University of Louisville

RBL Medical Surveillance Questionnaire

☐ **Initial** ☐ **Annual** ☐ **Interval/change**

INSTRUCTIONS:

Sections I, II, III should be completed by employee and supervisor.

Sections IV and V contain confidential personally identifiable health information and are to be completed by the employee only.

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, IV and V.**

Submission: Please submit completed form to Occupational Medicine at occmed@louisville.edu

I. PERSONAL INFORMATION

Name (Last, First):		Today's Date:
Employee ID:	DOB:	☐ Male ☐ Female
Cell Phone:	Email:	
Job Title:	Start Date:	
Supervisor/PI Name:	Supervisor/PI Phone:	
Supervisor/PI Department:	Supervisor/PI Division (if applicable):	
Unit Business Manager (UBM) Name:		
UBM Address:	UBM Phone:	

II. LABORATORY EXPOSURE

Work Assignment/Areas			
BSL-2 Areas	☐ Yes	☐ No	
BSL-3 Areas	☐ Yes	☐ No	If yes, ☐ RBL ☐ CTR
ABSL-2 Areas	☐ Yes	☐ No	If yes, ☐ RBL ☐ HSC ☐ Belknap
ABSL-3 Areas	☐ Yes	☐ No	
Animal cages, bedding and equipment	☐ Yes	☐ No	

Biohazard Agents					
Recombinant DNA/RNA	☐ Yes	☐ No	Human blood, tissues, blood products, cell lines, other potentially infectious materials (OPIM)	☐ Yes	☐ No
Viral vectors	☐ Yes	☐ No	Biological toxins or products	☐ Yes	☐ No
Pathogenic organisms (viruses, fungi, bacteria, protozoa)	☐ Yes	☐ No	Other:		
If you answered "Yes" to any question above, please specify:					

Chemical and Physical Agents					
Hazardous chemicals (e.g. benzene, chloroform, toluene, formalin, paraformaldehyde, etc.)	☐ Yes	☐ No	Anesthetic gases/vapors (e.g. flurane, isoflurane, nitrous oxide, metofane, halothane, ether, etc.)	☐ Yes	☐ No
Highly toxic, carcinogenic, mutagenic agents	☐ Yes	☐ No	Investigational drugs (non-FDA approved)	☐ Yes	☐ No
Radioactive material (radioisotopes, tracers)	☐ Yes	☐ No	Radiation (irradiator, X-ray, densitometer, etc.)	☐ Yes	☐ No
Loud noises	☐ Yes	☐ No	Other:		
If you answered "Yes" to any question above, please specify:					

Describe the type and extent of animal contact that you have currently.

Species	Hours/Month	Species	Hours/Month	Species	Hours/Month
Mice		Rabbits		Sheep	
Rats		Dogs		Guinea pigs	
Gerbils		Cats		Fish	
Pigs		Cows		Wildlife:	
Hamsters		Goats		Other:	

III. PERSONAL PROTECTIVE EQUIPMENT (PPE)

Respiratory Protection							
Does your work assignment require respiratory protection?			☐ Yes	☐ No			
If yes, specify type: ☐ PAPR ☐ N95 ☐ Other:							
If yes, have you received the following:							
Training	☐ Yes	☐ No	If yes, list date:	Fit testing	☐ Yes	☐ No	If yes, list date:

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

Gloves	☐ Yes	☐ No	Goggles/safety glasses	☐ Yes	☐ No	Hair cover/bouffant	☐ Yes	☐ No
Coveralls	☐ Yes	☐ No	Gown	☐ Yes	☐ No	Face shield	☐ Yes	☐ No
Shoe covers	☐ Yes	☐ No	Safety shoes/boots	☐ Yes	☐ No	Hearing protection	☐ Yes	☐ No
If you wear hearing protection, have you had your hearing checked within the last year?			☐ Yes	☐ No	If yes, indicate date last tested:			

_____ _____

Employee Signature Date

_____ _____

Supervisor Signature Date

IV. HEALTH HISTORY

Medical History		
Do you have any significant medical conditions?	☐ Yes	☐ No
Have you ever been told by a provider that you are immunocompromised?	☐ Yes	☐ No
If you answered "Yes" to either question, please specify:		

Please list all medications that you are currently taking: _____

_____

Are you currently pregnant or do you plan on becoming pregnant in the next 3 years? ☐ Yes ☐ No

Allergy History		
Do you have any allergies to animals, medications, chemicals, food, latex or environment?	☐ Yes	☐ No
Are you currently under a provider's care for allergies or asthma?	☐ Yes	☐ No
If you answered "Yes" to either question, please specify:		

Do you experience any of the following symptoms while working with animals? (check all that apply)

☐ Watery, burning, or itchy eyes	☐ Coughing	☐ Shortness of breath
☐ Chest tightness	☐ Runny nose or sneezing	☐ Skin rash or hives
☐ Wheezing	☐ Anaphylaxis	☐ None

Immunization History				
Disease	**Vaccinated**	**+Lab Test (Titer)**	**Unsure**	**Date(s) if Known**
COVID	☐	N/A	☐	
Hepatitis B	☐	☐	☐	
Seasonal Influenza	☐	N/A	☐	
Tetanus	☐	N/A	☐	

I understand as a condition of employment, I will immediately report to Occupational Medicine any health condition that would have the potential to increase the risk for injury or disease to my coworkers or myself.

_____ _____

Employee Signature Date

For Clinic Use Only

☐ No restrictions, and no further testing or evaluation required
☐ No restrictions, but recommend fit testing
☐ Reproductive health counseling provided
☐ Recommend the following vaccinations: ☐ COVID ☐ Influenza ☐ Tetanus ☐ Hepatitis B ☐ None
☐ Needs the following medical evaluation/intervention before receiving clearance:

_____

_____

_____ _____

Healthcare Provider Signature Date

University of Louisville

Ongoing Select Agent Suitability Questions

(Form PSP-2 Questions 1 and 2)

V. SELECT AGENT ONGOING SUITABILITY

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.**

Question 1

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 this past year?	☐Yes	☐No
Comments:		

Question 2

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 year?	☐Yes	☐No
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 any authorized access to select agent registered areas to suspension or removal.

_____ _____

Employee Signature Date

_____ _____

Healthcare Provider Signature Date