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| CONFIDENTIAL MEDICAL INFORMATION  For review by Health Care Provider Only |

Animal Handler Occupational Health Program

Health Surveillance Questionnaire

UMaine Student (NOT including student employees)

Your supervisor/PI and you are being asked to complete this questionnaire to help evaluate risks to your health from exposure to animals. Your supervisor/PI should complete section 1 first and then you will complete section 2. After completing the form, send it to the health care provider for your campus. A health care professional (HCP) will review your responses to this questionnaire and may contact you to schedule a visit or discuss further medical evaluation and/or diagnostic procedures. Once you are cleared for the work indicated on the form, the HCP will issue a medical clearance form and file this questionnaire at their office. The clearance form will be sent to your Human Resources Dept. and here it will be filed. Copies will be sent to you, your supervisor/PI, and the Office of Research Compliance. **Note: Incomplete forms will be returned to the sender.**

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| **Section 1** (to be completed by supervisor/PI) | |
| Supervisor/PI Name: | IACUC Project Description Brief: |
| Department: |
| Work Phone Number: |
| Email: |
| Chart field for service charges: |
| Supervisor/PI Signature:       Date: | |

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| **Section 2** (to be completed by employee) | | | | | |
| Participant Name: | | | | | Gender: |
| MaineStreet ID #: | | Date of Birth: | Cell/Home Phone: | | Work Phone: |
| Participant Email Address: | | | | Campus Address: | |
| Department: | | | |
| Supervisor/PI: | | | |
| **1.** | Check all the following statements applicable to your status:  I am an animal handler (have direct contact with animals)  I have direct contact with unfixed non-sterilized animal tissues  I have direct contact with non-sanitized animal cages or enclosures  I provide support for animal equipment, devices and/or facilities  I am active on an approved animal use protocol (listed above)  I am listed on an approved animal use protocol but will not be handling animals. | | | | |
| **2.** | Has there been any change in animal contact since your previous questionnaire? *Leave it blank if this is your first time completing the questionnaire.* This includes direct contact with animals, animal tissues and/or wastes, and animal.  Yes  No If Yes, describe: | | | | |
| **3.** | Have you received a Tetanus booster in the past 10 years?  Yes  No If Yes, you must provide the date of your last booster or a new booster will be required: | | | | |
| **4.** | Have you **ever** received Rabies vaccine?  Yes  No If Yes, please list dates (if not provided before): | | | | |
| **5.** | Are you pregnant, or planning to be pregnant in the next three years?  Yes  No  N/A  I choose not to answer | | | | |
| **6.** | Have you ever had an on-the-job injury related to animal exposure?  Yes  No If Yes, describe: | | | | |
| **7.** | Have there been any changes in your health related to animal handling?  Yes  No If Yes, describe: | | | | |
| **8.** | Have you developed any new conditions since you began working with animals?  Hay fever  Yes  No  Asthma  Yes  No  Allergic skin problems  Yes  No | | | | |
| **9.** | Do you have sneezing spells, runny or stuffy nose, watery or itchy eyes, coughing, wheezing, or shortness of breath after working with animals or their cages/bedding?  Yes  No  If yes, please answer the following:   1. When did the symptoms begin?       (Month and year) 2. Are the symptoms worse than one year ago?  Yes  No 3. Mark all the following that cause any of your symptoms   List animal(s) and or material(s) that may be causing symptoms | | | | |
| **10.** | Do you have a history of any of the following:  YES NO  Skin allergies  Environmental Allergies  Animal related asthma | | | | |
| **11.** | Do you have any other health or workplace concerns not covered by the questionnaire that you feel may affect your health and would like to confidentially discuss with the Occupational Health staff?  Yes  No  If yes, where can we reach you and what is the best time? | | | | |
| **12.** | Will you have exposure to potential disease-causing agents?"  Yes  No | | | | |
| Signature of Participant | | | | | |

The above information is true and complete to the best of my knowledge and I am aware that deliberate misrepresentation may jeopardize my health. I understand that this information is confidential and will not be released without my knowledge and written permission.

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| Signature of Participant | Date |
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| **Send completed and signed Questionnaire to:**  Northern Light EMMC – Cutler Health Center  [CutlerHealthcenter@Northernlight.org](mailto:CutlerHealthcenter@Northernlight.org) | **Health Care Provider, please send written opinion to:**  UMaine Human Resources: hr-um@maine.edu | |