**http://oregonstate.edu/publications/download/pc/pc_wm_h_1c.wmfOccupational Health & Safety**

**Tier 1 Select Agent Medical Questionnaire**

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| **PURPOSE**  The purpose of this form is to obtain information about your personal health and work exposures. This information will be used by the OSU Occupational Medicine (OCM) department to make an accurate assessment of your ability to safely work with biological agents in the BSL-3 laboratory. The OSU-OCM department 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 OSU-OCM may require that you be seen for an initial health assessment ***prior*** to starting work in an OSU BSL-2 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 *Occupational Health & Safety Tier 1 Select Agent Medical Questionnaire* periodically to assess ongoing risks and fitness for duty.  Part IIis confidential and is to be completed by employee.  All information must be completed and returned to:  **OSU - Occupational Medicine**  **201 Plageman Building**  **or Fax to 541-737-7236**  **Phone: 541-737-7566** |

**Part I: BSL-3 General Questionnaire**

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| SECTION A: Participant Information |  |
| Participant Name: | Date: |
| OSU ID#: | Job Title: |
| Participant e-mail address: | |
| Dept & work address: | |
| Project name: | |
| PI name and phone#:  PI email address: | |
| Supervisor name (if different) and phone #:  Supervisor email address: | |

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| SECTION B: Respirator User | |
| **Do you currently wear a mask or respirator?**  No  Yes If yes, answer the following questions: | |
| Type of mask/respirator**:** | Have you been fit tested?  Yes  No |
| For what reason/hazard are you using a mask/respirator: | |
| Is respirator use *required* in your work area?  Yes  No  If yes, complete the Respirator Questionnaire if you have not done so in the past year and submit it with this BSL-3 form.  (Occupational Health Forms: http://oregonstate.edu/occupationalhealth/forms) | |

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| SECTION C: Animal Handler |
| **Will you be working with animals in the BSL-3 facility?**  No  Yes |
| If yes, have you previously completed an Animal Exposure Questionnaire?  Yes  No |
| If you have not completed the Animal Exposure Questionnaire in the past year, please complete it and submit it with this Tier 1 Select Agent form.  (Occupational Health Forms: http://oregonstate.edu/occupationalhealth/forms) |

**Part II: BSL-3 Initial Health Surveillance Questionnaire**

**Information in this part is confidential and should be completed by employee only.**

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| SECTION A: Person Medical History | |
| **1. Do you have any of the following conditions?** | **Please comment on yes answers:** |
| Chronic respiratory disease  No  Yes |  |
| Disease that affects the immune system such as leukemia or lymphoma  No  Yes |  |
| Organ transplant  No  Yes |  |
| Chronic infectious disease  No  Yes |  |
| Valvular heart disease  No  Yes |  |
| Heart disease or condition  No  Yes |  |
| Diabetes  No  Yes |  |
| Immune disease such as lupus, scleroderma, or rheumatoid arthritis  No  Yes |  |
| Cancer  No  Yes |  |
| Ongoing cancer treatment or malignancy  No  Yes |  |
| History of active Tuberculosis or a  positive TB skin test  No  Yes |  |
| HIV/AIDS  No  Yes |  |
| Kidney or liver disease  No  Yes |  |
| Absence of spleen  No  Yes |  |

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| 2. Other than the conditions listed above, are you being treated for any ongoing health problems at this time? |
| No  Yes If yes, answer please explain: |

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| 3. Do you have any reason to believe that you cannot work safely with high consequence pathogens in a BSL-3 laboratory or animal room, or are unfit for duty at this time? |
| No  Yes If yes, answer please explain: |

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| 4. Do you have a medical condition that might impact your work at BSL-3? |
| No  Yes If yes, answer please explain, and an Occupational Medicine Nurse will contact you: |
| 5. Are you taking any of the following medications? |
| Treatment for latent or active tuberculosis (INH)  Prednisone or other steroids  Immunosuppressive drugs |

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| 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 |

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| 7. (for females only) 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 the OSU-OCM department to be referred to an occupational health physician. |

**Printed Participant Name**:

**Signature:**

**Date:**