UNIVERSITY OF MIAMI
Employee Health Office
Occupational Health Program for Animal Research Personnel
ACKNOWLEDGMENT FORM

PLEASE NOTE: Send this form to OHP@miami.edu

Last name:_____First Name:_____

Email address: _____ ☐ Employee ☐ Student ☐ Other

Title:_____Birth Date:_____Wk phone #:_____Dept:_____

Building:_____Room:_____Locator Code:_____Campus:_____

Supervisor/PI name:_____Supervisor/PI phone #:_____

A. Check the appropriate box

☐ Yes ☐ No Has contact with research animals at work

☐ Yes ☐ No Works in an area that requires participation in the Hearing Conservation Program

☐ Yes ☐ No Wears a respirator (if yes, complete *Respirator Medical Evaluation Questionnaire and forward to EHS)

B. List the animal species and/or infectious agent(s) to which you have contact at work:

_____

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 the care and use of research animals.

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.

_____ _____
Employee Signature *Date* *Provider Signature* *Date*