HealthPartners Occupational and Environmental Medicine

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 (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 Confirmed by BOHD/Date:_____________

☐ **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 the UHS-BOHD at 612-626-9643

UHS-BOHD Revised 09/10/2020

BSL-3

University of Minnesota
UHS: Biosafety and Occupational Health Dept.
Thompson Center for Environmental Management
503 23rd Ave. SE
Minneapolis, MN 55455

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 need to contact you or 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 assigned at birth, 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

Date:____________________

Name ____ Date of birth:______________
Last First Middle mm/dd/yyyy

Sex at birth: 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

Do you have or have you had any of the following health conditions?

Yes	No	Health Condition
☐	☐	Hypertension (high blood pressure)
☐	☐	Serious heart condition such as heart failure, coronary artery disease, or cardiomyopathy
☐	☐	Cerebrovascular disease (stroke)
☐	☐	Moderate to severe asthma
☐	☐	COPD (chronic obstructive pulmonary disease)
☐	☐	Cystic fibrosis
☐	☐	Other chronic lung disease
☐	☐	Chronic kidney disease
☐	☐	Chronic liver disease
☐	☐	Type I Diabetes
☐	☐	Type II Diabetes
☐	☐	Sickle cell anemia
☐	☐	Other blood disorder
☐	☐	Immunocompromised state (weakened immune system) from immune deficiencies or HIV
☐	☐	Rheumatologic disease such as lupus, rheumatoid arthritis, or scleroderma
☐	☐	Cancer
☐	☐	Leukemia or lymphoma
☐	☐	Ongoing cancer treatment
☐	☐	Bone marrow transplant
☐	☐	Solid organ transplant
☐	☐	Tuberculosis (latent or active)
☐	☐	Other chronic infectious disease

Other than the conditions listed above, do you have any health conditions that you think could be negatively affected by your work?

☐ Yes ☐ No If yes, please explain:

____

____

Other than the conditions listed above, are you being treated for any ongoing health problems?

☐ Yes ☐ No If yes, please explain:

____

____

Do you have any reason to believe that you cannot work safely in an isolated environment?

☐ Yes ☐ No If yes, please explain:

____

____

Are you taking any of the following medications?

Yes	No	**Medication**
☐	☐	Prednisone or other steroids (excluding topical steroids)
☐	☐	Other medications that may weaken or suppress your immune system
☐	☐	Chemotherapy
☐	☐	Treatment for latent or active tuberculosis

Do you have an exposed medical device?

☐ Yes ☐ No If yes, what is it:

- Can you work effectively without using this device? ☐ Yes ☐ No
- Can this device be effectively covered temporarily for work? ☐ Yes ☐ No
- Is the device waterproof or water resistant? ☐ Yes ☐ No
- In the event of contamination, is a backup device available for use? ☐ Yes ☐ No

Do you have any allergies to antibiotics?

☐ Yes ☐ No If yes, please explain:

____

____

Have you received any of the following vaccines?

Yes	No	**Vaccine**
☐	☐	Anthrax
☐	☐	Hepatitis B
☐	☐	Influenza (within the last year)
☐	☐	Measles Mumps and Rubella (MMR)
☐	☐	Rabies
☐	☐	Tetanus
☐	☐	Vaccinia/smallpox
☐	☐	Varicella (chicken pox)

For Those Assigned Female at Birth Only:

Are you pregnant or do you anticipate becoming pregnant in the next 12 months? ☐ Yes ☐ No

Are you breastfeeding? ☐ Yes ☐ No

Would you like to be contacted by an occupational health professional regarding pregnancy concerns? ☐ Yes ☐ No

How would you like to be contacted? Email or phone: ___________________________________

Animal Care/Use

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

Will you be working with Non-Human Primates or in the same room where they are present? ☐Yes ☐ No

If yes, have you previously completed an Animal Exposure Questionnaire? ☐ Yes ☐ No

Do you have any concerns or questions about personal medical conditions or occupational health and safety issues related to your job?

☐ Yes ☐ No If yes:

Please describe:

____

____

Would you like to be contacted by an occupational health physician? ☐ Yes ☐ No

How would you like to be contacted? Email or phone: ___________________________________

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's Biosafety and Occupational Health Department (BOHD) encourages employees to contact HealthPartners Occupational and Environmental Medicine to arrange for an appointment at (952) 883-6999 or their primary care provider to discuss any questions about how their health might be affected by exposure to workplace hazards.