

## Notice of Purpose and Authorization to Release Information

The purpose of the Medical Surveillance Questionnaire 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 Occupational Medicine, to assess your fitness to work with biohazardous material or animals. Occupational Medicine will evaluate the information on your questionnaire and notify you, your supervisor, and the Biosafety Officer 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 Medical Surveillance Questionnaire contain personally identifiable health information which is treated as confidential information as a part of your employment record.

Based on your answers to the questionnaire, UofL Occupational Medicine 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 the Medical Surveillance Questionnaire periodically to assess ongoing risks and fitness for duty.

I authorize Occupational Medicine to share any findings, assessments, recommendations and other information necessary 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:

- will treat this information (information on the Medical Surveillance Questionnaire as well as Occupational Medicine assessments as confidential,
- will limit access internally to those individuals who need to have access to assess the work-related exposure potential and to fulfill its legal and safety requirements (e.g. select agents) and
- will not share such information outside the University except as required by law or public safety.

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Employee Signature

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Date

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Employee Name (Print)

University of Louisville  
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](mailto:occmed@louisville.edu)

**I. PERSONAL INFORMATION**

Name (Last, First):		Today's Date:
Employee ID:	DOB:	<input type="checkbox"/> Male <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	
BSL-3 Areas	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, <input type="checkbox"/> RBL <input type="checkbox"/> CTR
ABSL-2 Areas	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, <input type="checkbox"/> RBL <input type="checkbox"/> HSC <input type="checkbox"/> Belknap
ABSL-3 Areas	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Animal cages, bedding and equipment	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Biohazard Agents					
Recombinant DNA/RNA	<input type="checkbox"/> Yes <input type="checkbox"/> No	Human blood, tissues, blood products, cell lines, other potentially infectious materials (OPIM)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Viral vectors	<input type="checkbox"/> Yes <input type="checkbox"/> No	Biological toxins or products	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Pathogenic organisms (viruses, fungi, bacteria, protozoa)	<input type="checkbox"/> Yes <input type="checkbox"/> 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.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Anesthetic gases/vapors (e.g. flurane, isoflurane, nitrous oxide, metofane, halothane, ether, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Highly toxic, carcinogenic, mutagenic agents	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Investigational drugs (non-FDA approved)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Radioactive material (radioisotopes, tracers)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Radiation (irradiator, X-ray, densitometer, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Loud noises	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?				<input type="checkbox"/> Yes	<input type="checkbox"/> No		
If yes, specify type: <input type="checkbox"/> PAPR <input type="checkbox"/> N95 <input type="checkbox"/> Other:							
If yes, have you received the following:							
Training	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, list date:	Fit testing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, list date:

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

Gloves	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Goggles/safety glasses	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hair cover/bouffant	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Coveralls	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gown	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Face shield	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shoe covers	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Safety shoes/boots	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hearing protection	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If you wear hearing protection, have you had your hearing checked within the last year?			<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been told by a provider that you are immunocompromised?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you currently under a provider's care for allergies or asthma?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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)

<input type="checkbox"/> Watery, burning, or itchy eyes	<input type="checkbox"/> Coughing	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Chest tightness	<input type="checkbox"/> Runny nose or sneezing	<input type="checkbox"/> Skin rash or hives
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> None

Immunization History				
Disease	Vaccinated	+Lab Test (Titer)	Unsure	Date(s) if Known
COVID	<input type="checkbox"/>	N/A	<input type="checkbox"/>	
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Seasonal Influenza	<input type="checkbox"/>	N/A	<input type="checkbox"/>	
Tetanus	<input type="checkbox"/>	N/A	<input type="checkbox"/>	

**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
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- ☐ 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, have you previously self-reported or voluntarily opted-out for this condition during this past year?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, have you previously self-reported or voluntarily opted-out for this within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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