EMPLOYEE HEALTH

Personnel LISTED on a Research protocol: FAX this form to ACUC- (305) 243-2853.
Send ORIGINAL to Employee Health Office, R-23, Suite 405, Dominion Tower.

UNIVERSITY OF MIAMI
ACKNOWLEDGEMENT FORM

Section 1: TO BE COMPLETED BY WORKER

PRINT

Last name _______________________ First name ______________________ ID# _____________________

E-mail address_______________________ ☐ Employee ☐ Student ☐ Other___________________

Title______________________ Birth Date ________ Wk phone#_______________ Dept__________________

Building _________________________ Room number _______ Locator code __________ Campus____________

Supervisor/PI name___________________________ Supervisor/PI phone#____________________________

INITIAL the appropriate area (**ANSWER A OR B)**

A. ___________ I **ACCEPT** participation in the Occupational Health Program for Animal Research Personnel.

COMPLETE the following:

- **CONSENT FORM FOR OCCUPATIONAL HEALTH PROGRAM**
- **BASELINE MEDICAL SURVEILLANCE QUESTIONNAIRE**

B ___________ I **DECLINE** participation in the Occupational Health Program for Animal Research Personnel.
I understand that I have animal contact and this is a health risk. All the health risks have been explained to me as well as all the components of the Occupational Health Program. I also understand that there are health risks in declining participation in this program. I was offered the opportunity to be included in the Occupational Health Program for Animal Research Personnel and decline to do so. I am given the opportunity to accept participation in this program in the future if I choose to do so.

Reason(s) for declining participation: ____
____

Suggestion(s) to improve the program: ____

Section 2: TO BE COMPLETED BY SUPERVISOR OR PRINCIPAL INVESTIGATOR

A. Check the appropriate box

☐Yes ☐ No Individual works in an area identified to require participation in the Hearing Conservation Program
☐Yes ☐ No Individual authorized to wear a respirator (if yes, complete **Respirator Medical Evaluation Questionnaire** and forward to EHS)
☐Yes ☐ No Individual has contact with animals

B. List the animal species and/or infectious agent(s) with which employee has occupational contact:
____
____

_________________________________ _________________________________
Signature of Employee ***Date*** ***Signature of Supervisor/PI*** ***Date***

EMPLOYEE HEALTH OFFICE (R-23), Dominion Tower, Suite 405.Office: (305) 243-3400. Fax: (305) 243-2393

EMPLOYEE HEALTH

SEND TO EMPLOYEE HEALTH OFFICE, R-23, Suite 405, Dominion Tower

UNIVERSITY OF MIAMI
CONSENT FORM FOR OCCUPATIONAL HEALTH PROGRAM

Last name: ___________________________________First name________________________________

ID number: _____________________________ Work phone # _________________________________

I hereby give permission to the University of Miami Employee Health Office and its designated provider, (hereinafter referred to as "Provider") to provide the following job-related services listed below:
a.) Physical examination
b.) Immunizations
c.) Audiometry
d.) Medical evaluation for use of a respirator
e.) Blood collection for serum banking and laboratory testing
f.) Other healthcare services as may be deemed professionally necessary

I understand that my blood may be examined if deemed medically necessary. I also give permission to the release of pertinent medical information to the current Provider and UM if medically necessary. I understand that this consent allows the disclosure of my confidential medical health records by University of Miami Employee Health Office or the provider to my supervisor and other University of Miami administrators in the event that may need to know this information to implement work restrictions that are necessary to protect my health 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 Employee Health Office.

WARNING TO EMPLOYEES WHO 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 the EMPLOYER of any health factors that may adversely affect your health, including, but not limited to live vaccines and work-related contact with animals.

____ __________________________
Employee Name (Print) Date

____
Employee Signature

____ __________________________
Witness Name (Print) Date

____
Witness Signature

EMPLOYEE HEALTH

SEND TO EMPLOYEE HEALTH OFFICE, R-23, Suite 405, Dominion Tower

UNIVERSITY OF MIAMI
BASELINE MEDICAL SURVEILLANCE QUESTIONNAIRE

PRINT

Last name ___________________________First name _________________________ID#_________________________

E-mail address___________________________☐ Employee ☐ Student ☐ other_________________________

Title_________________________ Birth Date ________ Wk phone#_________________ Dept____________________

Building _____________________________Room number _______ Locator code __________ Campus_____________

Home address____________________________________ City _______________ zip code_________________________

Supervisor/PI name_______________________________ Supervisor/PI phone#________________________________

A. History of Laboratory Animal Contact

1. In the first column below, enter the letter that corresponds to how frequently you are currently exposed to laboratory animals.

2. In the second column, enter the amount of time that you work with animals on days that you work with them.

3. In the third column, enter the length of time that you have worked with each type of animal throughout your entire career.

Laboratory Animal Type	Frequency of current exposure a = never b = less than once a week c = 1-2 times a week d = 3-4 times a week e = daily f= monthly	Exposure Time (in hours/day)	Total time worked with animals in your career Months	Years
Dogs				
Guinea pigs				
Mice				
Primates				
Rabbits				
Rats				
Other (specify)				

B. Do you have any of the following symptoms that you feel are caused by, or made worse by the work environment where you come into contact with laboratory animals?

Symptom	Yes	No	Animal involved
Watery, burning or itchy eyes			
Runny nose			
Sneezing			
Wheezing			
Cough			
Shortness of breath			
Chest tightness			
Hives			
Rash			

What, if any, over-the-counter or prescription medications do you take for these symptoms:

____

____

____

C. Do you have a history of:

	Yes	No
Asthma		
Hay fever		
If + for hay fever, is it Spring or Fall?		

Have you ever had a skin test performed to determine what your allergies are?

Yes ________ No ________

If "yes" what was the result? ______________________________________

Have you ever had a blood test performed to determine what your allergies are?

Yes ________ No ________

If "yes" what was the result? ____

Are you now, or have you ever been a cigarette smoker (one or more per week)?

Yes ________ No ________

If "yes" estimate how many cigarettes/day for how many years: ____________________

What animals are you exposed to away from work?

____

Do you have any allergic symptoms to these pets? Yes ________ No ________

If "yes", what were the symptoms?

____

Vaccination History

Please provide proof of vaccination

Vaccine	Yes	No	If Yes, When
Hepatitis B			
Hepatitis A			
MMR			
Rabies			
Tetanus			
*Tb skin test/screening			
Other			
Other			
Other			

* TB screening is done every 6 months for individuals working in high risk areas as well as with non-human primates. Other individuals working on the Medical campus are screened every 12 months.

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