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|  **Occupational and Health Risk Assessment**700# |
| **All employees/students engaged in animal care and use programs at UCM must enroll in the Occupational Health and Safety Program (OHSP). This is the form you must complete as a part of that program. This questionnaire, Occupational and Health Risk Assessment, solicits basic information about your animal use activities. It will help in assessing occupational hazards or risks you may incur in your activities. Please answer all questions and return to the University Health Center (UHC).** Because this information may be sensitive, this formgoes directly to UHC. Do not provide a copy to your supervisor since this personal health information is meant solely for the physician. |
| **Please type or print CLEARLY, failure to do so may delay your enrollment process.** |
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| Date: |  | Protocol Number: |  | Faculty  |  | Staff |  | Student |  |
|  |
| Name: |  | DOB (dd/mm/yyyy): |  | Male  |  | Female |  |
|  |
| Department: |  | Cell Number: |  | Email: |  |
|  |
| Position/Title:  |  | Supervisor/PI (required): |  |
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| 1. I have previously completed this form for another protocol: | YES  |  | NO  |  | If yes, protocol #: |  |
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| 2. List **ALL** species of animals you work with at UCM:  |  |
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| 3.Describe your work with animals (i.e. feed & water, perform surgery, clean cages, restrain animals, etc.):  |  |
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| 4.Do you work in a high noise area/building?  | YES |  | NO |  | Area or Building |  |
|  a. If yes, are you enrolled in a hearing conservation program? | YES |  | NO |  |  |
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| 5. Will you work with wild animals? | YES |  | NO |  | If yes, what species? |  |
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| 6. Do you work with sick animals?  | YES |  | NO |  | If yes, please explain: |  |
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| 7. Have you had a tetanus vaccination in the last 10 years? | YES |  | NO |  | If yes, approximate date: |  |
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| 8. Have you had the 3 shot pre-exposure series or the 5 shot post-exposure rabies vaccination? | YES |  | NO |  |  |
| a. If yes, approximate date: |  |
|  b. Have you had an antibody titer run? | YES |  | NO |  | If yes, approximate date: |  | Titer: |  |
|  |
| 9. Are you under the care of a physician for a medical condition that has or will last longer than 6 wks? | YES |  | NO |  |
|  a. If yes, please list the condition and medications taken, if any: |   |
|   b. Are you pregnant or attempting to become pregnant? YES NO |
|  |
| 10. Do you have any respiratory conditions (examples: asthma, emphysema, chronic bronchitis)? | YES |  | NO |  |  |
|  a. If yes, please list: |  |
|  |
| 11. Do you have any allergies (hay fever, asthma, hives, eczema, allergic skin rashes, etc.) or are you allergic to animals, plants, molds, pollens, latex, or other substances?  |  |
|  YES |  | NO |  | If yes, please circle: |
|  |
| 12. Do you have clinical symptoms of allergies in the workplace? | YES |  | NO |  |  |
|  a. If yes, would you describe your symptoms as: | Mild |  | Moderate |  | Severe |  |  |
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| 13. Do you have any medical or physical conditions that might affect your ability to work around animals, or health concerns about working with animals? |  |
|  | YES |  | NO |  | If yes, please explain: |  |
|  |
| 14. Do you have a medical condition or take any medication that might affect your ability to resist infections associated with working with animals? |  |
|  | YES |  | NO |  | If yes, please explain: |  |
|  |
|   Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**IACUC will require and initiate an annual update of your occupational risk/health status.** • **If you have any change in activities using animals that might affect your occupational risk, contact IACUC by emailing researchreview @ucmo.edu.** • **If have a change in health status that might affect your occupational risk with animals, it is your responsibility to contact the IACUC by emailing researchreview @ucmo.edu.** • **Remember that if you are injured or become ill working with animals, it is your responsibility to inform your supervisor and take appropriate action.** **Please return this form to the:** **University Health Center**600 S CollegeWarrensburg MO 64093 |
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