**QUESTIONNAIRE AND RISK ASSESSMENT**

**FOR TCU PERSONNEL IN CONTACT WITH ANIMALS**

**Please review our** [**website**](https://research.tcu.edu/research-compliance/iacuc/instructions-for-completing-and-submitting-health-questionnaire-forms/) **for specific instructions for submitting this form.**

Working in the Texas Christian University (“TCU”) Animal Care and Use Program may expose you to associated risks, such as allergic reaction, scratches, bites, and zoonoses. In an effort to help prevent occupational illness and injury, TCU has an Occupational Health and Safety for Animal Users Program (“TCU OHSP”). Participation in the program is **mandatory** for certain individuals. If you are required to participate in the TCU OHSP, you must complete the following questionnaire, and required training prior to engaging in the care and use of animals at TCU and, again, when any changes in your medical condition occurs. Failure to complete will result in a delay in process and your ability to participate in the program.

**Your assessment will be based on the information that you provide in the following questionnaire. Failure to provide complete and/or accurate information may result in an incomplete assessment. The responsibility to provide accurate and complete information is yours.** Please answer all sections of this form completely and accurately, sign and date it.

You will be notified if you have been cleared or not cleared to participate in TCU’s animal care and use program or if you need to make an appointment for a follow-up consultation with Concentra. TCU will be responsible for the cost of this consultation. You may consult with your personal physician, at your own expense, in lieu of initially submitting the questionnaire to Concentra or in response to a “not cleared” result. In any event, the completed questionnaire must be provided to Concentra by you or your physician. Your physician, may contact Concentra on your behalf. In all circumstances, only Concentra or the TCU Health Center can make the determination of “cleared”.

If you have questions about the occupational health plan contact the TCU Office of Research at (817) 257-4266. If you have medical questions, contact Concentra Inc:

Abraham Torres

817-882-8700 (o)

2500 West Freeway

Suite 100

Fort Worth, TX 76102

Email: [ARTorres@concentra.com](mailto:ARTorres@concentra.com)

This questionnaire is considered part of your confidential medical record with Concentra. The Clearance Recommendation Page (the last page) will be sent to the TCU Office of Research.

**QUESTIONNAIRE AND RISK ASSESSMENT**

**FOR TCU PERSONNEL IN CONTACT WITH ANIMALS**

**1. GENERAL INFORMATION.**

Name: (Last)      \_\_\_\_\_\_\_\_\_\_\_ (First)      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Campus/home Mail Address:       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_     \_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_     \_\_\_\_\_\_\_\_\_\_

Cell Phone #: ( )      \_\_\_\_\_\_\_ E-mail Address:           \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Department\_\_\_\_\_\_     \_\_\_\_\_\_\_\_\_\_\_\_ Name of Employer:                \_\_\_\_\_\_\_\_\_

Birth Date \_\_\_\_\_     \_\_\_\_\_\_\_\_\_\_\_ Sex  M  F Date Hired: \_\_\_\_\_\_\_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnicity: White/Caucasian  Black  Asian  Indian  Hispanic Other\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal Physician: Name: \_\_\_\_\_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone number: \_\_\_     \_\_\_\_\_\_\_\_\_\_\_\_

**Unit where employed or where handling animals:**

Vivarium Facility  Bat Facility  Classroom only

Fish Facility  Field Only

Other \_\_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Status (check all that apply):

Faculty/staff  Undergrad/Grad. Hourly  Grad Student/TA/RA

Visiting/temporary  Undergrad/RA/Independent Study

Unpaid graduate or undergrad  other:      ­­­­­­ (Please specify)

**Please check all circumstances that apply.** (“Contact” means direct handling or care)

Contact with vertebrate research animals. Specify: Common name: \_\_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact with vertebrate animals in the field. Specify: Common name: \_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact with research animal tissues/fluids not treated with chemical preservatives.

No direct animal contact, but working in the same research facility with animals or their non-preserved tissues.

Estimate research animal contact in **hours per week**:

**2. MEDICAL HISTORY**

**Do you have any current medical problems?**  Yes  No

If yes, explain.

**Have you had any of the following?** (Check all that apply and **indicate when**)

Pneumonia  Restriction on lifting limit \_\_     \_\_\_\_\_ Specify lbs.

Recurrent Bronchitis  Arthritis  Chronic Back or Joint Pain  Heart Disease

Carpal Tunnel Syndrome or Repetitive Motion Injury

Other chronic diseases

**Medication History**

**List all medications you currently take.** (Especially all asthma/allergy medications including inhalers. Also include any over the counter medications or herbal supplements):  none

          

          

          

List any allergies to medications:  none

**Do you have any of the following symptoms or conditions?** (Check all that apply that **are not associated with a cold**.)

Chronic cough  Asthma

Skin rash  Chronic allergies (animal, mold, dust, seasonal allergies)

Shortness of breath/wheeze  None

**Are you allergic to any of the following?** (Check all that apply)

Mice  Rats  Rabbits  Raptors/Birds

Weeds  Trees  Grass  Latex

Food  Pollen  Other:

Dogs  Cats

None

**Please know that certain medical conditions increase your risk of potential health problems when working with animals, these can include: animal-related allergies, chronic back injury, pregnancy and immunosuppression. If any such conditions apply, inform your personal physician/health care professional of your work with the care and use of research animals and indicate below:**

**3. PROTOCOL RELATED EXPOSURES.**

Indicate the IACUC-assigned number of the protocols in which you will be involved (if known), the species to be used, and any unique hazards associated with the animal care and use aspects of each protocol which have been identified to you by your principal investigator (attach additional sheets if necessary). If you are working with biohazardous materials in your experiences beyond the animals themselves, please indicate so.

|  |  |  |
| --- | --- | --- |
| IACUC# | Species | Physical, Chemical, Carcinogenic, or Radioactive Hazards |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**4. TETANUS.**

Puncture wounds from sharps, and from animal bites is an intermittent, but ubiquitous hazard. Animal bites, even those by rodents, can develop complications. All personnel working with animals must keep their tetanus immunization status current. The *Public Health Service Advisory Committee on Immunization Practices* (IPAC 1996) recommends administration of vaccine for tetanus every ten years.

**Have you had a tetanus booster in the past 10 years?**

Yes

No (Current tetanus required).

**5. RABIES VACCINE. (Complete this section 6 only if you are working in Dr. Bennett’s bat lab)**

***NOTE: Rabies vaccination is required for individuals working with wild caught mammals, such as bats. You must check at least one box in this section:***

**I have previously been vaccinated against Rabies:**

Date of Dose 1:\_      \_\_\_\_\_\_\_\_\_\_\_\_ Date of Dose 2: \_\_\_     \_\_\_\_\_\_\_\_\_\_

Date of Dose 3:\_\_\_\_\_      \_\_\_\_\_\_\_\_\_\_ Date of most recent titer: \_\_     \_\_\_\_\_\_\_\_\_\_

Name of administering physician or clinic: \_\_\_\_\_\_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I would like to be vaccinated against Rabies by Texas Christian University Health Center.** I understand that I will be responsible for any charges incurred for obtaining this vaccine. *(Access to the pre-exposure vaccine for rabies virus has been restricted by the CDC due to a disruption in the global supply. Vaccination will be provided as vaccine is available through the CDC approval system.)*

**I have previously been vaccinated against Rabies and would like to have a rabies titer drawn at the TCU Health Center.**

**I would like to be vaccinated against Rabies by the physician or clinic of my choice.** I understand that I will be responsible for any charges incurred for obtaining this vaccine.

**I am declining** **to be vaccinated against Rabies.** I understand that I will not be permitted to participate in any animal research at TCU that requires rabies vaccination.

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Clearance Recommendation Page**

### Patient's Consent and Authorization

**Name of Professor/Principal Investigator**

By signing below, I consent to and authorize Choose an item. to release my approval status for work with animals and any applicable restrictions to Texas Christian University Office of Research, the TCU Institutional Animal Care and Use Committee, and my professor/principal investigator. I understand this consent is revocable except to the extent action has already been taken. Authorization is not valid beyond one year from date of signature. Further disclosure or release of my health information is prohibited without specific written consent of person to whom it pertains.

|  |  |
| --- | --- |
| Print Patient name: |  |
| Patient’s signature | Date |

### Physician's Recommendations (Choose one from each table)

(Table 1)

|  |  |
| --- | --- |
|  | I am not aware of any contraindications toward participation in Animal Care or Handling. |
|  | Physical examination required for determination. Please make an appointment. |
|  | I believe the applicant can participate in animal care or Handling with the following restrictions |
|  | I recommend the applicant **not** participate in Animal Care or Handling. |

### (Table 2)

|  |  |
| --- | --- |
|  | Re-evaluation required when any changes in medical conditions or animal exposure intensity occur |
|  | Re-evaluation required annually |

|  |  |  |
| --- | --- | --- |
| Practitioner’s signature | | Date: |
| Practitioner’s name (print) | Phone: | Fax: |
| Clinic Address | City: | State & Zip |

**Medical staff: Please return this Clearance Recommendation Page only to TCU Office of Research by email** [**research@tcu.edu**](mailto:research@tcu.edu)**.**