

**POLICY NUMBER: A-002**

**TITLE: ANIMAL EXPOSURE PREVENTIVE MEDICINE PROGRAM (AEPMP) for PERSONNEL  
with ANIMAL CONTACT**

**1.0 PURPOSE**

The purpose of the Animal Exposure Preventive Medicine Program (AEPMP) is to provide:

- occupational health and safety information related to use and care of animals;
- occupational health and safety information and monitoring related to exposure to waste anesthetic gases (WAGs), when indicated;
- occupationally indicated immunizations; and
- clinical evaluation and treatment for individuals with animal related injuries or illnesses.

**2.0 REVISION HISTORY**

R&D Committee Approval Date	Revision #	Change	Reference Section(s)	Effective Date
July 24, 2018	3.1	Clarification to safety and health counseling	Section 6A1bii	July 27, 2018
June 27, 2017	3.0	Information regarding enrollment of Non-Research VA employees	Sections 4.0, 7.0; Appendix 5	June 30, 2017
July 26, 2016	2.5	Clarification of initial exam form	Appendix 1	July 29, 2016
July 28, 2015	2.4	Modifications to wording; removal of specific wording used to describe medical exams	All Sections including Appendices	July 31, 2015
January 28, 2014	2.3	Updated policy since enrollment in a program is no longer optional; update to Appendices requesting last four of Social Security Number.	Sections 5.0, 6.0, Appendix 1 and Appendix 2	January 28, 2014
April 23, 2013	2.2	Updated policy to become an optional program and added Declination Form.	Sections 4.0, 5.0, 6.0 and 8.0	April 24, 2013
November 23, 2010	2.1	Updated Policy re: applicability and need for waiver; Occupational Health procedures also updated/ revised.	Sections 3.0; 4.0 5.0 and 6.0	January 27, 2011
July 14, 2009	2.0	Updated Policy	Formatting Standardized throughout document; No substantive changes to text	July 15, 2009

### 3.0 SCOPE

This policy applies to all VA Pittsburgh Healthcare System (VAPHS) and Veterans Research Foundation employees (including those with WOC appointments) who are conducting VA research, are working in VA or VA leased space, and who meet either of the following criteria:

- A) handle animals (live or dead), their fresh, frozen, or non-fixed tissues, body fluids, or waste;
- B) are exposed to Waste Anesthetic Gases (WAGs) as a function of their work/contact with animals

### 4.0 RESPONSIBILITIES

- A. Principal Investigators: Principal Investigators (PIs) are responsible for ensuring that all Research personnel working with animals, their fresh, frozen, or non-fixed tissues, body fluids, or waste are listed both on the Research Project Staff Form (in Part I: Request to Conduct Research) and in the Animal Component of Research Protocol (ACORP), Section E. Additionally, PIs are responsible for ensuring that all research staff working with anesthetic gases is properly listed in the ACORP. PIs assume ultimate responsibility for ensuring that all Research personnel working on their protocol(s) are compliant with the AEPMP policy.
- B. Research & Development Office: The Research & Development (R&D) Office is responsible for maintaining records related to those who are enrolled in the AEPMP. These records must be updated as protocols are approved by the Institutional Animal Care and Use Committee (IACUC).
- C. Occupational Health: Occupational Health is responsible for conducting the initial and annual evaluations of staff enrolled in the AEPMP and for forwarding information related to the dates of those evaluations to the R&D Office. In addition, Occupational Health is responsible for notifying Non-Research VAPHS personnel about the risks of entering the Animal Research Facility (ARF) as well conducting annual evaluations for those that choose to enroll in the program.

### 5.0 POLICY

The AEPMP is a medical surveillance program primarily designed to address the needs of Research staff working with small animals (i.e., rodents and rabbits). The program, does however, include services aimed to address the needs of individuals exposed to other categories of animals should research at VAPHS expand to include work with large animals, including nonhuman primates or nonhuman primate tissues. Individuals who handle animals (live or dead), their fresh, frozen, or non-fixed tissues, body fluids or wastes within VAPHS facilities or VAPHS-owned property have the option to participate in the AEPMP at VAPHS. PIs and their approved staff who are conducting the same procedures within VA leased space or who have a partial or full off-site waiver to conduct VA research at an off-site location have the option of either enrolling in the VAPHS AEPMP or enrolling in a comparable program at that institution, provided that the alternate program meets VAPHS requirements.

Please note that for those that choose not to participate in the VAPHS AEPMP, a declination form must be signed (see Appendix 3). And, even though personnel may initially decline enrollment in the VAPHS AEPMP, they may elect to participate in the program at a future date.

### 6.0 PROCEDURE

All individuals to which this policy applies (outlined in Section 3.0 above) must be enrolled in the VAPHS AEPMP, have declined participation in the VAPHS AEPMP, or be enrolled in a similar program that meets VAPHS requirements prior to being permitted to enter the ARF and/or begin work with animals. Those individuals working with anesthetic gases on VA property are required to participate in the waste anesthetic gas (WAG) services offered by the AEPMP (see Section 6.B).

VAPHS PIs are required to list all individuals working with animals, their fresh, frozen, or non-fixed tissues, body fluids, or waste on both the Research Project Staff Form and the ACORP, Section E. Prior to IACUC review and approval, the VAPHS IACUC Coordinator verifies that all individuals identified via the Staff Form or ACORP are either enrolled in an appropriate preventive medicine program or have signed a declination form to participate. Those identified as needing to participate in the WAG preventative program will also be verified. Those who have not provided proof are notified by the IACUC Coordinator that they must present for clinical evaluation at VAPHS Occupational Health or provide documentation of their declination to participate in the program.

Those that initially enroll in the VAPHS AEPMP program (or other comparable program) must undergo a physical. If the evaluation is not completed, the name of the individual is provided to the IACUC to be considered for suspension of authorization to utilize laboratory animals and/or their viable tissues and body fluids. The R&D Office maintains a system to insure that annual evaluations are completed for those enrolled in the VAPHS AEPMP or other comparable program. The date of the completion of annual review is forwarded to the IACUC Coordinator from Occupational Health.

A. Services Provided to AEPMP Participants and Those Working with Small Animals

1. Pre-employment medical evaluation: In order to ensure that a prospective new employee is capable of the physical demands of the position and that pre-existing medical conditions do not place the employee or others at risk, a pre-employment medical evaluation must be performed. The evaluation includes:
  - (a) An initial physical exam which can include laboratory tests as recommended per Occupational Health.
  - (b) A medical evaluation that includes:
    - i. An occupational medical history
    - ii. Safety and health counseling that includes providing information on zoonoses, allergies, and any additional hazards involved when working with animals
    - iii. Appropriate immunizations (Rabies, Hepatitis B, etc.)
2. The participant is offered a booster dose of tetanus/diphtheria (Td) toxoid, if clinically indicated.
3. During the initial AEPMP enrollment, Occupational Health screens employees at risk for developing work related allergies by requesting a history of pre-existing allergies, asthma, seasonal rhinitis, or eczema. Enrollees are advised of the availability of clinical care and are encouraged to seek evaluation and treatment if they develop symptoms suggestive of a work related allergy.

B. Additional Services Offered to those Exposed to WAGs

Participants working with WAGs will be required to return to Occupational Health for counseling if environmental monitoring indicates that employee has been exposed to WAGs at a level exceeding NIOSH acceptable limits or in the case of an accidental release. A complete physical exam can be performed at that time if the participant chooses. Such individuals will be restricted from working in the VAPHS ARF until the R&D Office receives notification from Occupational Health that it is safe for the individual to return.

C. Outline of Services for Other Categories of Animal Exposure (if applicable)

1. Large Animal Contact: In addition to those listed in Section A, a participant with large animal contact would receive the following services, as indicated:
  - a. Medical counseling;
  - b. Tetanus immunization;
  - c. Rabies immunization, if applicable and desired;
  - d. Serologic testing for toxoplasmosis, if applicable;
  - e. Assessment and counseling for Q Fever, if applicable.
  
2. Live Non-human Primate Contact: In addition to those listed in Section A, a participant with live non-human primate contact would receive the following services, as indicated:
  - a. Medical counseling;
  - b. Tetanus immunization;
  - c. Tuberculosis screening;
  - d. Rubeola immunization/protection;
  - e. Rabies immunization, if applicable;
  - f. Viral hepatitis screening, if applicable.
  
3. Personnel in contact with non-fixed tissues from non-human primates would receive the following services, as indicated:
  - a. Medical counseling;
  - b. Bloodborne Pathogen Program;
  - c. Tuberculosis screening, if applicable.

D. Ongoing Preventive Medicine Program

1. All participants in the AEPMP are required to submit a health questionnaire to Occupational Health for an Annual Review of their health information. Particular attention is to be paid to immunizations needed for the prevention and development of allergies that could place the employee in jeopardy while in the presence or in contact with animals.
  
2. Medical examinations and counseling will be provided to those employees who:
  - a. Develop signs or symptoms indicating possible overexposure to WAGs
  - b. Desire medical advice concerning the effects of past exposure to WAGs, or
  - c. Desire medical advice regarding the employee's ability to produce a healthy child.

Participants are encouraged to contact Occupational Health before Annual Review if there is any substantial change in either their work assignment or their health status.

3. Prior to expiration of current enrollment period, personnel are notified by the R&D Office that they must renew in the program or decline the services. The IACUC Coordinator is notified if personnel have not renewed their enrollment in the VAPHS AEPMP or in a comparable program at another institution. If the evaluation is not completed by the current expiration date, the name of the individual is provided to the IACUC to be considered for suspension of authorization to utilize laboratory animals and/or their viable tissues and body fluids. The date of the completion of annual review is forwarded to the IACUC Coordinator from Occupational Health. Please note: Similar to initial approval, IACUC protocols will not be approved until all personnel listed on the study have submitted an annual review form.

E. Record Keeping

At the completion of the assessment (initial and annual), health information is maintained in an individual Occupational Health folder. This information is maintained by the Occupational

Health Service and only the dates of completion of the initial and annual assessments are reported to the R&D Office which incorporates this information in the AEPMP database. The HIPAA Privacy Rule, which protects the privacy of individually identifiable health information; the HIPAA Security Rule, which sets national standards for the security of electronic protected health information; and the confidentiality provisions of the Patient Safety Rule, which protect identifiable information being used to analyze patient safety events and improve patient safety are applied to this document.

## **7.0 NON-RESEARCH VAPHS EMPLOYEES**

Non-Research VAPHS Employees are individuals that work for a different Department at the VAPHS, however, they are authorized to enter the ARF for the purpose of facility maintenance or inspection (i.e., Facilities Management Services [FMS]). These individuals are provided an opportunity to submit an Occupational Health and Safety Questionnaire (see Appendix 5) to Occupational Health and receive a medical exam annually if they choose. The information provided advises them of the potential risks involved with entering the ARF. Enrollment in this part of the program for Non-Research VAPHS Employees is completely voluntary.

Veterinarians and other non-affiliated members of the IACUC must fill out the Occupational Health and Safety Questionnaire (Appendix 4) annually to be permitted entry into the ARF.

## **8.0 REFERENCES**

- VHA Handbook 1200.07, Use of Animals in Research
- Guide for the Care and Use of Laboratory Animals. National Research Council
- VAPHS Waste Anesthetic Gases and Vapors Exposure Control Policy #A-001

## **9.0 APPENDICES**

- Appendix 1: INITIAL HEALTH QUESTIONNAIRE Preventive Medicine Program for Personnel with Animal Exposure
- Appendix 2: ANNUAL HEALTH QUESTIONNAIRE Preventive Medicine Program for Personnel with Animal Exposure
- Appendix 3: DECLINATION FORM
- Appendix 4: OCCUPATIONAL HEALTH AND SAFETY QUESTIONNAIRE – Annual Review Form for Veterinarians and Non-affiliated Members of the IACUC
- Appendix 5: OCCUPATIONAL HEALTH AND SAFETY QUESTIONNAIRE – Annual Review Form for Non-Research VAPHS Personnel

*//signed copy on file //*

Gretchen L. Haas, PhD  
Research and Development Committee Chair

*//signed copy on file //*

Steven H. Graham, MD, PhD  
Associate Chief of Staff for Research and Development

APPENDIX 1

VAPHS Occupational Health  
University Drive C (001E-U)  
Pittsburgh, PA 15240

Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_

**Preventive Medicine Program for Personnel with Animal Exposure**  
**HEALTH QUESTIONNAIRE**

**INITIAL EXAM FORM**

**Complete and submit to Occupational Health – Mail code 001E-U**

VAPHS wants to reassure all individuals who have enrolled or are scheduled to enroll in this program, that your medical information will be handled with the strictest confidence and in compliance with the HEALTH INSURANCE PORTABILITY and ACCOUNTABILITY ACT of 1996 (HIPAA). Your personal and medical information will only be available to those clinical care providers in Occupational Health with a need to know.

**Please Print or Type**

Name: \_\_\_\_\_

Last Four Social Security #: \_\_\_\_\_

Department: \_\_\_\_\_

VA Mailing Address: \_\_\_\_\_

Telephone Number \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Male  Female

If female, Pregnant: Yes No

Job/Position: \_\_\_\_\_

Job Duties: \_\_\_\_\_

PI/Supervisor Name & Ext: \_\_\_\_\_

IACUC Protocol # \_\_\_\_\_ or NA

**I.**

**Must be completed by Employee and SUPERVISOR or PRINCIPAL INVESTIGATOR**

1. Species contact within VA Pittsburgh Healthcare System (check all that apply):

- Dog**
- Cat**
- Non-human primates** (baboon, monkey, etc.), please specify \_\_\_\_\_
- Sheep, Goats, Pig, Calves**, please specify \_\_\_\_\_
- Rodents** (mice, rats, hamster, gerbil, guinea pig, etc.), please specify \_\_\_\_\_
- Rabbit**
- Other**, please list: \_\_\_\_\_

2. Total number hours of animal exposure/contact per week at work: \_\_\_\_\_

3. For use with **live animals** only, any work with:

- A) **Recombinant DNA** Yes No
- B) **Infectious Agents** Yes No please list: \_\_\_\_\_
- C) **Bloodborne Pathogens** Yes No
- D) **Human Cell lines** Yes No

- E) **Very Hazardous Agents**       Yes    No   please list: \_\_\_\_\_
- F) **Radiation**                       Yes    No   please list: \_\_\_\_\_
- G) **Lasers (Class 3b, 4a)**         Yes    No   please list: \_\_\_\_\_
- H) **Toxins**                             Yes    No   please list: \_\_\_\_\_
- I) **Exposure to anesthetic gases**    Yes    No   please list: \_\_\_\_\_

\_\_\_\_\_  
Name and Signature of Supervisor or Principal Investigator

\_\_\_\_\_  
Date

**II.**

GENERAL OCCUPATIONAL HISTORY	YES	NO	LATEX HISTORY	YES	NO
A. Have you ever used protective clothing or equipment?			A. Have you ever had an anaphylactic (severe, life threatening) reaction to latex devices or products?		
Respirators (if yes, give type:_____ )			B. Have you ever been told by a Doctor that you have an allergy to any latex product?, If yes, specify:_____		
Hearing Protection			C. Were you born with any birth defects or limiting conditions which may predispose to latex sensitivity (spina bifida, Myeloma, myelodysplasia)		
Protective suit/isolation gown			D. After handling latex products have you ever experienced any of the following:		
Barrier Gloves			Difficulty breathing		
Eye/Face Protection			Chapping or 'cracking' of hands		
B. At work, have you ever been exposed to, or worked with any of the following types of hazards:			Runny nose/congestion		
Chemotherapeutics			Itchiness (hands/eyes)		
Bloodborne Pathogens			Redness		
Asbestos			Swelling		
Lasers			Hives		
Radiation/Radiology Exposure			Other:		
Mercury/Lead/Cadmium (i.e. heavy metals)			E. Have you had an allergic reaction to any of the following:		
Other Materials? _____			Avocados/bananas/chestnuts/kiwis/papaya/peaches/potatoes		
			Baby bottles/nipples/balloons/erasers		
<b>INFECTIOUS DISEASE: Tuberculosis:</b>			Elastic waistbands/elastic bandages		
Have you, or anyone in your family ever had Tuberculosis/TB?			Face masks/foam pillows		
Have you ever had a TB skin test? Date of most recent test:			Hot water bottles/ostomy bags/ condoms		
Have you ever had a reaction to the TB skin test?			Rubber bands/rubber gloves/rubber grips		
IF yes, were you treated with INH?			Other _____		
Date of last chest X-ray:_____					

Do you work with, or have you been immunized against any of the following:	Work With	Immunized	Date(s) of Immunization	Do you work with or are exposed to Anesthetic Gases?	YES	NO
Botulinum				If yes, is there any prior history of any of these medical problems:		
Vaccinia						
Q Fever				Reproductive problems or disorders for you or your spouse?		
Rabies virus						
Measles Virus						
Human Retroviruses				Liver Disorders		
Meningococcus					Kidney Disorders	
Tetanus Diphtheria (Td)						

Other: _____					Hematological/blood disorders		
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Do you have, or have you ever had:	Yes	No	COMMENTS (if YES)
Allergic rhinitis/conjunctivitis/hay fever			
Anaphylaxis			
Asthma			
Chronic cough			
Eczema/urticaria/hives			
Family history of allergic disease (explain if yes)_____			
Prior history of allergic symptoms with animal exposure			
Itching, tearing or swelling of eyes			
Nasal discharge			
Coughing			
Chest tightness or wheezing			
Skin rash or itching			

***\*Employees with suspected work related allergies should seek evaluation and treatment from their physician.***

Skin Diseases			
Diabetes			
Seizure disorder			
Back Pain			
Color blindness			
Other:_____			

### III.

A. Have you ever contracted an occupational illness, or had a serious injury from an animal or in animal-related work? Yes No If yes, please explain in detail. \_\_\_\_\_

B. Have you had a splenectomy? Yes No  
Are you on any immunosuppressant drugs? Yes No

C. Please note any other current health problems/history you consider significant: \_\_\_\_\_

D. Are you being treated by a physician for a health problem? Yes No (If yes, list):\_\_\_\_\_

E. Are you currently taking any medications (Over the Counter or Prescribed)? Yes No (If yes, list):\_\_\_\_\_

F. Do you have any allergies to medication? Yes No (If yes, list):\_\_\_\_\_

G. Do you have any work restrictions or physical limitations? Yes No (If yes, list):\_\_\_\_\_

H. Do you require any work accommodations for the position for which you are applying or presently performing? Yes No (If yes, list):\_\_\_\_\_

I. List all hospitalizations and surgeries with approximate dates:

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_

**I certify I understand all requests for information on this form and that the information I supplied is correct.**



EMPLOYEE SIGNATURE and DATE

\*\*\*\*\*

**For VAPHS Occupational Health Service Use Only:**

I have reviewed the information provided (Medical Practitioner Signature & Date): \_\_\_\_\_

Immunization/testing history:

Tuberculin Skin Test: \_\_\_\_\_ NEG POS \_\_\_\_\_ mm

Tetanus-diphtheria Vaccine: \_\_\_\_\_

RABIES 1: \_\_\_\_\_

RABIES 2: \_\_\_\_\_

RABIES 3: \_\_\_\_\_

Bloodborne Pathogen surveillance:

HBV vaccine 1: \_\_\_\_\_

HBV vaccine 2: \_\_\_\_\_

HBV vaccine 3: \_\_\_\_\_

POLIO vaccine: \_\_\_\_\_

VZV (Varicella) vaccine: \_\_\_\_\_

Toxoplasmosis: \_\_\_\_\_

Exposure to anesthetic gases? Yes No

If Yes, does review of reproductive history reveal any suspicion of work-related problems?

\_\_\_\_\_

If yes, medical surveillance will be initiated for exposure to anesthetic gases (which includes baseline CBC, liver profile, renal profile, and medical and reproductive history updates; if NIOSH limits are exceeded in the Animal Research Facility, blood workup will be repeated).

RECOMMENDATIONS/NOTES:

APPENDIX 2

VAPHS Occupational Health  
University Drive C (001E-U)  
Pittsburgh, PA 15240

Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_

**Preventive Medicine Program for Personnel with Animal Exposure**

**ANNUAL REVIEW FORM**

**Complete and submit to Occupational Health – Mail code 001E-U**

*VAPHS wants to reassure all individuals who have enrolled or are scheduled to enroll in this program, that your medical information will be handled with the strictest confidence and in compliance with the HEALTH INSURANCE PORTABILITY and ACCOUNTABILITY ACT of 1996 (HIPAA). Your personal and Medical information will only be available to those clinical care providers in Occupational Health with a need to know.*

**Please Print or Type:**

Name: \_\_\_\_\_

Last Four Social Security #: \_\_\_\_\_

Department: \_\_\_\_\_

VA Mailing Address: \_\_\_\_\_

Telephone Number \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Male  Female

If female, Pregnant: Yes No

Job/Position: \_\_\_\_\_

Job Duties: \_\_\_\_\_

PI/Supervisor Name & Ext: \_\_\_\_\_

IACUC Protocol # \_\_\_\_\_ or NA

**1. Species contact within VA Pittsburgh Healthcare System (check all that apply):**

**Dog**

**Cat**

**Non-human primates** (baboon, monkey, etc.), please specify \_\_\_\_\_

If working with non-human primates, have you ever been diagnosed with Tuberculosis?

Yes No

If Yes:

Medication taken \_\_\_\_\_ Duration of Therapy \_\_\_\_\_ Dates of diagnosis and therapy \_\_\_\_\_

BCG vaccination Yes No If Yes, give date: \_\_\_\_\_

Positive TB tests (Tine, PPD, Mantoux) Yes No If yes, provide history \_\_\_\_\_

**Sheep, Goats, Pigs, Calves**, please specify \_\_\_\_\_

**Rodents** (mice, rats, hamster, gerbil, guinea pig, etc.), please specify \_\_\_\_\_

**Rabbit**

**Other**, please list: \_\_\_\_\_

2. Total number hours of animal contact per week at work (including animal tissues, waste, body fluids, carcasses, or animal housing areas): \_\_\_\_\_

3. Work involves human pathogens:  Yes  No  
If yes, specify: \_\_\_\_\_

4. Work involves animal pathogens:  Yes  No  
If yes, specify: \_\_\_\_\_

5. Are you receiving immunosuppressive therapy that could increase risk of zoonotic disease?  Yes  No

6. As part of assigned duties, how often do you wear?

	<u>Never</u>	<u>Rarely</u>	<u>Sometimes</u>	<u>Always</u>
Gown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mask	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bonnet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Protective eye wear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disposable gloves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If use gloves, any evidence of latex sensitivity  Yes  No

7. How often do you do the following after handling animals during the day?

	<u>Never</u>	<u>Rarely</u>	<u>Sometimes</u>	<u>Always</u>
Wash Hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Change clothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8.

<b>Do you have, or have you ever had:</b>	Yes	No	(if YES) COMMENTS
Allergic rhinitis/conjunctivitis/hay fever	<input type="checkbox"/>	<input type="checkbox"/>	
Anaphylaxis	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	
Eczema/urticaria/hives	<input type="checkbox"/>	<input type="checkbox"/>	
Family history of allergic disease (explain if yes)	<input type="checkbox"/>	<input type="checkbox"/>	

9.

<b>Prior history of allergic symptoms with animal exposure</b>	Yes	No	If Yes, <b>Species</b> and <b>Frequency</b> (never, monthly, weekly, daily)
Itching, tearing or swelling of eyes	<input type="checkbox"/>	<input type="checkbox"/>	
Nasal discharge	<input type="checkbox"/>	<input type="checkbox"/>	
Coughing	<input type="checkbox"/>	<input type="checkbox"/>	
Chest tightness or wheezing	<input type="checkbox"/>	<input type="checkbox"/>	
Skin rash or itching	<input type="checkbox"/>	<input type="checkbox"/>	
Sneezing spells	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	

*\*Employees with suspected work related allergies should seek evaluation and treatment from their physician.*

10. Do you have any house pets that could be responsible for allergic symptoms, or could represent a disease transmission hazard to you or the animals in the Animal Research Facility?  Yes  No

If yes, list: \_\_\_\_\_



**11.**

<b>Have you ever suffered from:</b>	<b>Yes</b>	<b>No</b>	<b>Describe Severity &amp; and Corrective Measures</b>
Inguinal or similar hernia			_____
Back Pain			_____
Joint problems, arthritis			_____
<b>Other chronic health problems:</b>			
_____			_____
_____			_____

**12.** Do you work with Chemicals? Yes No

If Yes, describe any symptoms that could be associated with such exposure: \_\_\_\_\_

**13.** Do you have any significant health history that might suggest exposure to workplace hazards?

Yes No If Yes, describe \_\_\_\_\_

**14.** Are you exposed to waste anesthetic gases during your work? Yes No

If Yes, Describe \_\_\_\_\_

If Yes, has there been any evidence of reproductive, liver, kidney, or blood disorders during the past year?

Yes No If Yes, Describe: \_\_\_\_\_

**I certify I understand all requests for information on this form and that the information I supplied is correct.**

\_\_\_\_\_  
EMPLOYEE SIGNATURE and DATE

**15.** Do you wish to receive a medical exam with the submission of this questionnaire?

Yes No

If no, you may be contacted by someone in the VAPHS Occupational Health Service if there are any questions concerning the information provided.

**I am declining a Medical Exam with this annual medical review.**

\_\_\_\_\_  
EMPLOYEE SIGNATURE and DATE

\*\*\*\*\*

**For VAPHS Occupational Health Service Use Only:**

I have reviewed the information provided (Medical Practitioner Signature & Date): \_\_\_\_\_

**Immunization/testing history:**

Tuberculin Skin Test: \_\_\_\_\_ NEG POS \_\_\_\_\_ mm

Tetanus-diphtheria Vaccine: \_\_\_\_\_

RABIES 1: \_\_\_\_\_

RABIES 2: \_\_\_\_\_

RABIES 3: \_\_\_\_\_

**Bloodborne Pathogen surveillance:**

HBV vaccine 1: \_\_\_\_\_

HBV vaccine 2: \_\_\_\_\_

HBV vaccine 3: \_\_\_\_\_

POLIO vaccine: \_\_\_\_\_

VZV (Varicella) vaccine: \_\_\_\_\_

Toxoplasmosis: \_\_\_\_\_

Exposure to anesthetic gases? Yes No

If Yes, does review of reproductive history reveal any suspicion of work-related problems?

\_\_\_\_\_

If yes, Medical Surveillance will be initiated for exposure to anesthetic gases (which includes baseline CBC, liver profile, renal profile, and medical and reproductive history updates; if NIOSH limits are exceeded in the Animal Research Facility, blood workup will be repeated).

**RECOMMENDATIONS/NOTES:**

Appendix 3

VA Pittsburgh Healthcare System  
Animal Exposure Preventive Medicine Program

Medical Evaluation Declination Form

*Directions: Use this form when the designated employee elects NOT to participate in the VAPHS Animal Exposure Preventive Medicine Program. Maintain the form in the Employee's medical file.*

EMPLOYEE'S NAME: \_\_\_\_\_

I have been informed that due to the nature of my occupational exposure to animals I may be at risk of acquiring a zoonotic, allergic, or animal-related disease. The VA Pittsburgh Healthcare System (VAPHS) has established a medical surveillance program for early detection, diagnosis and treatment of animal-related illnesses. I understand that the records from the program are confidential and that all expenses are paid by my department. However, at this time, I choose to NOT participate in the VAPHS Animal Exposure Preventive Medicine Program. I am aware that I continue to be at risk of acquiring an animal-related illness. If in the future I continue to have occupational exposure to animals while employed at the VAPHS and I elect to participate in the VAPHS medical surveillance program, I may do so at no charge to myself.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

APPENDIX 4

VAPHS Occupational Health  
University Drive C (001E-U)  
Pittsburgh, PA 15240

Appointment Date: \_\_\_\_\_

Time: \_\_\_\_\_

**Veterinarians and Non-affiliated Members of the IACUC**

**Occupational Health and Safety Questionnaire**  
**ANNUAL REVIEW FORM**

**Complete and submit to Occupational Health – Mail code 001E-U**

*VAPHS wants to reassure all individuals who have enrolled or are scheduled to enroll in this program, that your medical information will be handled with the strictest confidence and in compliance with the HEALTH INSURANCE PORTABILITY and ACCOUNTABILITY ACT of 1996 (HIPAA). Your personal and Medical information will only be available to those clinical care providers in Occupational Health with a need to know.*

**Please Print or Type:**

Name: \_\_\_\_\_

Last Four Social Security #: \_\_\_\_\_

Department: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Telephone Number \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Male  Female

If female, Pregnant: Yes No or NA

Position: \_\_\_\_\_

**1. Species contact within VA Pittsburgh Healthcare System (check all that apply):**

**Dog**

**Cat**

**Nonhuman primate** (baboon, monkey, etc.), please specify \_\_\_\_\_

If working with primates, have you ever been diagnosed with Tuberculosis? Yes No

If Yes:

Medication taken \_\_\_\_\_ Duration of Therapy \_\_\_\_\_ Dates of diagnosis and therapy \_\_\_\_\_

BCG vaccination Yes No If Yes, give date: \_\_\_\_\_

Positive TB tests (Tine, PPD, Mantoux) Yes No If yes, provide history \_\_\_\_\_

**Sheep, Goats, Pigs, Calves**, please specify \_\_\_\_\_

**Rodents** (mice, rats, hamster, gerbil, guinea pig, etc.), please specify \_\_\_\_\_

**Rabbit**

**Other**, please list: \_\_\_\_\_



2. Total number hours of animal contact per week at work (including animal tissues, waste, body fluids, carcasses, or animal housing areas): \_\_\_\_\_

3.

Do you have, or have you ever had:	Yes	No	(if YES) COMMENTS
Allergic rhinitis/conjunctivitis/hay fever			
Anaphylaxis			
Asthma			
Chronic cough			
Eczema/urticaria/hives			
Family history of allergic disease (explain if yes)			

4.

Prior history of allergic symptoms with animal exposure	Yes	No	If Yes, <b>Species</b> and <b>Frequency</b> (never, monthly, weekly, daily)
Itching, tearing or swelling of eyes			
Nasal discharge			
Coughing			
Chest tightness or wheezing			
Skin rash or itching			
Sneezing spells			
Difficulty swallowing			

***\*Employees with suspected work related allergies should seek evaluation and treatment from their physician.***

5. Do you have any house pets that could be responsible for allergic symptoms, or could represent a disease transmission hazard to you or the animals in the Animal Research Facility? Yes No  
If yes, list: \_\_\_\_\_

6. Do you wish to receive a medical exam with the submission of this questionnaire?  
Yes No

If no, you may be contacted by someone in the VAPHS Occupational Health Service if there are any questions concerning the information provided.

**I certify I understand all requests for information on this form and that the information I supplied is correct.**

\_\_\_\_\_  
EMPLOYEE SIGNATURE and DATE

\*\*\*\*\*

**For VAPHS Occupational Health Service Use Only:**

I have reviewed the information provided (Medical Practitioner Signature & Date): \_\_\_\_\_

RECOMMENDATIONS/NOTES:

APPENDIX 5

VAPHS Occupational Health  
 University Drive C (001E-U)  
 Pittsburgh, PA 15240

Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_

**Non-Research VAPHS Personnel**

**Occupational Health and Safety Questionnaire**  
**ANNUAL REVIEW FORM**

**Complete and submit to Occupational Health – Mail code 001E-U**

*VAPHS wants to reassure all individuals who have enrolled or are scheduled to enroll in this program, that your medical information will be handled with the strictest confidence and in compliance with the HEALTH INSURANCE PORTABILITY and ACCOUNTABILITY ACT of 1996 (HIPAA). Your personal and Medical information will only be available to those clinical care providers in Occupational Health with a need to know.*

**Please Print or Type:**

Name: \_\_\_\_\_ Last Four Social Security #: \_\_\_\_\_

Department: \_\_\_\_\_ Mailing Address: \_\_\_\_\_

Telephone Number \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Male  Female  If female, Pregnant: Yes No or NA

Position: \_\_\_\_\_

Species that are housed in the VAPHS Animal Research Facility:

- Rodents (mice, rats)
- Rabbits

**1.**

<b>Do you have, or have you ever had:</b>	<b>Yes</b>	<b>No</b>	<b>(if YES) COMMENTS</b>
Allergic rhinitis/conjunctivitis/hay fever			
Anaphylaxis			
Asthma			
Chronic cough			
Eczema/urticaria/hives			
Family history of allergic disease (explain if yes)			

**2.**

<b>Prior history of allergic symptoms with animal exposure</b>	<b>Yes</b>	<b>No</b>	<b>If Yes, <u>Species</u> and <u>Frequency</u> (never, monthly, weekly, daily)</b>
Itching, tearing or swelling of eyes			
Nasal discharge			
Coughing			
Chest tightness or wheezing			
Skin rash or itching			
Sneezing spells			

Difficulty swallowing			
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***\*Employees with suspected work related allergies should seek evaluation and treatment from their physician.***

**3.** Do you have any house pets that could be responsible for allergic symptoms, or could represent a disease transmission hazard to you or the animals in the Animal Research Facility? Yes No

If yes, list: \_\_\_\_\_

**4.** Do you wish to receive a medical exam with the submission of this questionnaire?

Yes No

If no, you may be contacted by someone in the VAPHS Occupational Health Service if there are any questions concerning the information provided.

**I certify I understand all requests for information on this form and that the information I supplied is correct.**

\_\_\_\_\_  
EMPLOYEE SIGNATURE and DATE

\*\*\*\*\*

**For VAPHS Occupational Health Service Use Only:**

I have reviewed the information provided (Medical Practitioner Signature & Date): \_\_\_\_\_

RECOMMENDATIONS/NOTES: