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| **Instructions:** * *Please send this form to the Employee Health Office at* *OHP@miami.edu* *only.* ***Do NOT send to IACUC.***
 |
| Last Name: |       | First Name: |       | Today’s Date |       |
| UM ID #: |       |  Faculty [ ]  Staff [ ]  Student [ ]  Other [ ]  | Date of Birth: |       |
| Principal Investigator: |       | Department: |       | Mobile #: |       |
| Email Address: |       | Job Title: |       | Work #: |       |
| **Section A – Annual Update** |
|  | **Have you previously completed this form and are currently enrolled in the Occupational Health Program?** | **[ ]  Yes – Go to Question 2** | **[ ]  No – Read below** |
|  |  | I hereby give permission to the University of Miami Employee Health Office (“UM EHO”) and its designated provider (hereinafter referred to as “Provider”), to provide the following job-related health-care services: physical examination, immunizations, audiometry, medical evaluation for use of a respirator, blood collection and laboratory testing, and other healthcare services as may be deemed professionally necessary based on the nature, intensity and frequency of my exposure to hazards associated with biological, human, and animal research. I understand that my blood may be collected, examined and/or stored if deemed necessary based on the substantial likelihood of an occupationally acquired infection with an agent. Additionally, I understand that in the event of an occupational illness, injury or other adverse event it may be medically necessary for the UM EHO, as well as the Provider, to have access to any relevant medical health records. Further, I understand that such events may also require the disclosure of necessary medical information by the UM EHO and/or the Provider to persons with a need to know, including supervisory personnel and other University of Miami administrators who may need to know this information in order to implement work restrictions for the protection of my health and/or the health of others.REVOCATION: To effectively revoke this consent, I must deliver written notice of revocation to the University of Miami Employee Health Office. Such revocation will not apply retroactively and will be effective from the date received by the UM Employee Health Office. WARNING TO EMPLOYEES THAT ARE IMMUNO-COMPROMISED: The administration of live vaccines and/or exposure to job related hazards may be harmful to you. It is your responsibility as the EMPLOYEE to inform your EMPLOYER of any health factors that you believe may adversely affect your health, such as live vaccines and work-related contact with animals. E-Signature       ***Go to Section B on Page 2*** |
|  | Have there been changes to any of the following in the past 12 months? |  |  |
|  |  | Job Duties: | [ ]  Yes\* | [ ]  No\*\* |
|  | Personal health: | [ ]  Yes\* | [ ]  No\*\* |
|  | Animal Species you work with: | [ ]  Yes\* | [ ]  No\*\* |
|  | Developed new allergy signs or symptoms: | [ ]  Yes\* | [ ]  No\*\* |
|  | Infectious / biological / chemical agents you work with: | [ ]  Yes\* | [ ]  No\*\* |
|  | ***\* If you selected YES for any question above, read and sign the acknowledgement paragraph in Question 1 and complete form to specify changes.******\*\* If you selected NO for all questions above, skip to Section D.***  |
| **Section B – Work with Live Animals**  |
|  | **Are you currently working or planning to work with live animals?** | **[ ]  Yes *– specify below*** | **[ ]  No *– skip to Section C*** |
|  | *Species* | *Transgenic / GMO* | *Allergies to Animal?* | *Work Activities* | *Frequency of Current Exposure* | *Exposure Time* | *Experience Working with Animal* | *Symptoms made worse by animal work environment* |
|       | [ ]  Yes[ ]  No | [ ]  Yes[ ]  No | [ ]  Surgery/Necropsy[ ]  Hands on work w/ animal[ ]  Observation/No contact | Choose an item. |       *(hr/day)* |       Months      Years | Choose an item.Choose an item.Choose an item. |
|       | [ ]  Yes[ ]  No | [ ]  Yes[ ]  No | [ ]  Surgery/Necropsy[ ]  Hands on work w/ animal[ ]  Observation/No contact | Choose an item. |       *(hr/day)* |       Months      Years | Choose an item.Choose an item.Choose an item. |
|       | [ ]  Yes[ ]  No | [ ]  Yes[ ]  No | [ ]  Surgery/Necropsy[ ]  Hands on work w/ animal[ ]  Observation/No contact | Choose an item. |       *(hr/day)* |       Months      Years | Choose an item.Choose an item.Choose an item. |
|  | If you listed symptoms in Question 3, do you take any over-the-counter or prescription medication? | [ ]  Yes *– specify below* | [ ]  No [ ]  N/A |
|  | *List medications:*       |
|  | Do you have a history of asthma? | [ ]  Yes | [ ]  No |
|  | Do you have a history of hay fever? | [ ]  Yes | [ ]  No |
|  | Have you ever had a skin test performed to determine what your allergies are? | [ ]  Yes *– specify below* | [ ]  No |
|  | *If yes, what was the result:*       |
|  | Have you ever had a blood test performed to determine what your allergies are? | [ ]  Yes *– specify below* | [ ]  No |
|  | *If yes, what was the result:*       |
|  | Are you now, or have you ever been a cigarette smoker (one or more per week)? | [ ]  Yes *– specify below* | [ ]  No |
|  | *How many cigarettes / day?*       *For how many years?*        |
|  | Are you regularly exposed to animals away from work? | [ ]  Yes *– specify below* | [ ]  No |
|  | *List species:*       |
| 1.
 | Do you have any allergic symptoms to these pets? | [ ]  Yes *– specify below* | [ ]  No |
|  | *What were the symptoms?*       |

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| **Section C – Work with Biological / Infectious Material**  |
|  | **Are you currently working or planning to work with biological and/or infectious material?** | **[ ]  Yes *– specify below*** | **[ ]  No *– skip to Section D*** |
|  | Do you currently work or plan to work with microorganisms?  | [ ]  Yes *– specify below* | [ ]  No |
|  | *Type*  | *List examples (i.e., E. coli, Influenza Virus)* |
|  |       |
|  |       |
|  |       |
|  | Do you currently work or plan to work with human source material?  | [ ]  Yes *– specify below* | [ ]  No |
|  | *Type* | *List examples (i.e., HEK 293T cells, epidermal tissue, feces, saliva)* |
|  |       |
|  |       |
|  |       |
|  | Do you currently work or plan to work with animal source material?  | [ ]  Yes *– specify below* | [ ]  No |
|  | *Type* | *Animal Species* | *List examples (i.e., BHK cells, epidermal tissue, feces, saliva)* |
|  |       |       |
|  |       |       |
|  |       |       |
|  | Do you currently work or plan to work with plants? | [ ]  Yes *– specify below* | [ ]  No |
|  | *List species:*       |
| 1.
 | Do you currently work or plan to work with biological toxins? | [ ]  Yes *– specify below* | [ ]  No |
|  | *List biological toxins:*       |
|  | Do you currently work or plan to work with prions? | [ ]  Yes *– specify below* | [ ]  No |
|  | *List prions:*       |
|  | Do you currently work or plan to work with recombinant and/or synthetic nucleic acid molecules? | [ ]  Yes *– specify below* | [ ]  No |
|  | *List recombinant and/or synthetic nucleic acid molecules:*       |
| **Section D – Additional Information** |
|  | If you answered **No** to **questions** **3** and **12** above, list all of your duties related to the lab research environment: *List duties:*       |
|  | Are you required to use respiratory protection at work? | [ ]  Yes *– specify below* | [ ]  No |
|  | *Were you fit tested for the use of a respirator?* |
|  | Do you have any health or workplace concerns? |
|  | If you’re pregnant, planning a pregnancy, or are immunocompromised, please contact the Employee Health Office for additional assessment and guidance. [ ]  Acknowledged [ ]  N/A |

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| **Section E – Vaccination History (if applicable\*\*\*)** |
|  | **\*\*\*If this is your first time completing this form, please complete this section to the best of your knowledge.** |
|  | **Vaccine** | **Check No** | **Check Yes *– specify in next column*** | **Date of Vaccination** |
| Hepatitis B | [ ]  No | [ ]  Yes *– specify when* | Click or tap to enter a date. |
| Hepatitis A | [ ]  No | [ ]  Yes *– specify when* | Click or tap to enter a date. |
| MMR | [ ]  No | [ ]  Yes *– specify when* | Click or tap to enter a date. |
| Rabies | [ ]  No | [ ]  Yes *– specify when* | Click or tap to enter a date. |
| Tetanus | [ ]  No | [ ]  Yes *– specify when* | Click or tap to enter a date. |
| Tb skin test / screening | [ ]  No | [ ]  Yes *– specify when* | Click or tap to enter a date. |
| Other:       | [ ]  No | [ ]  Yes *– specify when* | Click or tap to enter a date. |
| Other:       | [ ]  No | [ ]  Yes *– specify when* | Click or tap to enter a date. |
| Other:       | [ ]  No | [ ]  Yes *– specify when* | Click or tap to enter a date. |

***Disclaimer: Certain medical conditions may increase potential risk of health problems when working with animals and/or biological materials. These conditions could include but are not limited to allergies and/or animal dander, asthma, heart valve disease, and immunosuppression.***

***Acknowledgement: I certify that I completed this form myself, accurately, and to the best of my understanding.***

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| *E-Signature* |  | *Date* |