University of Puerto Rico
Medical Sciences Campus
Deanship of Administration
Environmental Quality, Occupational Safety and Health Office
Occupational Health Clinic
ANIMAL EXPOSURE SURVEILLANCE PROGRAM

MEDICAL HEALTH SCREENING QUESTIONNAIRE

This Form MUST be submitted at least one month prior to initiating your work at the facility. All fields required. Please print.

Name (Last, First, MI)	**E-mail**	**Birth Date** (mm,dd,yy)	**Sex (M/F)**
Job Title	**PI/Supervisor's Name**	**Student** ☐ **Yes** ☐ **No** **Campus:** **Academic Program:**	
Department	**PI/Supervisor's E-mail & Phone**	**Visitor** ☐ **Yes** ☐ **No**	
Work Phone	**Protocol Tittle & Number**	**Minor** ☐ **Yes** ☐ **No**	
Today's Date (mm,dd,yy)	**Employee** ☐ **Yes** ☐ **No**	**Volunteer** ☐ **Yes** ☐ **No**	

This questionnaire is designed to collect information to assist with assessing possible health risks of working with animals and it is an important component of the Medical Sciences Campus (MSC) ability to monitor health status associated with work activities and to comply with requirements of regulatory, accreditation, and funding agencies. Information in this form is reviewed by a health care professional and kept in your confidential medical record at the Medical Sciences Campus Occupational Health Clinic (MSC OHC) or the Students Medical Services (SMS). It is important that all questions be answered completely. If you have experienced changes to your medical status, you should submit a new questionnaire. Otherwise, the questionnaire shall be re-submitted as often as indicated by medical reviewer.

INSTRUCTIONS: Your PI/supervisor must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To ensure the correct information, ***please have your PI/supervisor help with Part A***. To maintain your confidentiality, ***your PI/supervisor must not review your answers to Part B***. This form is received and managed through the facility Occupational Health Coordinator (OHC) who are certified in Health Information Privacy and Security (HIPS) in research settings. The OHC for the different facilities are:
Cayo Santiago Biological Field Station- Ms. Nahirí Rivera nahiri.rivera@upr.edu
Sabana Seca Field Station – Celimar Rosado celimar.rosado@upr.edu
Animal Resource Center- Frances Venegas frances.venegas@upr.edu

The Occupational Health Coordinator will submit the completed questionnaire to the Occupational Health Clinic at the address above, or email it to Yeimi Vázquez, the Occupational Health Nurse, to clinicaocupacional.rcm@upr.edu.

MSC Students must mail or bring the completed questionnaire to the Students Medical Services located on the 3rd Floor of the School of Medicine Main Building.

PART A

1. Animal Use/Contact (check all that applies)

- ☐ No contact with animals through my employment or studies at the MSC.
- ☐ Contact with animals through a university offered course or courses. List course number(s): _____.
- ☐ I have no direct contact with animals, but I currently work or may work in areas where animals are used or housed. (This includes administrative, facility, maintenance, and safety personnel who provide service support to animal care facilities, including equipment and devices housed there)
- ☐ I have contact with animals in teaching or research through an approved IACUC protocol.
  List protocol if known: _____
- ☐ I am involved in animal care or provide veterinary care to research or teaching animals.
- ☐ I am a member of MSC IACUC (includes lay members).
- ☐ Other: _____

2. Contact with Animals (Please mark Yes or No for each animal species)

The types of contact are defined as follows:

1. No direct contact
2. Animal husbandry or animal care
3. No contact with live animals; contact with "unfixed" tissues and/or body fluids.
4. Handle, restrain, and/or give drugs to animals, etc. in teaching or research.
5. Collect animal tissues or body fluid specimens, perform surgery or other invasive procedures, or provide veterinary care.

Animal Species	Yes	No	Type of Contact	Actual Contact Hours/Week
Rats				
Mouse				
Rabbits				
Pigs				
Non-Human Primates[1]				
• Macaques[1]				
• Other primate species				
Dog				
Cats				
Birds				
Fish /Amphibians/Reptiles				
Invertebrates (Specify Species)				

[1]TB and measles screening will be required.

3. Hazards Associated with Animal Work/ Contact

Complete the following section for each chemical, biological and physical hazard you are exposed to in conjunction with animal studies. You must place a response in each row.

Hazard Type	Exposure			Specify Chemical, Biological, Physical Hazard
	Yes	No	Don't know	
Infectious agent				
Recombinant DNA				
Genetically altered Material				
Radioactive material				
Hazardous chemicals (E.g., Corrosives, carcinogenic, teratogenic)				
Anesthetic gases				
Loud noise				
High Heat				
Repetitive body movements				
Lifting of heavy items				
Lasers, radiation				
Animal bites and scratches				
Other occupational hazards: Ex. Falls, guillotines, walk in refrigerators or freezers, dirty tank water (aquatic vertebrates), insect bites				

4. Hazards Associated with Animal Contact - Personal Protection Equipment
Do you wear or need to wear any of the following personal protective equipment?

Personal Protective Equipment	Yes	No	Don't know	Period of approval and date of medical clearance (if applies)
Disposable gloves				
Laundered (Non-Disposable) gown, scrub suite or lab coat				
Disposable gown, scrub suite or lab coat				
Tyvek sleeves				
Head cover				
Mask				
Face shield				
Safety glasses				
Safety goggles				
Disposable coveralls				
Laundered (Non-Disposable) coveralls				
Work footwear				
Boots				
Shoe covers				
Hearing protection				
Respirator (Ex. N-95, N-100)				
Other protective equipment used:				

5. Immunizations and/or Test Requirements
Does your work with animals require specific immunizations or screening testing? Please specify.
_____
_____

I certify that all hazards and safety controls associated with the participants job responsibilities working with animals, have been communicated to the employee/student:

_____ _____
PI/Supervisor(s) Signature Date

_____ _____
Participant Signature Date

PART B

CONFIDENTIAL MEDICAL INFORMATION

Please Note: The following sections are confidential and are to be completed by the Employee. If you would like to talk with a physician concerning any of these questions, you may contact Occupational Health Clinic, at extensions 2910 or 2913. This form is received and managed through the facility Occupational Health Coordinator who are certified in Health Information Privacy and Security (HIPS) in research settings.

1. Immunization and Infectious Disease History

You must supply the most recent year for immunization and titers if applicable. Have you ever had, or do you now have any of the following immunizations or diseases? **If the answer is yes, you must indicate a date. If the answer is no, check 'no' on column.**

	I have immunization for			I have had the following disease		
	Yes	Last Year Immunized	No	Yes	Year Infected	No
Tetanus/Diphtheria						
Rabies (Series of 3)						
Rabies Titer						
Vaccinia (cow pox)						
Hepatitis A						
Hepatitis B (Series of 3)						
Rubeolla						
Measles Titer						

i. Tuberculosis Surveillance

Tuberculin skin, Interferon-Gamma Release Assays (IGRAs), or Chest X-ray: Yes □ No □
Most recent year: _____ Results: Positive □ Negative □

a. If there is a history of positive TB test, please indicate the date and if you receive medical treatment.
Date: _____ Medical Treatment: Yes □ No □

ii. Have you ever received a rabies vaccination after a rabies exposure or suspected rabies exposure? Yes □ No □

iii.. Have you ever been diagnosed with an infectious, viral, bacterial, or parasitic illness that had been confirmed to have come from an animal and was associated with your research/studies/work at MSC or elsewhere? Yes □ No □

If yes, please explain: _____

iv. Have you ever suspected that you have acquired an illness from an animal, animal materials/tissue at MSC or elsewhere, but were unable to confirm this? Yes □ No □

If yes, please explain: _____

2. Medical History
What are your ongoing medical problems? Use an additional sheet of paper if necessary.

□ Pneumonia
□ Heart Disease
□ Diabetes
□ Cancer
□ Seizures
□ Cystic Fibrosis
□ Visual Impairment(e.g.Daltonism)
□ Recurrent Bronchitis
□ Rheumatic Fever
□ Kidney Disease
□ Gastrointestinal Disorder
□ Arthritis
□ Emphysema/Chronic Lung Condition
□ Neurological Disorders
□ Tuberculosis
□ Heart Murmur/ Valve Disease
□ Liver Disease
□ Loss of Consciousness
□ Chronic Back or Joint Pain
□ Auto Immune Disease
□ ***None of the above***

Have you been told by a physician that you have an immune compromising medical condition or are you taking medications that impair your immune system (steroids, immunosuppressive drugs, or chemotherapy)? Yes □ No □

If yes, please explain: _____

Are you currently taking any other medications Yes □ No □

If yes, please list below: _____

3. Allergies/Asthma

a. Are you allergic to any animal(s)? Yes □ No □
   If yes, list the animals that caused your allergy symptoms: _____
b. Do you have any known allergies to any medications? Yes □ No □
   If yes, please describe: _____
c. Do you have any other known allergies? (e.g., Insect Bites)
   Yes □ No □
   If yes, please describe: _____
d. List symptoms that occur when you are suffering from your allergies: _____
   _____
e. List treatment that you receive to relieve your allergies (e.g., EpiPen): _____
   _____
f. Have you been treated for asthma? Yes □ No □
   If yes, please list:
   1) the cause(s) of your asthma: _____
   2) the number of asthma attacks per month: _____
   3) the medications you take for your asthma: _____
g. Do you have skin problems related to work (e.g., reactions to latex gloves, dry cracked skin, rashes)? Yes □ No □
   If yes, describe: _____
h. Do you experience shortness of breath at work? Yes □ No □
i. Is there a family history of hay fever, asthma, allergic skin problems or eczema? Yes □ No □
   If yes, please explain_____
j. Outside of work, do you have any exposure to animals? Yes □ No □
   If yes, please explain_____
k. Please use this space to explain or make comments:

4. Pregnancy

a. Are you pregnant, suspect you are pregnant or contemplating pregnancy? Yes □ No □
b. Do you have work related questions concerning pregnancy that you would like to discuss with an Occupational Medicine Physician? Yes □ No □

5. Additional Questions and Concerns

Do you wish to talk to a medical provider concerning laboratory animal hazards or regarding this questionnaire? Yes □ No □

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.

_____ _____

Participant Signature **Date**

ANIMAL EXPOSURE SURVEILLANCE PROGRAM

Medical Health Screening Clearance for work with research animals in the Medical Sciences Campus of the University of Puerto Rico

FOR MEDICAL SERVICE PROVIDER USE ONLY

All documents have been reviewed, and the participant _____
Participant's Name

___complies ___doesn't comply with the requirements as established in the Animal Care and Use Program. Therefore, the participant is:

☐ Not Cleared

☐ Cleared

☐ Cleared with the following restrictions: _____

_____

☐ Has the following documentation incomplete:_____

_____

Provider Signature: _____ Date: _____
NPI:

Researchers, students and participants from other campuses of the UPR System or other organizations and institutions, will exclusively send this MEDICAL CERTIFICATION FORM to the supervisor or person in charge of the program for whom they will be working. The medical certification must be sign by their organization's medical health care provider or their private physician.

Investigadores, estudiantes y participantes de otros campuses del sistema UPR u otras organizaciones e instituciones, remitirán, exclusivamente, esta HOJA DE CERTIFICACIÓN MÉDICA al supervisor o persona a cargo del programa para el cual estará trabajando. La certificación médica debe estar firmada por el proveedor de atención médica de su organización o su médico privado.