



OCCUPATIONAL MEDICINE ENROLLMENT FORM

YOUR RESPONSES ARE STRICTLY CONFIDENTIAL

General Information:

1. To minimize risks to employees, health screening at the beginning of the job and at periodic intervals is recommended for certain job categories. Likewise, it is important that you notify OH&S Occupational Medicine about any change in your job, exposures or activities at UAB.
2. If you have ever been diagnosed with or had symptoms of the following, you may be at increased risk of injury or health problems when conducting research at UAB:

Skin rashes	Glove Allergies/rashes	Allergies to animals, dander, and/or hair
Asthma	Muscle or bone problems	Allergies to pollen, food, etc.
Latex Allergy	Mitral valve prolapse	Repetitive motion injury (i.e., carpal tunnel)
Diabetes	Repeated episodes of diarrhea	Problems with visual acuity, hearing ability
Hernia	Splenectomy (missing spleen)	Allergic skin problems, eczema
Seizure disorder	Drug or alcohol dependency	Family history of hay fever, asthma
3. If you are pregnant or if your immune system is suppressed, you may be at increased risk. Please make sure your private/personal physician knows about your job duties.
4. Employees working with certain animals may require immunizations specific to that species.
5. If you have any disability (limitation) for which you believe an accommodation is needed for you to perform your job, it is your responsibility to inform your supervisor and request a workplace accommodation.
6. An annual tuberculosis (TB) screening is required for employees with exposure to nonhuman primates and other specified areas at UAB. Vaccination against TB by Bacillus Calmette-Guerin (BCG), does not exclude one from annual TB screening requirements.
7. Allow 1-2 weeks for processing forms. Your OH&S Occupational Medicine Clearance will be delayed for incomplete forms.

Specific Information for Attachments 1 and Attachment 2:

1. In addition to completing pages 2, 3, and 4, you will be required to complete **Attachment 1** if any of the following apply to you:
 - have direct contact with or enter rooms occupied by nonhuman primates,
 - work in an area that requires TB screening,
 - work with material of human or nonhuman primate origin,
 - work with restricted material or in a restricted area,
 - work in or enter a BSL3 or ABSL3 area,
 - receive either a required or recommended immunization through this program,
 - work with animals or walk through an area where animals are present,
 - have a current or past medical condition that may affect your ability to work in an area.
2. You must either complete **Attachment 1** **OR** complete **Attachment 2**, which acknowledges by signature that you understand that you may be placing yourself and others at risk by not disclosing the information requested.

Form submittal:

1. You may submit completed forms electronically to OHSocmed@uab.edu. **This is preferred.**
2. You may place the completed forms in a *Confidential Envelop* and return it to:
UAB OH&S Occupational Medicine
CH19, Suite 445-2041
3. You may fax the completed forms to (205) 934-7487. Please be aware that the fax machine is located in the main OH&S office and confidentiality cannot be assured.
4. You may deliver your completed forms to CH19 Suite 412 and place the forms in the secured lock box at the receptionist desk.

Please complete **ALL** of the following information.
Incomplete paperwork will delay processing and approval. **DATE:**

Check all that apply: Mr. Mrs. Ms. Dr. Male Female
 Are you employed by UAB? Yes No Are you (circle one): Full Time Part Time Temporary

Last Name	First Name	MI
Job Title	Work Address	Blazer ID
Date of Birth	Best way to contact you	Dept.
Work Phone	Alt. Phone	Email
Supervisor Name		

So that we can perform a risk assessment on your work activities at UAB, please provide a brief job description in the space below (use back of form if more space is required):

Status: Faculty Staff/Employee Research Technician/Associate
 (Check all that apply) Student Post Doc Visiting Scientist
 Volunteer Other (specify) _____

Work Area:

Lab Location (Bldg and Room): _____
 Animal Facilities (Bldg and Room): _____
 Other Areas (Bldg and Room): _____

Do you wear a respirator?: NO YES If YES, for what exposure: _____
 If YES, what type of respirator: _____ If YES, date of last Fit Test: _____

Do you anticipate wearing a respirator?: NO YES

Work Exposure:

Does your work involve any of the following?	NO	YES	If YES, specify/list
1. Biological Agents			
a. Recombinant DNA/RNA			
b. Infectious Agents			
2. Human Blood, Body Fluids, Tissues, or Cells			
3. Physical Agents			
a. Caustics or Flammables			
b. Noise			
c. Radiation			
d. Radioisotopes			
e. Extreme Environmental Conditions			
f. Lasers			
4. Chemical Agents			
a. Anesthetic Gases			
b. Drugs/Chemotherapeutic Agents			
c. Heavy Metals			
d. Carcinogens			
e. Corrosive Agents			
f. Acid and Bases			
5. Animals			<i>If YES, complete the following table on next page</i>

Work Exposure (Cont.):

Species	Contact Type			Level of Contact*		
	Current at UAB	In Past but not now	Outside of UAB	Level 1	Level 2	Level 3
Mouse						
Rat						
Hamster						
Guinea Pig						
Rabbit						
Dog						
Cat						
Sheep						
Goat						
Pig						
Ferret						
Non-Human Primate Specify: _____						
Tree Shrews						
Bird(s) Specify: _____						
Fish Specify: _____						
Sea Urchins						
Reptile(s) Specify: _____						
Amphibian(s) Specify: _____						
OTHER:						

* Level 1: No direct contact with live animals, but either you enter animal room or animal is in your work space
 Level 2: No direct contact with live animals, but you handle “unfixed” animal tissue and/or fluids
 Level 3: Direct contact with live animal(s); (e.g., handle, restrain, collection of specimens, administers)

Immunizations:

To meet the UAB Occupational Medicine policies, please provide the following information regarding immunizations, vaccinations, or tests. Also, attach documentation of vaccinations.

Vaccination	Date of Vaccination	Have you had this disease?	
		No	Yes
BCG (tuberculosis vaccine)			
Hepatitis A (give dates of both vaccinations)	1)		
	2)		
Hepatitis B (give dates of all three vaccinations)	1)		
	2)		
	3)		
Hepatitis A/B Combo (give dates of all three vaccinations)	1)		
	2)		
	3)		
Measles (Rubeola)			
Mumps			
Rubella			
MMR (Measles, Mumps, Rubella combination) (give dates of both vaccinations)	1)		
	2)		
Rabies			
Tetanus			
Toxoplasmosis			
Vaccinia (smallpox)			
Varicella (chickenpox)			
Other: (specify) _____			

Date of last TB Skin Test (PPD) _____ Result? _____

If result was positive, what was the date of your last chest X-Ray? _____ Result? _____

Assurances:

I certify that information provided is true and complete to the best of my knowledge. I understand that any intentional false statement or omission of facts may place me or my coworkers at increased risk of health-related injury/illness and may be grounds for disciplinary action.

I have read the information in this form. I am aware that some health conditions may increase my risk of injury or illness when working with research animals. I understand that I should make my physician aware of these conditions and my duties.

Signature

Date

If electronically submitted, the form must be sent from the employee's UAB email account to satisfy the signature requirement.

ATTACHMENT 1

Medical History

Printed Name: _____ **Blazer ID:** _____

Have you had any of the following (check all that apply)?		
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Recurrent Bronchitis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Heart Murmur or Valve Disease
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Gastrointestinal Disorder	<input type="checkbox"/> Loss of Consciousness
<input type="checkbox"/> Seizures	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Chronic Back or Joint Pain

Allergy	Symptoms*			Frequency of Symptoms**			Treatment
	A	B	C	X	Y	Z	Please Describe Here
Animal Specify: _____							If so, do you have plans to work with these animals in your research?
Chemicals: Specify: _____							
Medications: Specify: _____							
Latex							
Other: (pollen, food, talc, etc.) Specify: _____							

***Symptoms:** A – itchy eyes, runny nose, sneezing
 B – wheezing, shortness of breath, asthma
 C - hives

****Frequency:** X – less than 1 time per year
 Y – more than 1 time per year
 Z – seasonal only

Please answer the following:	NO	YES	If YES, explain or list
Do you have any ongoing medical problems?			
Have you ever contracted a disease from animals or experienced an animal-related injury (including bites, scratches, etc.)?			
Have you ever been told by a physician that you have an immune-compromising medical condition or are you taking medication that might impair your immune system (e.g., steroids, immunosuppressive drugs, chemotherapy)?			
Are you currently under a physician's care for allergies or asthma?			
Are you currently taking any medications?			
For women: Are you pregnant, or planning to become pregnant in the next two years?			Explanation not necessary

ATTACHMENT 2
Declination to Disclose Medical History

Printed Name: _____ **Blazer ID:** _____

I certify that none of the following applies to me that would require me to complete **Attachment 1**:

1. have direct contact with or enter rooms occupied by nonhuman primates,
2. work in an area that requires TB screening,
3. work with material of human or nonhuman primate origin,
4. work with restricted material or in a restricted area,
5. work in or enter a BSL3 or ABSL3 area,
6. receive either a required or recommended immunization through this program,
7. work with animals or walk through an area where animals are present,
8. have a current or past medical condition that may affect your ability to work in an area.

I understand that I have the option of completing **Attachment 1** in order to provide OH&S Occupational Medicine with a more complete history. I am, however, declining to provide this information at this time and will ensure that my primary care physician is aware of the work that I am conducting here at UAB. I understand that I may be placing myself and others at risk by not disclosing the information requested on the form to OH&S Occupational Medicine or my personal physician.

I understand that I may choose to complete **Attachment 1** at a later time in order to provide OH&S Occupational Medicine with a more complete history and to receive services through OH&S Occupational Medicine.

Signature

Date