THE UNIVERSITY OF ALABAMA AT BIRMINGHAM
OH&S Occupational Medicine

ENROLLMENT RENEWAL 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 page 2, 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, or
   - 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.
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 OHSoccmed@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 them in the secured lock box at the receptionist's desk.

Demographic Information:

Please complete **ALL** of the following information:	**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		Alternate 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 (please note any exposure changes and use back of form if more space is required):

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, type of respirator: _____ If YES, date of last Fit Test: _____

Do you anticipate wearing a respirator?: ☐ NO ☐ YES

Have your work exposures changed? ☐ NO ☐ YES

If yes, please include changes above on this form under job description.

Immunizations:

Have you had any immunizations from another healthcare facility/provider since your last enrollment form?

☐ NO ☐ YES If so, please list:

Immunization	Date of Immunization

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 and/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:

Have you had any of the following (check all that apply)?		
☐ Pneumonia	☐ Recurrent Bronchitis	☐ Tuberculosis
☐ Heart Disease	☐ Rheumatic Fever	☐ Heart Murmur or Valve Disease
☐ Diabetes	☐ Kidney Disease	☐ Liver Disease
☐ Cancer	☐ Gastrointestinal Disorder	☐ Loss of Consciousness
☐ Seizures	☐ Arthritis	☐ 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 then 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 be come 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, or
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.

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