College of Charleston

IACUC Occupational Health Risk Questionnaire

Name: _____ **College ID#** _____ **Date:** _____

Email address: _____ **Telephone:** _____

Department: _____

Please select: ○ **Roster Faculty** ○ **Adjunct Faculty** ◉ **Staff**
○ **Undergraduate Student** ○ **Graduate Student**

This questionnaire will be used only to determine any health risks you may encounter in your work with vertebrate animals under the auspices of the College of Charleston. You may decline to participate by checking the appropriate box and signing below. Information provided in this questionnaire will be reviewed by a College of Charleston authorized healthcare provider or your own healthcare provider and maintained in a secure file in the Office of Environmental Health and Safety.

PROTOCOL AND ANIMAL INFORMATION

What species of animals will you be exposed to? (This includes direct contact with animals, animal tissues and/or wastes, and animal enclosures.)

List known or potential health or safety risks related to the species or the activities to be performed.

What health and safety protections or practices will be required while working with these species?

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☑ **I accept participation** in the College of Charleston IACUC Occupational Health and Safety Program. Complete the attached confidential sections of this questionnaire.

☑ I agree to risk assessment evaluation by the College authorized health care professional (free).

or

☑ I prefer to contact my personal physician to complete the risk assessment evaluation (my expense).

OR

☐ **I decline participation** in the College of Charleston IACUC Occupational Health and Safety Program. I have reviewed the information concerning the College of Charleston IACUC Occupational Health Program. (Do not complete the remainder of this questionnaire). I understand that

- my recurring animal contact or exposure to biological, chemical or physical hazards may have a health risk exposure, and I am advised to have a health assessment;
- there are possible health risks are associated with not accepting the health assessment;
- proof of test or immunizations may be needed to meet job function requirements;
- I may participate at any time in the future.

Signature_____ **Date**_____

SUBMISSION INSTRUCTIONS

Evaluation by College of Charleston Healthcare Provider:

1. Email or convey via SecureShare one copy of THIS PAGE ONLY to Research Protections & Compliance, compliance@cofc.edu.
2. Send the original of this page and the attached Confidential Questionnaire in a SEALED ENVELOPE marked "Confidential IACUC OHS" to Environmental Health & Safety, Robert Scott Smalls Building, Room 121. **Do not** use email; it is not a secure form of transmission of Protected Health Information. **Do not** send to Research Protections & Compliance

Evaluation by Personal Health Care Provider:

1. Email or convey via SecureShare one copy of THIS PAGE ONLY to Research Protections & Compliance, compliance@cofc.edu.
2. Take the original of this page and the attached Confidential Questionnaire to your healthcare provider.
3. Ask your provider to send the completed questionnaire (all pages) in a SEALED ENVELOPE market "Confidential" to the Office of Environmental Health & Safety, 66 George Street, Charleston, SC, 2941. **Do not** use email; it is not a secure form of transmission of Protected Health Information. **Do not** send to Research Protections & Compliance.

Decline Participation:

1. Email or convey via SecureShare one copy of THIS PAGE ONLY to Research Protections & Compliance, compliance@cofc.edu

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MEDICAL HISTORY - do you have any of the following? (Check all that apply)

- ☐ Allergies to animals (Please specify): _____
  _____
- ☐ Allergies to other substances (Please specify): _____
  _____
- ☐ Cardiovascular or heart problems
- ☐ Chronic health problem such as diabetes
- ☐ Condition treated with oral corticosteroids, radiation therapy or cancer therapy
- ☐ Immune deficiencies
- ☐ Kidney or liver disease
- ☐ Physical limitations
- ☐ Pulmonary or lung disease such as asthma, emphysema, chronic bronchitis, pneumonia (please specify):
  _____
- ☐ Tobacco use

IMMUNIZATIONS

Tetanus Booster: ◯ Within 10 years ◯ Over 10 years ◯ Unknown

Notice: If over 10 years or unknown, a Tetanus Booster is strongly recommended.

Have you received the Rabies vaccination series? ◯ Yes ◯ No

If yes, please provide the date you completed the series: _____

Reason for being vaccinated: ◯ Post-Exposure ◯ Pre-Exposure

OTHER MEDICAL INFORMATION

Do you have any health or workplace concerns not covered by the questionnaire that you feel may affect your occupational health and that you would like to discuss with the Occupational Health Physician?

Important Notice for Women: *If you are pregnant or planning to become pregnant, you should be aware that some animal-borne infections may pose a danger to the fetus. Please discuss your risk level with a healthcare professional prior to working with animals.*

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.

_____ _____

Signature of Participant Date

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Name: _____College ID# _____Date: _____

For Healthcare Professional Use Only

Healthcare Reviewer Name _____Telephone _____

Address _____

Signature _____ Date_____

Comments and Recommendations

- ☐ Approved
- ☐ Needs Vaccination(s), List: _____
- ☐ Needs enhanced Personal Protective Equipment (PPE)
  - ☐ Respirator
  - ☐ N-95 filter Mask
    - ☐ Fit test required
    - ☐ Optional – Employee Choice
- ☐ Allergy
  - Latex – alternative gloves
  - Other Precautions: _____
  - _____
- ☐ Other Recommendations