Work Ability Report for BSL-3 Facilities

Employee Instructions: Please fill in your name and employee ID and/or X.500 and submit with your BSL-3 Questionnaire by fax to 612-626-9643. Copies of this clearance form will be provided to University Health and Safety: Biosafety and Occupational Health Department (UHS-BOHD) and to your supervisor.

Employee Name (please print)    Employee ID    X.500

For HealthPartners Office Use Only:

Based on the BSL-3 Medical Questionnaire reviewed by HealthPartners, the above employee is:

☐ Cleared for Work in BSL-3 Facilities (no animal care/use)

☐ Cleared for Work in BSL-3 Facilities (animal use)
   ☐ Animal Exposure Questionnaire Submitted/Verified in ROHP

☐ Not Cleared for Work in BSL-3 Facilities
   Needs to complete Animal Exposure Questionnaire or other ROHP requirements

☐ Cleared for Work in BSL-3 Facilities—Appointment suggested but not required
   If you would like to be seen by a physician at HealthPartners, call 952-883-6999 to schedule a BSL-3 exam with Occupational Medicine.

☐ Not Cleared at for Work in BSL-3 Facilities—Appointment Required
   Employee must call HealthPartners at 952-883-6999 to schedule a BSL-3 exam with Occupational Medicine prior to working in BSL-3 facilities.

Other:

Provider’s Signature    Date Signed

Fax this form to Biosafety-Occupational Health Dept. at 612-626-9643
PURPOSE
The purpose of this form is to obtain information about your personal health and work exposures. This information will be used by the contracted Occupational Health Professional (OHP) to make an accurate assessment of your ability to safely work with biological and chemical agents in the BSL-3 laboratory. The OHP will evaluate the information on this form and document for you and your supervisor any work restrictions or protective measures to be followed. If restrictions and/or protective measures are required, it is the University’s expectation that you will comply.

Upon review of your questionnaire, the occupational health provider at HealthPartners Occupational and Environmental Medicine (HPOEM) may require that you be seen for an initial health assessment prior to starting work in a University of Minnesota BSL-3 lab. If you are contacted for an appointment, you must be seen before being cleared to start work.

You will be asked to complete the BSL-3 Medical Questionnaire periodically to assess ongoing risks and fitness for duty.

PRIVACY STATEMENT
The following information requested on the form is confidential: date of birth, sex, home address (unless listed in the campus directory) and all items under Medical History.

HPOEM will maintain health and treatment information about you in a confidential medical record to ensure your privacy. HPOEM will not release confidential information about you without your written consent, except as required by law. HPOEM will, however, notify your supervisor and University Health and Safety: Biosafety and Occupational Health Dept. (UHS-BOHD) of work restrictions or protective measures to be followed and whether you have completed all occupational health requirements applicable to you.

DIRECTIONS
Please fill out the questionnaire. Fax the completed form, including the attached cover sheet, to 612-626-9643. You may also return the form in a sealed envelope marked Confidential to UHS—BOHD at the address above.

The OHP may contact you via phone or email for any further information. If you have questions regarding this form, please call 612-626-5008 or e-mail uohs@umn.edu.

PARTICIPANT INFORMATION

Name ___________________________ Date ___________________________

Last First Middle Date of birth mm/dd/yyyy

Sex: Female [ ] Male [ ] Email ___________________________ Employee ID ___________________________

Job title ___________________________ P.I./Supervisor ___________________________ Department ___________________________

Home address ___________________________ Campus mailing address ___________________________

City ___________________________ State _____ Zip ___________________________

Home phone ___________________________ Cell ___________________________ Work phone ___________________________
MEDICAL HISTORY

1. Do you have any of the following conditions?

☐ Chronic respiratory disease
☐ Disease that affects the immune system such as leukemia or lymphoma
☐ Organ transplant
☐ Chronic infectious disease
☐ Valvular heart disease
☐ Artificial heart valves
☐ Immune disease such as lupus, scleroderma, or rheumatoid arthritis
☐ Cancer
☐ Ongoing cancer treatment or malignancy
☐ Tuberculosis HIV/AIDS Vascular grafts
☐ Chronic renal disease

☐ Other (please list any health condition you have that you think could be negatively affected by your work):

2. Other than the conditions listed above, are you being treated for any ongoing health problems? □ Yes □ No
   If yes, please explain: _____________________________________________________________

3. Do you have any reason to believe that you cannot work safely in an isolated environment? □ Yes □ No
   If yes, please explain: _____________________________________________________________

4. Do you have a medical condition for which you feel you should be seen by the Occupational Health Physician?

   □ Yes □ No

   If yes, please explain: _____________________________________________________________

5. Are you taking any of the following medications?

   ☐ Treatment for latent or active tuberculosis (INH)
   ☐ Prednisone or other steroids
   ☐ Immunosuppressive drugs

6. Do you have an exposed medical device (e.g., insulin pump) that cannot be removed or decontaminated with immersion if it were to be contaminated with a biologic agent?

   □ Yes □ No □ Not sure

   6a. If yes, can you work without using this device?

   □ Yes □ No □ Not sure

   6b. If yes, in the event of contamination, is a backup device available for use?

   □ Yes □ No □ Not sure
NOTE: QUESTIONS 7-9 ARE FOR FEMALES ONLY

7. Are you pregnant or planning to become pregnant within the next 12 months?  
   □ Yes  □ No  
   Note: If you have any questions about work exposure(s) and are pregnant or are thinking of becoming pregnant you should see the occupational health physician. If you become pregnant, please contact UOHS to be referred to an occupational health physician.

7a. If yes, are you potentially exposed to any of the following? (check all that apply)  
   Note: It is not possible to list all exposures that may affect pregnancy here.
   □ Toxoplasma gondii (Toxoplasmosis)  □ Varicella-zoster virus (chicken pox)
   □ Brucella bacteria (Brucellosis)  □ Herpes simplex virus I and/or II
   □ Lymphocytic choriomeningitis virus (LCMV)  □ Venezuelan equine encephalitis virus
   □ Rubella virus  □ Q fever
   □ Anesthetic gases  □ Wild animals (not screened for possible infections)
   □ Ionizing radiation  □ Cancer treatment drugs
   □ Listeria bacteria  □ Human parvovirus B19
   □ Cytomegalovirus (CMV)  □ Campylobacter bacteria
   □ Hepatitis B virus  □
   □ Human immunodeficiency virus (HIV)  □

8. Are you breastfeeding? (Note: Anthrax immunization while breastfeeding is acceptable)  
   □ Yes  □ No

9. Would you like to be contacted by an occupational health professional regarding pregnancy concerns?  
   □ Yes  □ No  
   NOTE: ONLY COMPLETE QUESTIONS 9-13 IF YOU ARE WORKING WITH BACILLUS ANTHRACIS.

10. Do you have a known allergy to the following antibiotics?  
    □ Yes  □ No  □ Not sure
    Ciprofloxacin (Cipro)
    □ Yes  □ No  □ Not sure
    Doxycycline (tetracyclines)
    □ Yes  □ No  □ Not sure
    Levofloxacin
    □ Yes  □ No  □ Not sure

11. Do you have an allergy to other antibiotics?  
    □ Yes  □ No  □ Not sure
    If yes, please specify:

12. Have you been treated for anthrax in the past? (Prior treatment for anthrax may increase the risk of reaction to the vaccine)  
    □ Yes  □ No  □ Not sure
    If yes, please specify:
13. Have you received the anthrax vaccine in the past?  
☐ Yes  ☐ No  ☐ Not sure

13a. If yes, how many immunizations did you have?

13b. If yes, when was your last immunization?

14. Do you have a question or concern regarding the anthrax vaccine for which you would like to be seen by an Occupational Health Professional at this time?  
☐ Yes  ☐ No

If yes, please specify:

**ANIMAL CARE/USE**

15. Will you be working with animals in the BSL-3 facility?  
☐ Yes  ☐ No

If yes, have you previously completed an Animal Exposure Questionnaire?

If you have not completed the Animal Exposure Questionnaire, you must submit one online or request a paper copy from uohs@umn.edu. The form can be found at: https://eresearch.umn.edu/researchforms/.

**OTHER CONCERNS**

16. Do you have any concerns or questions about occupational health and safety issues related to your job?  
☐ Yes  ☐ No

16a. If yes, please describe your concern.

16b. If yes, would you like to be contacted by an Occupational Health professional to discuss them?  
☐ Yes  ☐ No

*Please remember to sign after printing!*

The above information is accurate and complete to the best of my knowledge.

**SIGNATURE OF PARTICIPANT**

Signature __________________________________________________________________________________________

University Health and Safety: Biosafety and Occupational Health Department (UHS-BOHD) encourages employees to contact their primary care provider or UHS-BOHD at uohs@umn.edu with any questions about how their health might be affected by exposure to workplace hazards.