UNIVERSITY OF NOTRE DAME

Category A Form
Medical & Occupational Health History Form for Animal Exposures

As part of the University of Notre Dame's (UND) Occupational Health Program this form shall be completed triennially by all individuals working with live or dead whole animals (except those working exclusively with aquatic species), or biohazards in conjunction with animals. A medical professional will review this information to determine whether any additional testing, exams, precautions, or limitations are necessary.

Please note that ALL information on this form is required.
The Form will not be processed if information is missing.
Processing may take up to 2 weeks.

Upon completion, forward **ALL 5 pages of this form** to Workforce Health at 19567 Cleveland Road, South Bend, IN 46637. It can be dropped off, mailed through the Postal Service, or secure faxed to 574-277-7690. Workforce Health phone: 574-277-7600.

After this form is reviewed by the physician you will receive via the U.S. Postal Service a "Category A – Medical and Occupational History Evaluation". This will provide you instructions of what is required of you prior to starting your research/work.

Part I: General Information – ALL FIELDS ARE REQUIRED (unless otherwise noted)

Today's Date:	FOAPAL #: This is used to cover vaccination costs. Contact the PI or manager for the #.	
First Name:	Middle Initial:	Last Name
Former Name/Maiden Name Used at ND (if applicable)	Gender: □ Male □ Female	
Date of Birth (MM/DD/YYYY):	UND NetID (if available):	
UND NDID (9 digit number found on the ND ID Card, if available):		
Your Current Mailing Address: (Note – Inform the Wellness Center if your address changes)		
City:	State/Country:	Zip Code:
Email Address:	Cell or Home Phone Number:	
Campus Mailing Address:		
Department at UND in which you will be working:		
UND PI or Faculty Member Name or Manager:		
Employment Status		

□ Faculty □ Staff □ Post-doc □ Graduate Student □ Undergraduate □ High School Student □ Middle School Student □ Summer Employee □ Visitor/Collaborator □ Contractor □ IACUC Member
Is this a limited assignment? Yes / No If Yes, what is the end date?

Name: _____

Date of Birth: _____

Part II: Occupational Risk Factors

Animal and/or Tissue Exposure		
Animal Species	**Type of Exposure** Check (x) All that Apply	
	Animal	**Tissue**
Amphibians and/or Reptiles		
Birds (wild-caught)		
Fish		
Guinea Pigs		
Mice		
Non-Human Primates		
Rabbits		
Rats		
Wild Carnivores		
Wild Rodents		
Other Wild Mammals		
Other (Specify):		

Other Potential Exposures			
Laboratory Exposures	**Yes**	**No**	**If Yes, provide exposure explanation**
Chemical carcinogens			
Hazardous chemical exposures			
Infectious Agents/r-DNA technologies			
Parasites			
Radiation			
Reproductive hazards/teratogens			
Other biological agents (adjuvants, vaccines, human cells and tissues, etc.) *List agents:*			

Name: _____

Date of Birth: _____

Part III: Personal Medical History
Have you ever had the following immunizations?

Disease	Yes	No	Provide dates of vaccination
Hepatitis A Series			
Hepatitis B Series			
Measles/Mumps/Rubella *(Non-human primate users only)*			
Rabies series			Date of last vaccine:
If yes, were you tested for antibody to Rabies?			Date of titer:
Tetanus			Date of last vaccine:

Tuberculosis (Tb) Surveillance
Only required for non-human primate users or those working with active or Live Tb organisms

Question	Yes	No	Explanation – provide if known
Have you ever had active tuberculosis?			
If Yes, list date and describe treatment			
If no, list date and results of Tb skin test *Enter "N/A" if not available*			Date: Test Result: (Circle) Positive or Negative
Have you received the tuberculosis vaccine Bacillus Calmette-Guerin (BCG)?			If not sure, check the box:
Have you had lab testing related to a Tb test (Quantiferon Gold Test)?			If not sure, check the box:
Have you had a positive Tb skin test?			If yes, list date
Do you have sensitivity or reaction to the Tb purified protein derivative used in the skin test?			If not sure, check the box:
Have you had x-rays taken			If yes, describe the reason for the

related to Tb screening?			x-rays.

Name: _____

Date of Birth: _____

Allergy/Asthma Information:

Question	Yes	No	Explanation
Do you have asthma?			If yes, what are the causes of your asthma?
Are you allergic to any animals?			If Yes, list the animals you are allergic to:
Do you have allergy symptoms / asthma related to animals that you currently work with?			If Yes, list the animals you are allergic to:
Do you have any other known allergies?			If Yes, list them.
List the symptoms that occur related to your allergies.			If none, write “N/A”.
List treatments that you receive for allergy/asthma.			If none, write “N/A”.
Do you have skin problems related to work (reactions to gloves, dry/cracked skin, rashes)?			If yes, describe.
Do you have a condition, or take medications, which could suppress your immune system?			If yes, explain.
Do you have any ongoing medical conditions?			If yes, explain.

Are you allergic to latex?			

Name: _____

Date of Birth: _____

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

Circle: Yes No

If yes, please describe what those concerns are:

_____
_____
_____
_____

Part IV: Certification

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

Name (Print):_____

Signature: _____

Date: _____

Signature of Legal Guardian (if under age 18)**: _____**

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2. Dropped off at the Workforce Health at 19567 Cleveland Road, South Bend, IN 46637
3. Secure faxed to 574-277-7690