Animal Handler Risk Assessment Form

Name (Last, First, M.I.)	UM ID	
PI/ Supervisor	Department	Email Address

INSTRUCTIONS:

1) Form must be completed with black or blue pen only.
2) The Risk Assessment must be completed prior to animal use and any time you change or add species. If you add or delete a species, complete the Risk Assessment form listing ALL animals contacted, not just the new species.
3) **Female Personnel:** If you are pregnant or become pregnant while at the University of Maryland, certain precautions may need to be taken during your pregnancy if you work with animals, biohazardous materials, or chemical agents. (*It is recommended that you discuss your pregnancy and your work environment with your personal care physician or Occupational Health Care Professional as early as possible in case precautions need to be instituted.*)
4) Employees notified of incomplete forms will be charged an additional $10 fee after 14 days.

Part A: Risk Assessment for Animal Contact
I. Animal/Tissue Use (Check all boxes that apply.)

☐ No direct contact: observes animals or enters animal facility.
☐ Does not conduct procedures on live animals but handles “unfixed” animal tissues and body fluids.
☐ Handles, restrains, collects specimens from or administers substances to live animals.
☐ Performs invasive procedures such as obstetric procedures, surgery, necropsy.

II. Exposure to Animals/Tissues/Body Fluids (Check all that apply)

☐ Amphibians
☐ Bats
☐ Birds
☐ Cats
☐ Cattle
☐ Chickens
☐ Ferrets
☐ Fish
☐ Goats
☐ Horses
☐ Pigs
☐ Rabbits
☐ Reptiles
☐ Rodents (purpose bred)
☐ Rodents (wild)
☐ Sheep
☐ Other (specify): ___________
____

III. RISK ASSESSMENT FOR LABORATORY ANIMAL USE
Provide the following for each agent you are exposed to in conjunction with animal studies

		Yes	No	If yes, specify which agents
a.	Infectious Agents/r-DNA Technologies i.e. HIV, Hepatitis A, B or C	☐	☐	____________
b.	Chemical Carcinogen	☐	☐	____________
c.	Radiation	☐	☐	____________
d.	Anti-Neoplastic Agents	☐	☐	____________
e.	Other	☐	☐	____________

Supervisor Signature: ______________________________ **Date**____________________

UNIVERSITY HEALTH CENTER

Animal Handler Immunization and Allergy History Form

Name (Last, First, M.I.)		UM ID	Date of Birth
Contact Number		Department	PI/ Supervisor
Work Address	Email Address	Work Phone	Job Title

INSTRUCTIONS:

1) Form must be completed with black or blue pen only.
2) The Immunization and Allergy History must be submitted every 3 years. The Risk Assessment must be completed prior to animal use and any time you change or add species. If you add or delete a species, complete the Assessment form listing ALL animals contacted, not just the new species.
3) **Female Personnel:** If you are pregnant or become pregnant while at the University of Maryland, certain precautions may need to be taken during your pregnancy if you work with animals, biohazardous materials, or chemical agents. (*It is recommended that you discuss your pregnancy and your work environment with your personal care physician or UM Occupational Medicine Physician or Licensed Health Care Professional as early as possible in case precautions need to be instituted.*)
4) Employees notified of incomplete forms will be charged an additional $10 fee after 14 days.

Part B: PERSONAL HEALTH HISTORY

I. IMMUNIZATIONS

Have you ever had any of the following vaccinations or screenings?
If yes, you must provide documentation. If no, or if it has been more than 10 years since last Tetanus, please schedule an appointment at (301)314-8184.

	Immunizations (Most Recent)		
	Yes	Year	No
Tetanus (Required in last 10 years)			
Rabies (series of 3 shots)			
TB Skin Test			

II. ENVIRONMENTAL ALLERGIES/ ASTHMA

	Yes	No
1. Are you allergic to any animal(s)?	☐	☐
2. Do you have any other known allergies?	☐	☐
5. Do you have asthma?.	☐	☐

1. Are you allergic to any animal(s)?
   If yes, list animals that cause your allergy symptoms:
   ____
2. Do you have any other known allergies?
   If yes, what? ______________________________
   List causes of allergies:
   ____
3. List symptoms that occur when you are suffering from your allergies:
   ____
4. List treatment that you receive to relieve your allergies:
   ____
5. Do you have asthma?
   If yes, list cause(s) of asthma.
   ____

UNIVERSITY HEALTH CENTER

	Yes	No
6. Do you have allergy symptoms or asthma specifically related to animals that you currently work with?	☐	☐
If yes, have you been seen by a physician for this?	☐	☐

List symptoms:

____

	Yes	No
7. Do you have any skin problems related to work (e.g., reactions to latex gloves; dry, cracked skin; rashes)?	☐	☐

If yes, describe:

____

	Yes	No
8. Do you experience shortness of breath at work?	☐	☐

If yes, explain:

____

	Yes	No
9. Do you wear a fit tested respirator to perform any activities at work?	☐	☐

If yes:

Date of last respirator clearance medical questionnaire/evaluation:______________

Date of last respirator training: ______________________________

Date of last respirator fit testing: ______________________________

III. ADDITIONAL PERSONAL HEALTH CONCERNS

	Yes	No
1. Do you have any health or workplace concerns not covered by the questionnaire that you feel may affect your occupational health and would like to confidentially discuss with the Occupational Health Clinicians or your personal care physician?	☐	☐
2. Do you have any diseases causing immune suppression that you would like to discuss with the Occupational Health Clinician?	☐	☐

IV. INDIVIDUALS WORKING WITH SHEEP

	Yes	No
1. Do you work with female sheep?	☐	☐
2. Do you have a history of known valvular disease (heart murmurs) or congenital heart disease?	☐	☐

If yes, date of diagnosis: ______________________________

Type of disease: ______________________________

Treatment: ______________________________

	Yes	No
3. Do you now have or have you ever had Q-fever?	☐	☐

I have answered the questions on this form truthfully and to the best of my recollection.

______________________________ ______________

Signature **Date**

With your completed form, please also send a signed copy of the University Health Center Notice of Privacy Practice. This form is located at the end of this form. To view **Notice of Privacy Practice** visit:

www.health.umd.edu

Send completed and signed questionnaire to:
Occupational Health/ University Health Center
Campus Drive, Bldg 140, Room 0106
College Park, MD 20742

Occupational Health to Complete

☐ Cleared

☐ Cleared with Restrictions Listed ____________________

☐ Not Cleared ____________________

☐ Incomplete ____________________

Provider Signature ____________________ Date __________

UNIVERSITY HEALTH CENTER
Accredited by the Accreditiation for Ambulatory Health Care

University Health Center
Building 140, Campus Drive
College Park, Maryland 20742
301.314.8180 TEL 301.405.9755 FAX

ACKNOWLEDGEMENT OF RECEIPT OF THE UNIVERSITY HEALTH CENTER'S NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the University of Maryland Health Center's **Notice of Privacy Practices**.

____________________	____________________	__________
Printed Name	Signature	Date

FOR INTERNAL USE ONLY

☐ Patient refused to provide signature for acknowledging receipt of privacy practices.

______________________________________.
UHC Staff signature or designee and date.

☐ Patient was incapacitated and unable to provide signature for acknowledging receipt of privacy practices. ______________________________________.
UHC Staff signature of designee and date