Animal Exposure Program Enrollment Checklist

1. Personnel shall enroll initially when listed on an IACUC protocol or identified for enrollment due to job duties.

2. Personnel are required to re-enroll in the AEP only when there is a change in job duties or animal species in research, or personal health status.

3. Personnel shall not incur any costs or fees as part of their enrollment in the Animal Exposure Program.

4. To begin the enrollment process, personnel can download the AEP enrollment packet from the EHS website by clicking on the "Research and Environmental Support" section of the toolbar and scrolling down to the "Animal Exposure Program" heading. The three required forms are:
    - Animal Exposure Program Enrollment Checklist
    - Animal Exposure Program – Medical Surveillance Form
    - Animal Exposure Program - Medical Questionnaire

5. Principal Investigators, Supervisors or Designated Contact Person should fill out and sign the Medical Surveillance Form for their personnel.

    Note: If you arrive at a Centra Care location without a Supervisor completed and signed Medical Surveillance Form, your forms will not be accepted and you will be directed to report to your supervisor to obtain a signature and then return to Centra Care.

6. Personnel should fill out the Medical Questionnaire Form to the best of their ability and sign them. Questions about personal medical history contained in the Medical Questionnaire Form are considered confidential and should only be shared directly to Centra Care, not the PI or supervisor.

7. It is important for the enrollee to provide all requested information on the forms so that he or she can be properly evaluated by the physician. The information gathered will help identify existing conditions that may influence the health of the individual with potential animal exposure. For example, if the participant works in a room that houses two or more species, he or she will be potentially exposed to all species present. Also, whenever a participant works with a different species in the future (or taxonomic group for wildlife studies), a new questionnaire must be completed and sent for evaluation by the Centra Care physician.

8. If additional services other than screening for animal exposure are needed, select the appropriate section on the Medical Surveillance form. Please call ESH at 407-823-6300 to request a consultation with the ESH Bio Safety Officer if you have questions on which additional ESH services may be applicable to your research. These services may include:
    - Respirator Medical Evaluation Questionnaire, if respiratory protection is needed
    - Hepatitis B/Tetanus immunizations
    - QuantiFERON®-TB Gold Test for BSL-3 access

9. Once the forms are completed, the PI or supervisor shall **only** review, sign and date the Medical Surveillance Form to authorize medical evaluation and service by Centra Care. The PI may sign her or his own form when self-enrolling. The Medical Questionnaire Form is to remain confidential between the employee and Centra Care.

10. Bring both completed forms to a Centra Care location at either University, Conway, South Orange or Employer Care for processing. A medical evaluation may also be requested by the occupational physician during your visit or you may be requested to return for an additional visit. If further evaluation is required, Centra Care will reach out to the enrollee directly. Most individuals will not require a physical exam. The Occupational Health Physician will determine if further evaluation(s) or testing are necessary.

10. Once the evaluation is completed, Centra Care will issue a Medical Clearance Form identifying animal species evaluated. Centra Care will send one copy to the enrollee and one copy to EHS to be filed. EHS will additionally provide a copy of the completed form to the PI or supervisor.

Note: No confidential medical information is present on the Medical Clearance Form.

Animal Exposure Program Medical Questionnaire

Name: _____ UCF ID#_____ ☐Employee ☐Student ☐Volunteer

Address:_____ Phone:_____

Email:_____ Date of Birth: _____Cell Phone: _____

Supervisor/PI: _____ Department Name:_____ Date:_____

A. Immunization and Infectious Disease History

Have you ever had or do you now have any of the following immunizations? You must supply most recent year for immunization.

If the answer is yes, you must supply a date. If the answer is no, check the 'no' column. If the answer is unknown, select "Don't know".

Incomplete forms will be returned.

Vaccination History

	Yes	Date	No	Don't Know	Incomplete (Hep. B only)
Tetanus	☐	_____	☐	☐	
Hepatitis B (Series of 3)	☐	_____	☐	☐	☐

1. Will you be working with any biological materials? ☐ Yes ☐ No
   If yes, please explain:
   _____

2. Have you ever been diagnosed with an infectious, viral, bacterial, or parasitic illness that had been confirmed to have come from an animal? ☐ Yes ☐ No
   If yes, please explain:
   _____

3. Have you ever suspected that you have acquired an illness from an animal or animal materials/tissue at work or elsewhere, but were unable to confirm this? ☐ Yes ☐ No
   If yes, please explain:
   _____

B. Medical History

1. Have you been told by a physician that you have an immune compromising medical condition or are you taking medication that impair your immune system (steroids, immunosuppressive drugs, or chemotherapy)? ☐ Yes ☐ No
   If yes, please explain:
   _____

2. Have you been told by a physician that you have a chronic medical condition? ☐ Yes ☐ No
   If yes, please explain:
   _____

3. Are you currently taking any other medications? ☐ Yes ☐ No
   If yes, please explain:
   _____

C. Allergies/Asthma

1. Are you allergic to any animal(s)? ☐ Yes ☐ No

If yes, list the animals that caused your allergy symptoms: _____

2. Do you have any other known allergies? ☐ Yes ☐ No

If yes, please describe: _____

3. List symptoms that occur when you are suffering from your allergies.

☐ Sneezing ☐ Skin rash or hives ☐ Shortness of breath
☐ Watery or itchy eyes ☐ Runny or stuffy nose ☐ Other: _____
☐ Wheezing / Chest tightness ☐ Coughing

4. Does personal protective equipment alleviate these symptoms? ☐ Yes ☐ No

5. Have you ever been treated at a hospital, emergency room, urgent care or by paramedics for animal allergies? ☐ Yes ☐ No

6. List treatment that you receive to relieve your allergies: _____

7. Have you been treated for asthma? If yes, please list: ☐ Yes ☐ No

a. The cause(s) of your asthma: _____

b. Have you ever been hospitalized for asthma: _____

c. The number of asthma attacks per month: _____

d. The medications you take for your asthma: _____

8. Do you have skin problems related to work (e.g. reactions to latex gloves, dry/cracked skin, rashes)? ☐ Yes ☐ No

If yes, please describe: _____

9. Do you experience shortness of breath at work? ☐ Yes ☐ No

If yes, please explain: _____

10. Is there a family history of hay fever, asthmas, skin problems, or eczema? ☐ Yes ☐ No

If yes, please explain: _____

11. Outside of work, do you have any exposure to animals? ☐ Yes ☐ No

If yes, please explain: _____

D. Pregnancy

1. Are you pregnant, suspect you are pregnant or contemplating pregnancy? ☐ Yes ☐ No

2. Do you have work related questions concerning pregnancy that you would like to discuss with an Occupational Medicine Physician? ☐ Yes ☐ No

If yes, please explain: _____

E. Additional Questions and Concerns

1. Do you wish to talk to a medical provider concerning laboratory/client animals, hazards, or this questionnaire? ☐ Yes ☐ No

I have answered the questions on this form truthfully and to the best of my knowledge.

Enrollee Name (print) _____

_____ Date: _____

Enrollee Signature

Centra Care
FLORIDA HOSPITAL URGENT CARE

Employee / Applicant: _____

University of Central Florida

_____ **Medical Surveillance AEP (24501094)**

Available at University, Conway, South Orange Employer Care

	Exams		Lab Tests
	Animal Worker Medical Directorship questionnaire review		Hepatitis B Antibody
	Respirator Examination Medical Directorship questionnaire review		Complete Metabolic Panel (CMET Panel)
	Dive Physical Examintion		HEMGPD
	Other: _____		Lipid Panel
	Other: _____		Other: _____
	Occupational Health Testing		**Immunizations**
	Spirometry - Pulmonary Function (For Respirators)		Hepatitis B Vaccination
	Audiometry (Hign Noise Areas)		PPD - TB Test
	Titmus Vision Screening - Conway does not have this machine		
	OSHA Respirator Questionnaire		Hepatitis A Vaccination- call ahead to the center - this is special order
	Resting EKG		Influenza Vaccination
	Two View Chest X-ray		Meningitis - at Employer Care only
	Exit Exam		MMR - call ahead to the center - this is special order
			Pneumonia - at Employer Care only
			Polio - at Employer Care only
			Typhoid - at Employer Care only
			Varicella - at Employer Care only
			Yellow Fever - at Employer Care only
			Twinrix - call ahead to the center - this is special order
			Tdap
			Tetanus
			Shingles (Zoster) - at Employer Care only

******This form must be signed and completed by your Supervisor PRIOR to going to Centra Care!!!***

Supervisor: Date: Phone:

Phone Auth From: Received by: Date:

Revision 10/2/17