

Request for Medical Evaluation for Animal Contact

Section A: COMPLETED BY REQUESTING DEPARTMENT MANAGER OR SUPERVISOR

Name (please print): _____
Last
First
Middle

Employee ID # or SSN: _____ Date of birth: _____

Position/Job title: _____ Work tel #: _____

Department: _____ Work location: _____

School/Unit: CN GSBS NJMS SDM SHRP SN SPH UBHC Other _____

Supervisor name (print): _____ Supervisor tel #: _____

Hazardous agents: Animals Other, specify _____

Animal	Cats	Dogs	Frogs	Goats	Mice	Pigs	Primates	Rabbits	Rats	Sheep	Other
Contact hours/week											

Special work considerations (e.g., respirator or other personal protective equipment, rabies, hepatitis B or other vaccinations):

Department Manager/Supervisor Signature

Section B: COMPLETED BY OCCUPATIONAL MEDICINE SERVICE – Animal Contact Medical Classification:

Employee name: _____

Assessment: Initial Revision number _____

The individual is medically qualified to work with the animals noted above without limitations/restrictions.

The individual is medically qualified to work with the animals noted above with the following limitations/restrictions:

The individual is currently NOT medically qualified to work with the animals noted above.

Please have the individual contact the Occupational Medicine Service, in SSB Suite GA 167, tel 973.972.2900, fax 973.972.2904, to schedule additional examinations.

Other comments: _____

Evaluator's signature _____ Date: _____

Name (please print): _____

MEDICAL CONFIDENTIAL Animal Contact Health Questionnaire

Name (please print): _____

Last

First

Middle

How would you describe your health? Excellent Good Fair Poor

Each of the following questions should be answered "NO" or "YES."

"YES" answers should be clarified and described in more detail in the space provided.

Do you have now or have you ever had any of the following:	NO	YES	Please explain all YES answers
1. Eczema, rash, hives or other skin problems			
2. Rheumatic fever or rheumatic heart disease, heart murmur or disorder of the heart valve			
3. Asthma or other chronic pulmonary disease			
4. Splenectomy, absent or non-functioning spleen			
5. Sickle cell anemia			
6. Recently taken medications which might suppress the immune system (for example, prednisone, cortisone, chemotherapy)			
7. Other medications.			
8. Chronic medical problem that might suppress the immune system, for example, cancer, leukemia, lymphoma, diabetes, HIV or AIDS, tuberculosis, liver or kidney disease, alcoholism			
9. Allergies to medicines			
10. Allergies to any animals			
11. Skin test for allergies			
12. Other allergies, including latex-related			
13. Tetanus toxoid booster: give date of most recent vaccination			
14. Rabies vaccine series and boosters if needed: give date of most recent vaccination			
15. Hepatitis B vaccine 3 dose series: give date of most recent			
16. Documented hepatitis B immunity			
17. Tuberculosis testing – TB skin test, Quantiferon-TB Gold test or chest x-ray: specify test and give date of most recent test & result			

18. Please note the weekly hours of contact with each type of animal and any symptoms experienced.

Animal	Contact Hours/week	Symptoms						
		Asthma	Cough	Congestion	Runny nose	Short of breath	Skin rash	Other (specify)
Cats								
Dogs								
Frogs								
Goats								
Mice								
Pigs								
Primates								
Rabbits								
Rats								
Sheep								
Other (specify)								

I certify that the above is accurate and true to the best of my knowledge.

Signature _____ Date: _____

NOTE: All medical records and test results are considered MEDICAL CONFIDENTIAL.