANDLERS

THIS STATEMENT IS REQUESTED FOR PURPOSES OF THE ADMINISTRATION OF THE OCCUPATIONAL HEALTH PROGRAM. ALL INFORMATION WILL BE KEPT CONFIDENTIAL.

EMPLOYEE NAME: ____________________________ JAG#: ____________________________

SUPERVISOR NAME: ____________________________ DEPARTMENT: ____________________________

FROM THE MEDICAL INFORMATION I HAVE PERFORMED AND/OR FROM THE MEDICAL INFORMATION I NOW HAVE, I CONSIDER THIS INDIVIDUAL MEDICALLY:

☐ CLEARED  ☐ NOT-CLEARED

PHYSICIAN COMMENTS:

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IF THE INDIVIDUAL HAS A MEDICAL PROBLEM THAT IN YOUR JUDGEMENT REQUIRES FURTHER EXAMINATION OR TREATMENT, PLEASE EXPLAIN. PLEASE INDICATE WHETHER INDIVIDUAL HAS BEEN SO ADVISED OF THIS POTENTIAL RISK. ☐ YES  ☐ NO

DOES THE EMPLOYEE HAVE ANY CHRONIC CONDITION WHICH MAY ALTER IMMUNE RESPONSE (EG., GLUCOCORTICOID TREATMENT, ETC.) OR CLINICAL CONDITION WHICH COULD RESULT IN AN ACUTE CLINICAL EPISODE IN THE WORKPLACE (EG., DIABETES, EPILEPSY, HIGH BLOOD PRESSURE, ETC..)?

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__________________________________________
MEDICAL EVALUATOR NAME

__________________________________________ DATE
MEDICAL EVALUATOR SIGNATURE