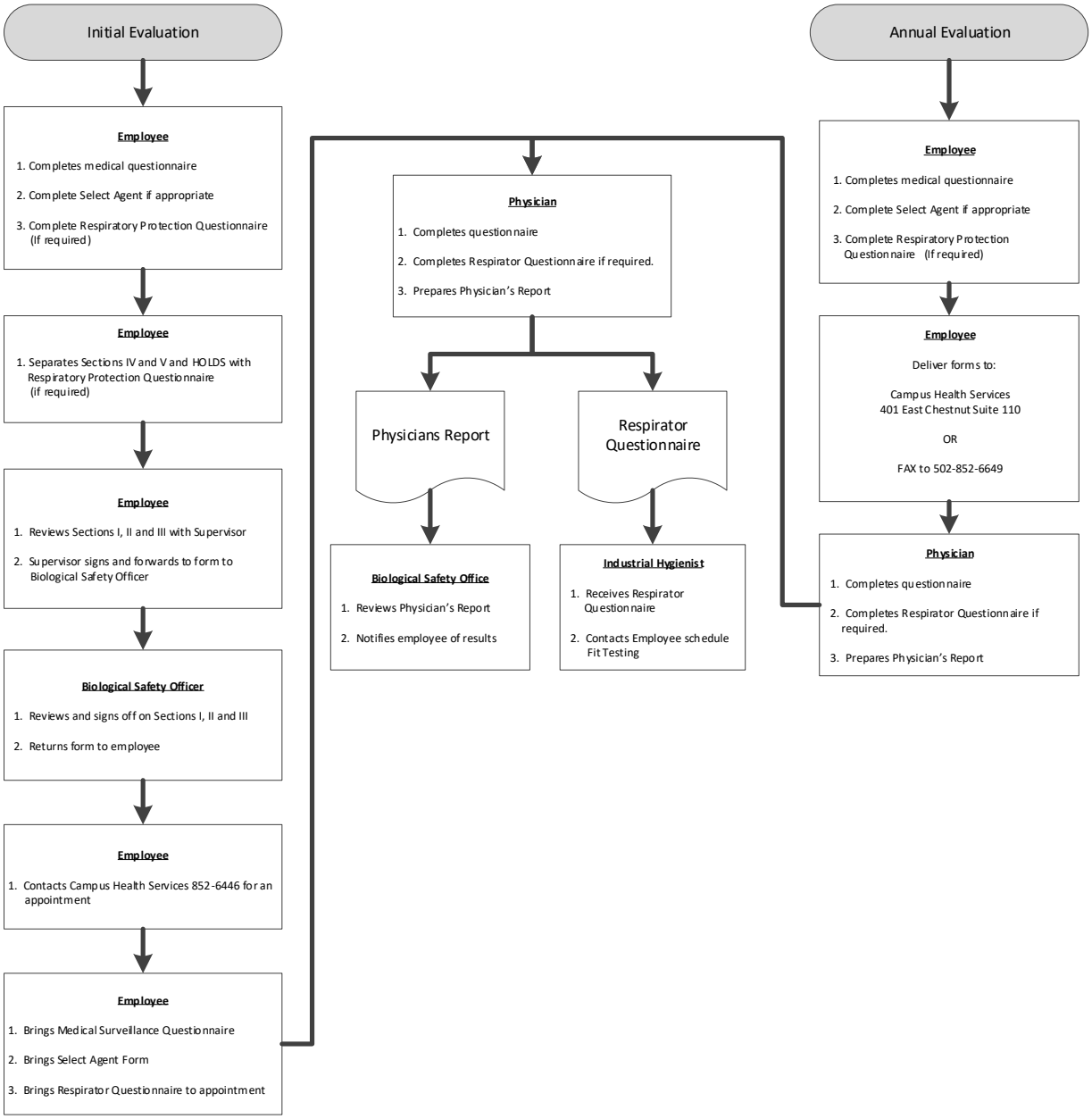
BSL3-ABSL3 Select Agent Medical Surveillance Questionnaire

Clearance Process



Billing Notice

Your department will be invoiced for your evaluation. We must have the following information before we can complete your approval.

1. Department Name
2. UBM or their designee contact name and phone number
3. Mailing address for invoicing.

Please supply this information in writing prior to or on the day of your visit.

Non Printing Page

This page is to gather some basic information which recurs throughout the form when completing it electronically. Only some basic information such as name, employee ID is collected on this page.

Clear Entire Form

First Name: Phillip

Middle Initial: F

Last Name: Bressoud, MD

Employee ID: 102466

Date of Birth: 03/22/1959
(mm/dd/yyyy)

Name: Bressoud, MD Phillip F DOB: 03/22/1959 EmpID: 102466

Notice of Purpose

And

Authorization to Release Information

The purpose of this form is to obtain information about your personal health and work-related exposure potential. This information will be used by your employer, UofL, including UofL's Campus Health Services, (Occupational Medicine Service) to make an assessment of your fitness to work with biohazardous material or animals. Campus Health Services will evaluate the information on this form and notify you, your supervisor, and the Biosafety Office at UofL Department of Environmental Health and Safety (DEHS) of work restrictions or additional protective measures required for your health, as well as whether you have completed all applicable occupational health requirements needed for you to continue your work with biohazards. Note that sections IV and V of the form contain individually identifiable health information which is treated as confidential information as a part of your employment record.

Based on your answers to this questionnaire, UofL Campus Health Services may request that you be seen for a medical exam prior to initiating work with certain biohazards or contact with animals, or on a periodic basis after that. You will be asked to complete this Medical Health Questionnaire periodically to assess ongoing risks and fitness for duty.

I authorize Campus Health Services to share any findings, assessments, recommendations and other information necessary ("assessments") to appropriate University officials responsible for administering the Select Agent program including the select agent review panel or certifying official so that the University as employer can comply with the appropriate safety obligations (e.g.7 CFR Part 331, 9 CFR Part 121, 42 CFR Part 73.)

I understand that UofL

(1) will treat this information (information on the form as well as Campus Health Services assessments) as confidential,

(2) will limit access internally to those individuals who need to have access to assess this work-related exposure potential and to fulfill its legal and safety requirements (e.g. select agents) and

(3) will not share such information outside the University except as required by law or public safety.

_____ 03/04/2019

Employee Signature Date

Phillip F Bressoud, MD

Employee Name

SELECT AGENT MEDICAL SURVEILLANCE QUESTIONNAIRE

❑ Initial ❑ Annual ❑ Interval/Change Date: 03/04/2019

I. Personal Information

Last: Bressoud, MD	First Phillip	Middle F
Employee ID #: 102466	Date of Birth: 03/22/1959	❑ Male ❑ Female

Home Address (Street):	
City (Home):	
State (Home):	Kentucky
Home/Cell Phone:	
Email:	

Position Information

Job Title:		Work Phone:		Start Date:	
PI/Supervisor:					
PI/Supervisor's Department:					
PI/Supervisor's Division (if applicable):					

Select Agent support personnel (e.g. security, police, administrative) with work assignment/areas that are NOT in containment and are required to participate in SA Personnel Suitability Program, must complete the Authorization to Release Information and Sections I, V and VI.

Unit Business Manager Information or Designee

Name of UBM:		UBM Telephone:	(502) 852-
UBM Mailing Address:			

INSTRUCTIONS: Sections I, II, III, and IV should be completed by employee and supervisor in consultation with Biosafety Officer. Section V and VI contain confidential personally identifiable health information and are to be completed by the employee. The Campus Health Services Physician is responsible for receiving and reviewing the questionnaire and updating the employee immunization records.

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Name: Bressoud, MD Phillip F DOB: 03/22/1959 EmpID: 102466

II. WORK ASSIGNMENT/AREAS

1. Work Assignment/Areas

	❑	Yes	❑	No	a)	BSL-2 Areas
	❑	Yes	❑	No	b)	ABSL-2 Areas Work ❑ RBL ❑ HSC ❑ Belknap
	❑	Yes	❑	No	c)	BSL-3 Areas, select all applicable areas: ❑ RBL ❑ CTR* (*Annual TB screening required)
	❑	Yes	❑	No	d)	ABSL-3 Areas
	❑	Yes	❑	No	e)	Animal Cages, Bedding, and Equipment

2. Biohazardous Agents

	❑	Yes	❑	No	a)	Recombinant DNA/RNA (Plasmids, Genes, Vectors, Etc.)
	❑	Yes	❑	No	b)	Pathogenic Organisms (Viral, Bacterial and Fungal Organisms or Human/Animal Parasites) If yes, list organisms:
	❑	Yes	❑	No	c)	Human Blood, Tissues, Blood Products, Cell Lines, OPIM
	❑	Yes	❑	No	d)	Biological Toxins or Products
						If yes, list toxins/products:

3. Chemical and Physical Agents

	❑	Yes	❑	No	a)	Hazardous Chemicals (e.g. benzene, chloroform, toluene, formalin, paraformaldehyde, etc…)
						If yes, list:
	❑	Yes	❑	No	b)	Highly Toxic, Carcinogenic, Mutagenic Agents
	❑	Yes	❑	No	c)	Anesthetic Gases/Vapors (e.g. flurane, isoflurane, nitrous oxide, metafane, halothane, ether, etc…)
	❑	Yes	❑	No	d)	Investigational Drugs (non-FDA Approved)
	❑	Yes	❑	No	e)	Other Chemical Toxins Types:
	❑	Yes	❑	No	f)	Radioactive Material (Radioisotopes, Tracers)
	❑	Yes	❑	No	g)	Radiation (Irradiator, X-ray, Densitometer, Etc.):
	❑	Yes	❑	No	h)	Loud Noises
	❑	Yes	❑	No	i)	Other:

4. Human or Animals Tissues or Body Fluids which are fresh or not fixed in a preservative such as formalin

Hours per Day	Species	Hours per Day	
	Cats		Pigs
	Cows		Rabbits
	Dogs		Rats
	Ferrets		Sheep
	Goats		Wild-type or field capture animals(specify type):
	Guinea pigs		
	Hamsters		Other species:
	Mice		

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III. VACCINES OR TESTS THAT MAY BE REQUIRED:

	❑	Anthrax Vaccine	❑	Seasonal Flu Vaccine
	❑	EEE Vaccine	❑	Small Pox Vaccine
	❑	Hepatitis B Vaccine	❑	Tetanus-diphtheria-pertussis Vaccine
	❑	HIV testing	❑	Tuberculosis screening
	❑	Medical Clearance for Respirator Use	❑	Tularemia Vaccine
	❑	MMR Vaccine	❑	VEE Vaccine
	❑	Q Fever blood test	❑	WEE Vaccine
	❑	Rabies Vaccine	❑	Other:

IV. PERSONAL PROTECTIVE EQUIPMENT

When performing your work assignment, do you wear the following? (Check all that apply)

❑	Yes	❑	No	Gloves	❑	Yes	❑	No	Hair Cover/Bouffant
❑	Yes	❑	No	Coveralls	❑	Yes	❑	No	Face Shield
❑	Yes	❑	No	Gown	❑	Yes	❑	No	Shoe covers
❑	Yes	❑	No	Hearing Protection	❑	Yes	❑	No	Safety Shoes/Boots
❑	Yes	❑	No	Goggles/Safety Glasses					

	If you wear hearing protection, have you had your hearing checked within the last year?	❑ Yes	❑ No	
		If Yes, indicate date last tested		

Respiratory Protection: Does the work require respiratory protection? (Check all that apply)

❑	Yes	❑	No	Negative-Pressure (Ex. N95) Positive Pressure Respirator (ex. PAPR) Self-Contained Breathing Apparatus (ex. SCBA)	Specify type:	❑ N95 ❑ PAPR ❑ SCBA ❑ Other
				If yes, have you received and completed:		
				❑ Yes ❑ No Training	If Yes, Date:	
				❑ Yes ❑ No Fit Testing	If Yes, Date:	

Employee Signature _____ Date 03/04/2019

Supervisor Signature _____ Date _____

Biosafety Officer Signature _____ Date _____

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Section V and VI contain confidential personally identifiable health information which is to be completed by the employee.

DO NOT SHARE SECTIONS **V or VI** WITH YOUR SUPERVISOR.

1. Once you complete the form, forward Section I, II, III and IV to the **Biosafety Officer** and retain sections V and VI for physician consult.

2. Once the Biosafety Office has signed off on Sections I, II, III, and IV it will be returned to you.

3. Reassemble your medical questionnaire Sections I through VI along with the Respirator Questionnaire if applicable.

4. Contact Campus Health Services at 852-6446 to schedule an evaluation if this is your initial evaluation. If this is your annual evaluation, please FAX your forms to 852-6649 or hand deliver them to:

   Campus Health Services
   401 East Chestnut Street Suite 110
   Louisville, KY 40202

5. Please be sure to bring your Medical Surveillance Questionnaire and Respirator Questionnaire to your appointment.

V. Health History

1. Medical History

Have you had or are you currently being treated for any of the following:

Never	Currently	Past	Condition	Comments
❑	❑	❑	Anxiety	
❑	❑	❑	Arthritis (Osteoarthritis, Degenerative Arthritis)	
❑	❑	❑	Asthma	
❑	❑	❑	Cancer	
❑	❑	❑	Coronary Artery Disease	
❑	❑	❑	Chronic Back or Joint Pain	
❑	❑	❑	Chronic Lung Disease	
❑	❑	❑	Congenital Heart Disease or Surgery	
❑	❑	❑	Depression	
❑	❑	❑	Diabetes	
❑	❑	❑	Eczema	
❑	❑	❑	Heart Murmur	
❑	❑	❑	Heart Valve Disease	
❑	❑	❑	Gastrointestinal Disorder	
❑	❑	❑	Kidney Disease	
❑	❑	❑	Liver Disease	
❑	❑	❑	Loss of Consciousness	
❑	❑	❑	Pneumonia	
❑	❑	❑	Recurrent Bronchitis	
❑	❑	❑	Psoriasis	
❑	❑	❑	Rheumatic Fever	
❑	❑	❑	Seizures	
❑	❑	❑	Tuberculosis	
❑	❑	❑	Tuberculosis skin test positive	

❑	Yes	❑	No	Do you regularly see a physician or other provider any health problems?
❑	Yes	❑	No	Any new medical problems in the last year?
❑	Yes	❑	No	Have you ever been told by a physician that you have an immune compromising medical condition or are you taking medications that might impair your immune system (e.g. steroids, immunosuppressive drugs, chemotherapy)?
				If yes, please describe:
❑	Yes	❑	No	Have you ever contracted a disease from animals or experienced a severe animal-related injury?
				If yes, explain:

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1. Medical history (continued)				
❑	Yes	❑	No	Do you wear prescription glasses or contacts? Please check all that apply.
				❑ Contact lens ❑ Glasses
❑	Yes	❑	No	For women: Are you pregnant, or planning to be pregnant in the next three years?

2. Allergy History: (Please check the boxes below that apply)

Animals	Rash	Wheezing	Itching	Tearing	Other
Cats	❑	❑	❑	❑	❑
Cows	❑	❑	❑	❑	❑
Dogs	❑	❑	❑	❑	❑
Fish	❑	❑	❑	❑	❑
Gerbils	❑	❑	❑	❑	❑
Goats	❑	❑	❑	❑	❑
Guinea pigs	❑	❑	❑	❑	❑
Hamster	❑	❑	❑	❑	❑
Mice	❑	❑	❑	❑	❑
Pigs	❑	❑	❑	❑	❑
Rabbits	❑	❑	❑	❑	❑
Rats	❑	❑	❑	❑	❑
Sheep	❑	❑	❑	❑	❑
Tree Shrews	❑	❑	❑	❑	❑
Other:	❑	❑	❑	❑	❑
Chemicals					
	Rash	Wheezing	Itching	Tearing	Other
Specify:	❑	❑	❑	❑	❑
Specify:	❑	❑	❑	❑	❑
Medications					
	Rash	Wheezing	Itching	Tearing	Other
Specify:	❑	❑	❑	❑	❑
Specify:	❑	❑	❑	❑	❑
Food/Environmental/Other					
	Rash	Wheezing	Itching	Tearing	Other
Foods(specify)	❑	❑	❑	❑	❑
Plants (specify):	❑	❑	❑	❑	❑
Pollen	❑	❑	❑	❑	❑
Dust	❑	❑	❑	❑	❑
Other:	❑	❑	❑	❑	❑

❑	Yes	❑	No	Are you currently under a physician's care for allergies or asthma?
				If yes, please explain:
❑	Yes	❑	No	Do any of your household contacts have an immune compromising medical condition such as cancer, autoimmune disease, receiving radiation or chemotherapy treatments?
				If yes, please explain:
❑	Yes	❑	No	Do you current require accommodations when you work with animals such as masks or PAPRs?
				If yes, please describe:

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3. Immunization History :

Please provide information on your immunization/vaccination status for each disease listed below. Indicate if you have a history of the disease, have been vaccinated, tested for antibody (positive blood test, titer, antibody) or are unsure of your status for each disease by checking the appropriate box. Indicate the date(s) of vaccinations or tests if known.

History of	Vaccinated	+ Lab Test	Unsure	Disease	Date(s) if known	History of	Vaccinated	+ Lab Test	Unsure	Disease	Date(s) if known
☐	☐	☐	☐	Hepatitis A		☐	☐	☐	☐	Smallpox	
☐	☐	☐	☐	Hepatitis B		☐	☐	☐	☐	Tetanus	
☐	☐	☐	☐	Measles		☐	☐	☐	☐	Toxoplasmosis	
☐	☐	☐	☐	Mumps		☐	☐	☐	☐	Varicella (Chicken Pox)	
☐	☐	☐	☐	Rabies		☐	☐	☐	☐	Yellow Fever	
☐	☐	☐	☐	Rubella		☐	☐	☐	☐	Other:	

4. Tuberculosis History

☐	Yes	☐	No	Have you received the tuberculosis vaccine Bacillus Calmette Guerin (BCG)?	
	☐	Yes	☐	No	If yes, have you had a skin test since last receiving BCG?
				If Yes, please indicate approximate date of last test	
☐	Yes	☐	No	Have you been treated for tuberculosis or a positive TB skin test?	
				If Yes, date of last chest X-ray:	
☐	Yes	☐	No	Have you had a skin test or blood test for Tuberculosis?	
				Date of last TB skin test (PPD, TST), if known	

I understand as a condition of employment I will immediately report to Campus Health Services Executive Director any health condition that would have the potential to increase the risk for injury, or disease to my co-workers or myself.

_____ 03/04/2019

Employee Signature Date

_____ _____

Health Care Provider Date

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University of Louisville
Ongoing Select Agent Suitability Questions
(FORM PSP-2 Questions 1 and 2)
Individuals who have access to Tier 1 select agents must participate in Personnel Suitability Program.

Only complete this page if you are registered with UofL's Select Agent Program

VI. Select Agent Ongoing Suitability

Question 1

☐	Yes	☐	No	Within the past year has there been a change in your health or medications that have adversely affected your ability to safely have access to or work with select agents and toxins, or to safeguard select agents and toxins from theft, loss or release?	
	☐	Yes	☐	No	If YES, have you previously self-reported or voluntarily opted-out for this condition during the past year.

Patient's Comments:

Question 2

☐	Yes	☐	No	Within the past year have you experienced fatigue, anxiety, depression, or frustration that adversely affects your ability to safely have access to or work with select agents and toxins, or to safeguard select agents and toxins from theft, loss, or release?	
	☐	Yes	☐	No	If YES, have you previously self-reported or voluntarily opted-out for this within the last years?

Patient's Comments:

I hereby state that the information contained in this application is true, accurate and complete to the best of my knowledge and belief. I understand any false information on my application may subject my authorized access to select agent registered areas to suspension or removal.

Applicant Signature:_____ **Date:** 03/04/2019

Reviewing Physician Signature:_____ **Date:**_____

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