UNIVERSITY
HEALTH CENTER

Animal Handler Risk Assessment Form

Name (Last, First), M.I.	University ID#	Email Address	
PI/Supervisor	Department	☐ Male ☐ Female	☐ Initial ☐ Renewal

☐ Faculty/Staff ☐ Graduate ☐ Undergraduate ☐ Other ____________________

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

PART A: Risk Assessment for Animal Contact

I. Animal/Tissue Use (Check all 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	☐ Chickens	☐ Horses	☐ Rodents (purpose bred)
☐ Bats	☐ Ferrets	☐ Pigs	☐ Rodents (wild)
☐ Birds	☐ Fish	☐ Rabbits	☐ Sheep
☐ Cattle	☐ Goats	☐ Reptiles	☐ 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	☐	☐	____________

Supervisors Signature: ______________________________ Date: ____________________

REQUIRED: FRS#: ______________________________

Revised 5.15

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Animal Handler Immunization and Allergy History Form

Name (Last, First), M.I.)	University ID#	Date of Birth
Contact Number	Department	PI/ Supervisor
Work Address		Work Phone
Job Title	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 or Licensed Health Care Professional as early as possible in case precautions need to be instituted.)*

PART B: PERSONAL HEALTH HISTORY

I. IMMUNIZATIONS

Have you ever had the following vaccinations or screenings? If **YES**, you must provide documentation

For Tetanus: If NO or if it has been more than 10 years since last vaccination, schedule an appointment with Occupational Health at the University Health Center by calling (301) 314-8184.

Immunizations (Most Recent)	NO	YES	YEAR
Tetanus (Required in last 10 years)			
Rabies (series of 3 shots, for specific labs/jobs)			
TB Skin Test (for specific labs, jobs)			

1. Are you allergic to any animal(s)? ☐ YES ☐ NO
   If yes, list animal(s) that cause your allergy symptoms: ____________________
2. Do you have any other known allergies? ☐ YES ☐ NO
   If yes, list cause(s) 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? ☐ YES ☐ NO
   If Yes, list cause(s) of asthma:
   ____

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Animal Handler Immunization/Allergy History Continued:

6. Do you have sneezing spells, runny or stuffy nose, watery or itchy eyes, coughing, wheezing, or shortness of breath after working with laboratory animals or their cages/bedding? ☐ YES ☐ NO

   If no, go to question #7.

   If **YES,** please answer the following:
   a. When did the symptoms begin? (month & year) ___________________
   b. Are the symptoms worse than one year ago? ☐ YES ☐ NO
   c. Are you taking medications to control the symptoms? ☐ YES ☐ NO
   d. Do you have any work restrictions? ☐ YES ☐ NO

7. Do you have frequent cold symptoms and/or cough? ☐ YES ☐ NO
   a. If **YES**, do these symptoms change on weekends, vacations, or other times you are away from work with animals? ☐ YES ☐ NO
   b. If **YES**, are your symptoms ☐ **better** or ☐ **worse**?

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

   If **YES**, describe: ____

9. Do you wear a fit-tested respirator to perform any activities at work? ☐ YES ☐ NO

   IF YES:
   a. Date of last respirator clearance medical questionnaire/evaluation: ______________
   b. Date of last respirator training: ______________
   c. Date of last respirator fit testing: ____________

III. ADDITIONAL PERSONAL HEALTH CONCERNS

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? ☐ YES ☐ NO

IV. INDIVIDUALS WORKING WITH SHEEP

1. Do you work with **FEMALE** sheep? ☐ YES ☐ NO
2. Do you have a history of known valvular disease (heart murmurs) or congenital heart disease? ☐ YES ☐ NO

   IF YES:
   a. Date of diagnosis: ______________
   b. Type of disease: ______________________________________
   c. Treatment: ____

3. Do you have any diseases or are you taking any medication that may cause immune suppression? ☐ YES ☐ NO
4. Do you now have or have you ever had Q-fever? ☐ YES ☐ NO

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

Signature: ____ **Date:** _________________________________

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With your completed form, please send a signed copy of the University Health Center Notice of Privacy Practice which is located at the end of this form.

To view Notice of Privacy Practice visit:

www.health.umd.edu/privacy

Please send completed and signed questionnaire to:

Occupational Health/ University Health Center
Campus Drive, Bldg 140, Room 0106
College Park, MD 20742

FOR OFFICE USE ONLY

☐ Cleared ______________________________

☐ Cleared with Restrictions Listed ______________________________

☐ Not Cleared ______________________________

☐ Incomplete ______________________________

Providor 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