University of Vermont Occupational Health Program

Reason for the Program

The University of Vermont (UVM) Occupational Health Program covers the costs of work-related medical services for UVM employees, including Federal, State, and University mandated medical surveillance programs. The aim of the Program is to reduce the risks associated with occupationally related injuries and illnesses. The Program is administered by the UVM Department of Risk Management and Safety (RMS).

Applicability of the Program

This program applies to all University of Vermont faculty, staff and students who, as part of academic, research or employment activities at UVM:

- Wear a respirator;
- Handle animals;
- Require baseline, routine, or exit physical examinations and/or biological monitoring for exposure to hazardous materials including but not limited to: lead, asbestos, formaldehyde, tuberculosis, other disease organisms;
- Require prophylactic or work-related travel vaccinations;
- Operate vehicles and vessels under a commercial driver or Coast Guard license;
- Require occupational physicals for work in medical or other facilities, or work regulated under other federal or state programs; or

This program also applies to persons who have been offered a position at UVM for which there is a post-offer pre-employment physical and to UVM employees who may need a return to work assessment after medical leave unrelated to a workplace injury. This program does not apply to medical services required following a workplace injury. This program also does not cover costs associated with routine vaccinations.

The UVM Occupational Health Program applies only to UVM employees and students. The Program will not cover the cost of occupational health services for non-UVM employees working at UVM, including contractors, visiting researchers, or volunteers unless a visiting researcher is working as part of a UVM-funded program or otherwise stated in a Contract or Memorandum of Understanding with UVM. Non-UVM employees must follow their employer’s occupational health program and should contact their supervisors with any questions.

Program Elaboration

The UVM Occupational Health Program covers the cost of occupational health services from a general fund account within RMS. Supervisors are responsible for determining whether an employee within their unit requires occupational health services. RMS personnel are available to assist with that determination. A price list for all approved services is included in Appendix A.

Currently, RMS has contracted with the following healthcare facilities to provide occupational health services for UVM employees:
• Champlain Medical Urgent Care, 150 Kennedy Drive, South Burlington VT (802-448-9370) – provides all occupational health services;
• Concentra Urgent Care, 7 Fayette Drive #1, South Burlington, VT (802-658-5756) – provides physicals and drug screenings for commercial driver’s license holders and members of the Coast Guard;
• Injury & Health Management Solutions (IHMS), 441 Water Tower Circle Suite 100, Colchester, VT (802-655-1115) – provides pre-employment post-offer physicals only; and
• University of Vermont Medical Center – 111 Colchester Ave, Burlington VT (802-847-0000) – provides immunizations, pre-exposure testing, and post exposure prophylaxis to UVM employees working with biological agents only.

On rare occasions, a UVM employee may need to see their personal physician or other medical provider for occupational health services. In these cases, UVM Occupational Health Program will cover the cost of the service at the price listed in Appendix A and the employee or the employee’s Department will be responsible for paying the difference.

Definitions
None.

Procedures
1. UVM employees must fill out and have their supervisor sign an Authorization for Examination or Treatment Form prior to receiving occupational health services.
2. UVM employees are required to present this completed form at the health care facility before treatment will be given. Failure to do so will result in cancellation of the appointment. A copy of the Authorization for Examination or Treatment Form is included in Appendix B.

Occupational Health Services Covered by the Program
1. Medical Questionnaire Review – UVM administers the following annual medical surveillance questionnaires:
   o OSHA-Mandated Respirator Questionnaire in accordance with OSHA 29 CFR 1910.134
     ▪ UVM employees and students who are enrolled in the UVM Respirator Protection Program
   o Animal Handler Questionnaire
     ▪ UVM employees and students working with animals under an Institutional Animal Care and Use Committee (IACUC) protocol
2. Physicals – UVM pays for the following physicals per Federal standards and UVM policies:
   o Pre-Employment Physical Exams – are provided to the following:
     ▪ Job candidates of RMS who are covered under OSHA 29 CFR 1910.120 Hazardous Waste Operations and Emergency Responses (HAZWOPER) standard
Post Offer Pre-Employment Physicals (POPES) – The University provides POPES as part of an ongoing effort to reduce the likelihood of workplace injuries. POPES are provided based on a Job Analysis for specific job titles in the following departments:

- Custodial
- Residential Life
- Risk Management & Safety
- TSP/IMF
- Physical Plant
- University Book Store
- Proctor Maple Research Center

Annual Physicals – Are provided for the following employee groups based on Federal requirements:

- UVM employees covered by the OSHA HAZWOPER standard (provided annually or at the physician’s discretion)
- Physical Plant employees in the Asbestos Management Program per OSHA 29 CFR 1910.1001 and 1926.1101
- Physical Plant employees in the Lead/Lead Based Paint Program per OSHA 29 CFR 1910.1025 and 1926.62

Physical Exams Upon Termination – Are provided to the following employees based on Federal requirements:

- Employees of RMS who are covered under the OSHA HAZWOPER standard
- Employees of Physical Plant Asbestos Management Program per OSHA 29 CFR 1910.1001

Department of Transportation (DOT) Commercial Driver’s License (CDL) Physicals – Per Federal law, CDL holders must have a physical every 24 months. The University will cover the cost of this physical for all UVM employees who are required to hold a CDL as part of their job. This includes employees in the following departments:

- Transportation and Parking
- RMS (these employees must also meet federal requirements for HazMat endorsements)
- Coast Guard licensed employees acting as a crewmember on board on a Coast Guard regulated vessel

Pulmonary Function Tests – Are administered in accordance with federal law for the following employees:

- Physical Plant employees in the Asbestos Management Program
- Additional employees in the following areas as determined by a physician:
  - Employees who wear respirators and enrolled in the UVM Respiratory Protection Program
  - Physical Plant Employees in the Lead/Lead Based Paint Program
  - RMS employees covered by the OSHA HAZWOPER standard

Drug and Alcohol Screenings – Are performed for the following two employee groups:

- UVM employees who are required to hold a CDL as part of their job. Screenings are conducted per DOT 49 CFR Part 40, U.S. Coast Guard 46 CFR 16.230, and the UVM Commercial Driver and Coast Guard Employee Testing for Alcohol and Controlled Substances Policy. Drug and alcohol screenings are required in the following situations:
- Pre-employment
- Two hours following an accident with a University vehicle or vessel
- Randomly throughout the year
- Reasonable suspicion
- Prior to returning-to-duty or follow up after a positive drug or alcohol test
- A minimum of six unannounced follow-up tests will be conducted after a violation of the DOT regulations over the first year and up to five years following a return to duty
  - For any UVM employee in instances of probable cause that the employee is under the influence on the job as per Vermont Statue 21 V.S.A. § 513.

5. Vaccinations and Related Bloodwork (including titers and boosters):
   - Hepatitis B Three Shot Series – is offered to any employee determined to be at risk for exposure to human blood or bodily fluids in accordance with OSHA 29 CFR 1910.1030, including employees in the following departments:
     - Custodial
     - College of Medicine Infectious Disease Vaccine Testing Center
     - Residential Life
     - Center for Health and Wellbeing
     - TSP/IMF
     - UVM Police Services
     - UVM Rescue
   - Other vaccinations are offered, as appropriate, to employees who are part of an UVM-approved Institutional Biosafety Committee (IBC) protocol

6. Tuberculosis (TB) Screening – Per CDC guidelines, screening for TB, including purified protein derivative (PPD) skin tests and subsequent readings, is not routinely provided for UVM employees unless:
   - The employee is covered under an approved IBC protocol that involves working with TB bacteria
   - The employee is a healthcare provider at the Center for Health and Wellbeing

7. Biomonitoring for specific substance(s) – UVM will provide biomonitoring services for the following employees:
   - Employees enrolled in the Physical Plant Lead/Lead Based Paint Program
   - Any employee at risk of overexposure to a hazardous substance as determined by RMS staff

8. Pre-Exposure Testing and Routine Screenings – Are offered to on a case-by-case basis for UVM employees working with infectious agents under a University-approved IBC protocol.

Health Services Not Covered by the Program

Immunizations
The UVM Occupational Health Program does not cover the cost of common childhood and adult vaccinations that are routinely administered by a primary care physician per the most recent CDC Recommended Immunization Schedule (available at: https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html) or any services associated with these vaccines (i.e. bloodwork, titers, or boosters). The only exception is for a UVM employee working with an infectious agent as part of a University-approved IBC protocol. Examples of routine vaccinations that are not covered by the Program are:
- Influenza
- TdaP – (diphtheria, tetanus, and pertussis)
- Varicella (chicken pox)
- MMR (measles, mumps, and rubella)
- Meningococcal vaccines
- Pneumococcal vaccines
- Hepatitis A
- Human Papillomavirus (HPV)

Workplace Injuries and Illnesses
Medical expenses related to the treatment of work-related injuries or illnesses are covered under UVM’s Workers Compensation system and are not covered by the UVM Occupational Health Program. This includes post-exposure prophylaxis and monitoring following a documented workplace exposure to blood or bodily fluids, such as a needlestick injury. UVM students who are injured on campus receive treatment through UVM Student Health Services and related expenses are billed to the student’s insurance.

For more information on UVM Worker’s Compensation system please visit: https://www.uvm.edu/~riskmgmt/?Page=insurance/workerscomp.html&SM=insurance/insuranceclaims_submenu.html

Non-Work Related Health Conditions
During a work related physical, an occupational health physician may recommend a UVM employee follow up with their personal physician regarding a health issue that does not affect the employee’s ability to do their job. In these instances, the employee is responsible for any costs incurred during the diagnosis or treatment of a non-work related health condition.

Contact
All questions regarding the program should be directed to ohealth@uvm.edu

Attachments
- A. Pricing for Occupational Health Services
- B. Authorization for Examination or Treatment Form
- C. OSHA Respirator Questionnaire
- D. UVM Animal Handler Baseline Questionnaire

Effective Date
April 9, 2018
Appendix A

University of Vermont Pricing for Occupational Health Services
Calendar Year 2018

QUESTIONNAIRE REVIEW
OSHA Medical Respirator Review $35.00
Animal Handler Review $35.00

Vaccinations/Titers/General Bloodwork
Hepatitis B Vaccination $75.00
TDaP Vaccination $75.00
MMR Vaccination $90.00
Flu Vaccination $32.00
Venipuncture $25.00
Hepatitis B Titer $50.00
Varicella Titer $60.00
Mumps Titer $25.00
Rubella Titer $15.00
HIV1/HIV2 $75.00
CBC w/diff $25.00
CMP $40.00
Zinc & Lead $90.00
Phenol Urine $100.00

Physicals
Post Offer/Periodic Physical $110.00
Respirator Physical $110.00
HazMat Physical $110.00
DOT Physical $110.00
Drug Screen (5 panel) with MRO Reporting $80.00
Drug Screen/DOT look alike with MRO Reporting $95.00

Miscellaneous
Spirometry Screening $60.00
PPD Screening and Interpretation $42.00
Chest X-Ray w/B read $150.00
Audiometry Screening $75.00
AUTHORIZATION FOR EXAMINATION OR TREATMENT

**You are required send this form to one of the contacts above and to present this completed form at the health care facility before treatment will be given. Failure to do so will result in cancellation of your appointment.**

NAME:________________________________________ DATE OF BIRTH:____________________

DEPARTMENT:______________________________________________________________

DEPT. CONTACT NAME:________________________________________________________

DEPT. CONTACT PHONE:________________________________________________________

DEPT. CONTACT EMAIL:________________________________________________________

FACILITY YOU WILL VISIT:

- Champlain Medical Urgent Care, 150 Kennedy Dr., S. Burlington 802-448-9370
- Concentra Urgent Care, 7 Fayette Dr #1, S. Burlington 802-658-5756
- IHMS, 441 Water Tower Circle – Suite 100, Colchester, 802-655-1115
- □ Other – Provide name and address of Medical Facility:
  __________________________________________________

Reason for Visit (check all that apply)

- Injury (date of injury____________________)
- Illness
- Respirator physical
- PFT/Spirometry
- Animal handler physical
- DOT physical
- Pre-employment physical
- Post offer/pre-employment Screening (POPES)
- Hazardous material physical
- Vaccination (for)____________________
- Blood draw (for)____________________
- Drug screening
- Tuberculosis screening
- □ Other______________________________

Authorized by:________________________________________ Date:____________________
University of Vermont Respiratory Protection Program  
OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

UVM employees who wear a respirator must complete this form annually and be medically cleared by the University’s designated Physician or Licensed Health Care Professionals (PLHCP) who will perform medical evaluations using the information provided on this medical questionnaire. The completed form will be maintained in accordance with the Health Insurance Portability and Accountability Act (HIPPA), which in this case means that only designated PLHCP and clinic staff that require this information to support the employee’s health and safety will see and/or maintain medical information will be the only people that have access to these records. Employees found to have risk factors that require further medical evaluation will be contacted by the designated PLHCP to schedule an appointment.

Submission Instructions: Place pages 3-7 of the completed questionnaire in a sealed envelope with your name on the outside and mail it with this page and the signed consent form (next page) in an intra-office envelope to the Respiratory Protection Program Coordinator:

Amy Kutchukian  
Risk Management  
004 Rowell  
Burlington, VT 05405

You must sign the next page to consent to review of your questionnaire

Date: ___________  Employee Name: _______________________________ Date of Birth: _______________  
Job Title: _______________________________ Campus Address: _______________________________  
Email Address: ____________________________________________________________  
Best Phone and Time for Healthcare Provider to reach you: _______________________________

Supervisor Name: _______________________________ Email: _______________________________
Appendix C

University of Vermont Respiratory Protection Program
OSHA Respirator Medical Evaluation

General Consent for Review and Release of Medical Information

I certify that the statements herein are true, complete, and correct to the best of my knowledge and belief.

I consent to review of this information by Champlain Medical Urgent Care on behalf of the University of Vermont. I understand that this review is undertaken for my safety in the job environment and understand that I may be further contacted by a medical provider either for clarifications or further evaluation. Further evaluation may include, but is not limited to, a physical examination, blood tests, an evaluation of lung function, and other diagnostic tests as necessary. Costs for evaluation and testing will be covered by the University.

I further understand that the determination of whether I can safely wear a respirator will be based on the information gathered and this determination as it relates to my job and the performance of essential job functions will be released to me, my supervisor and the Respiratory Protection Program Coordinator.

Employee Signature: ___________________________________________________________
Employee Printed Name: _______________________________________________________
Date Signed: ________________________________

OR

I understand that if I decline participation in the Respiratory Protection Program, my employment status might change to meet acceptable safety and wellbeing standards.

Employee Signature: ___________________________________________________________
Employee Printed Name: _______________________________________________________
Date Signed: ________________________________

You will be contacted by Champlain Medical directly if applicable sections are not complete.

__________________________________________________________

Champlain Medical Urgent Care Use Only

Reviewed by: ________________________________________________________________
Date:_______________________________________________________________
To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

To the employee: Can you read (check one): _____Yes _____No

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Part A. Section 1. (Mandatory)
The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Today’s date: ________________________________
2. Your name: ________________________________
3. Your age (to nearest year):___________________
4. Sex (check one): _____ Male _____ Female
5. Your height: _____ ft. _____ in.
7. Your job title: ______________________________
8. A phone number where you can be reached by the healthcare professional who reviews this questionnaire (include the Area Code): ________________________________
9. The best time to phone you at this number:
10. Has your employer told you how to contact the health care professional who will review this questionnaire (check one): _____Yes _____ No
11. Check the type of respirator you will use (you can check more than one category)
    a. _____ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
    b. _____ Other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).
12. Have you worn a respirator (check one): _____Yes _____ No If “yes,” what type(s): __________________________
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**Part A. Section 2. (Mandatory)**

Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please check “yes” or “no”).

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month:  
   ___Yes  ___No

2. Have you ever had any of the following conditions?
   a. Seizures (fits):  
      ___Yes  ___No
   b. Diabetes (sugar disease):  
      ___Yes  ___No
   c. Allergic reactions that interfere with your breathing  
      ___Yes  ___No
   d. Claustrophobia (fear of closed-in places):  
      ___Yes  ___No
   e. Trouble smelling odors:  
      ___Yes  ___No

3. Have you ever had any of the following pulmonary or lung problems?
   a. Asbestosis:  
      ___Yes  ___No
   b. Asthma:  
      ___Yes  ___No
   c. Chronic bronchitis:  
      ___Yes  ___No
   d. Emphysema:  
      ___Yes  ___No
   e. Pneumonia:  
      ___Yes  ___No
   f. Tuberculosis:  
      ___Yes  ___No
   g. Silicosis:  
      ___Yes  ___No
   h. Pneumothorax (collapsed lung):  
      ___Yes  ___No
   i. Lung cancer:  
      ___Yes  ___No
   j. Broken ribs:  
      ___Yes  ___No
   k. Any chest injuries or surgeries:  
      ___Yes  ___No
   l. Any other lung problem that you’ve been told about:  
      ___Yes  ___No
4. Do you currently have any of the following symptoms of pulmonary or lung illness?
   a. Shortness of breath:  
   b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline:  
   c. Shortness of breath when walking with other people at an ordinary pace on level ground:  
   d. Have to stop for breath when walking at your own pace on level ground:  
   e. Shortness of breath when washing or dressing yourself:  
   f. Shortness of breath that interferes with your job:  
   g. Coughing that produces phlegm (thick sputum):  
   h. Coughing that wakes you early in the morning:  
   i. Coughing that occurs mostly when you are lying down:  
   j. Coughing up blood in the last month:  
   k. Wheezing:  
   l. Wheezing that interferes with your job:  
   m. Chest pain when you breathe deeply:  
   n. Any other symptoms that you think may be related to lung problems:  

5. Have you ever had any of the following cardiovascular or heart problems?
   a. Heart attack:  
   b. Stroke:  
   c. Angina:  
   d. Heart failure:  
   e. Swelling in your legs or feet (not caused by walking):  
   f. Heart arrhythmia (heart beating irregularly):  
Appendix C

g. High blood pressure:  ___Yes  ___No

h. Any other heart problem that you’ve been told about:  ___Yes  ___No

6. Have you ever had any of the following cardiovascular or heart symptoms?
   a. Frequent pain or tightness in your chest:  ___Yes  ___No
   b. Pain or tightness in your chest during physical activity:  ___Yes  ___No
   c. Pain or tightness in your chest that interferes with your job:  ___Yes  ___No
   d. In the past two years, have you noticed your heart skipping or missing a beat:  ___Yes  ___No
   e. Heartburn or indigestion that is not related to eating:  ___Yes  ___No
   f. Any other symptoms that you think may be related to heart or circulation problems:  ___Yes  ___No

7. Do you currently take medication for any of the following problems?
   a. Breathing or lung problems:  ___Yes  ___No
   b. Heart trouble:  ___Yes  ___No
   c. Blood pressure:  ___Yes  ___No
   d. Seizures (fits):  ___Yes  ___No

8. If you have used a respirator, have you ever had any of the following problems? (If you’ve never used a respirator,
   check the following space and go to question 9:)
   a. Eye irritation:  ___Yes  ___No
   b. Skin allergies or rashes:  ___Yes  ___No
   c. Anxiety:  ___Yes  ___No
   d. General weakness or fatigue:  ___Yes  ___No
   e. Any other problem that interferes with your use of a respirator:  ___Yes  ___No

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to
   this questionnaire?  ___Yes  ___No
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Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-face piece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. Have you ever lost vision in either eye (temporarily or permanently):  ___Yes ___No

11. Do you currently have any of the following vision problems?
   a. Wear contact lenses:  ___Yes ___No
   b. Wear glasses:  ___Yes ___No
   c. Color blind:  ___Yes ___No
   d. Any other eye or vision problem:  ___Yes ___No

12. Have you ever had an injury to your ears, including a broken eardrum:  ___Yes ___No

13. Do you currently have any of the following hearing problems?
   a. Difficulty hearing:  ___Yes ___No
   b. Wear a hearing aid:  ___Yes ___No
   c. Any other hearing or ear problem:  ___Yes ___No

14. Have you ever had a back injury?  ___Yes ___No

15. Do you currently have any of the following musculoskeletal problems?
   a. Weakness in any of your arms, hands, legs, or feet:  ___Yes ___No
   b. Back pain:  ___Yes ___No
   c. Difficulty fully moving your arms and legs:  ___Yes ___No
   d. Pain or stiffness when you lean forward or backward at the waist:  ___Yes ___No
   e. Difficulty fully moving your head up or down:  ___Yes ___No
   f. Difficulty fully moving your head side to side:  ___Yes ___No
   g. Difficulty bending at your knees:  ___Yes ___No
Appendix C

h. Difficulty squatting to the ground: ___Yes  ___No
i. Climbing a flight of stairs or a ladder carrying more than 25 lbs: ___Yes  ___No
j. Any other muscle or skeletal problem that interferes with using a respirator: ___Yes  ___No
Occupational Health and Safety Program for Employees Working with Animals

Baseline Questionnaire

An Occupational Health and Safety Program is a required part of the overall animal care and use program. The focus is maintaining a safe and healthy workplace. The UVM Department of Risk Management has contracted with an outside firm to provide occupational health monitoring for all UVM personnel who work with animals. This firm, Champlain Medical, is located in South Burlington (802-448-9370).

UVM employees who work with animals must complete this baseline form and be cleared by Champlain Medical prior to working with animals. The completed form is maintained at Champlain Medical. UVM does not maintain a copy. Employees found to have risk factors that require further medical evaluation will be contacted directly by Champlain Medical to schedule an appointment. An employee’s supervisor may be contacted if repeated attempts to contact the employee regarding this questionnaire are unsuccessful.

Submission Instructions:

**Option 1:** Complete, scan into PDF and then email the form to iacucrpo@uvm.edu. While we cannot completely ensure confidentiality of the information contained utilizing this option, there is only one person in our office who will reference the information on the first page only to record your name as having completed the requirement.

**Option 2:** Place completed form in a sealed envelope, legibly write your name and “CONFIDENTIAL- OCC HEALTH FORM”. Forward the sealed envelope by campus mail to the IACUC office at the address below.

Research Protections Office - IACUC
213 Waterman Building, 85 South Prospect Street
Burlington, VT 05405

The form is then forwarded to Champlain Medical for review. You will be contacted by Champlain Medical directly if applicable sections are not complete.

You must sign the last page to allow Champlain Medical review.

Date:
Employee Name: _________________ Job title: _________________
Date of Birth: _________________ Age: _________________
Campus Address: _________________
Work phone: _________________ Home phone: _________________

If healthcare provider needs to contact you, what is the best time to call?

Your Supervisor Information:
Name: ______________________ Phone: _________ Email: ______________________

Laboratory Information:
PI/Laboratory: ______________________ Protocol #: ______________________
Appendix D

Medical Background Questions
1. What is your country of origin?  
   How many years did you reside there?
2. What is your height?
3. What is your weight?

Health History
1. Do you now have or have you ever had any of the following:
   Y[ ] N[ ] Diabetes?  Y[ ] N[ ] Allergies to pollen, food, etc.?
   Y[ ] N[ ] Seizure disorder?  Y[ ] N[ ] Muscle or bone problems?
   Y[ ] N[ ] Skin rashes?  Y[ ] N[ ] Repeated episodes of diarrhea?
   Y[ ] N[ ] glove allergies/rashes?  Y[ ] N[ ] Drug or alcohol dependency?
   Y[ ] N[ ] Diagnosis of latex allergy?  Y[ ] N[ ] Have you ever had measles?
   Y[ ] N[ ] Hernia  Y[ ] N[ ] Measles vaccine?
   Y[ ] N[ ] Problems with visual acuity/hearing ability?
   Y[ ] N[ ] Immune system suppression? If yes the cause of the suppression was/is

2. When was your last tetanus vaccination?

3. What was the date and result of your last TB skin test?

4. Have you ever been vaccinated against Tb? Y[ ] N[ ]

5. Y[ ] N[ ] Do you have any current health problems not listed above that affect your work with animals? If yes, please explain.

6. Y[ ] N[ ] Are you aware of the health risks associated with your job?

7. Have you ever lost vision in either eye (temporarily or permanently) Y[ ] N[ ]

8. Do you currently have any of the following vision problems?
   a) Wear contact lenses Y[ ] N[ ]
   b) Wear glasses Y[ ] N[ ]
   c) Color blind Y[ ] N[ ]
   d) Any other eye or vision problem Y[ ] N[ ]

9. Have you ever had an injury to your ears, including a broken ear drum? Y[ ] N[ ]

10. Do you currently have any of the following hearing problems?
    a) Difficulty hearing Y[ ] N[ ]
    b) Wear a hearing aid Y[ ] N[ ]
    c) Any other hearing or ear problem Y[ ] N[ ]

11. Have you ever had a back injury? Y[ ] N[ ]

12. Do you currently have any of the following musculoskeletal problems?
    a) Weakness in any of your arms, hands, legs, or feet Y[ ] N[ ]
    b) Back pain Y[ ] N[ ]
    c) Difficulty fully moving your arms and legs Y[ ] N[ ]
    d) Pain or stiffness when you lean forward or backward at the waist Y[ ] N[ ]
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e) Difficulty fully moving your head up or down  [Y] [N]  
f) Difficulty fully moving your head side to side  [Y] [N]  
g) Difficulty bending at your knees  [Y] [N]  
h) Difficulty squatting to the ground  [Y] [N]  
i) Climbing a flight of stairs or a ladder  [Y] [N]  

13. [Y] [N] Do you work with patients? 

14. Do you currently smoke tobacco, or have you smoked tobacco in the last month?  [Y] [N]  

Animal Contact History 
1. What animals will you be working with? 

2. What chemicals will you be working with? 

3. [Y] [N] Do you have a history of hay fever, asthma, allergic skin problems or eczema? To what are you allergic? 

4. [Y] [N] Is there a family history of hay fever, asthma, allergic skin problems or eczema? 

5. [Y] [N] Have you been vaccinated against rabies? 

6. [Y] [N] Have you ever worked with or had regular contact with primates? 

7. [Y] [N] Do you have sneezing spells, runny or stuffy nose, watery or itchy eyes, coughing, wheezing, or shortness of breath after working with laboratory animals or their cages? 

If yes, which of the following species cause any of the problems? 
 Guineapig  [Y] [N] 
 Hamster  [Y] [N] 
 Dog  [Y] [N] 
 Cat  [Y] [N] 
 Mouse  [Y] [N] 
 Rat  [Y] [N] 
 Rabbit  [Y] [N] 
 Goat  [Y] [N] 
 Horse  [Y] [N] 
 Sheep  [Y] [N] 
 Bedding  [Y] [N] 
 Other  [Y] [N] 

If yes, please describe symptoms: 

8. In general, how frequently are you bothered by the following symptoms? 
 Watery, itchy eyes  Not troubled [ ] Once/wk or more [ ] Almost daily [ ] 
 Runny or stuffy nose  Not troubled [ ] Once/wk or more [ ] Almost daily [ ] 
 Sneezing spells  Not troubled [ ] Once/wk or more [ ] Almost daily [ ] 
 Frequent cough  Not troubled [ ] Once/wk or more [ ] Almost daily [ ] 
 Wheezing in chest  Not troubled [ ] Once/wk or more [ ] Almost daily [ ] 

9. Do you have any house pets?  [Y] [N]  
 If yes, what type of animals? 

If you work with sheep, cows, or goats please answer the following: 
1. Have you ever worked with sheep, cows, or goats before? If yes, when? 

2. How frequently do you work with sheep, cows, or goats? 
 [ ] daily  [ ] once a week  [ ] once a month 

3. [Y] [N] Do you directly handle birth products of sheep, cows, or goats? If yes, how frequently?
Appendix D

4. [ ] Y [ ] N [ ] Do you live on a farm or work with animals at home? If yes, which animals?

Do you wear a respirator to perform any part of your job? [ ] Y [ ] N

If No, STOP! Skip to the General Consent at the end of the questionnaire.

You must sign the General Consent to allow Champlain Medical review.

If Yes, please continue.

Respirator Clearance Questions
Part A

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? [ ] Y [ ] N

2. Have you ever had any of the following conditions?
   a) Seizures (fits) [ ] Y [ ] N
   b) Diabetes (sugar disease) [ ] Y [ ] N
   c) Allergic reactions that interfere with your breathing [ ] Y [ ] N
   d) Claustrophobia (fear of closed in places) [ ] Y [ ] N
   e) Trouble smelling odors [ ] Y [ ] N

3. Have you ever had any of the following pulmonary or lung problems?
   a) Asbestosis [ ] Y [ ] N
   b) Asthma [ ] Y [ ] N
   c) Chronic bronchitis [ ] Y [ ] N
   d) Emphysema [ ] Y [ ] N
   e) Pneumonia [ ] Y [ ] N
   f) Tuberculosis [ ] Y [ ] N
   g) Silicosis [ ] Y [ ] N
   h) Pneumothorax (collapsed lung) [ ] Y [ ] N
   i) Lung cancer [ ] Y [ ] N
   j) Broken ribs [ ] Y [ ] N
   k) Any chest injuries or surgeries [ ] Y [ ] N
   l) Any other lung problem that you’ve been told about [ ] Y [ ] N

4. Do you currently have any of the following symptoms of pulmonary or lung illness?
   a) Shortness of breath [ ] Y [ ] N
   b) Shortness of breath when walking fast on level ground or walking up a slight hill or incline [ ] Y [ ] N
   c) Shortness of breath when walking with other people at an ordinary pace on level ground [ ] Y [ ] N
   d) Have to stop for breath when walking at your own pace on level ground [ ] Y [ ] N
   e) Shortness of breath when washing or dressing yourself [ ] Y [ ] N
   f) Shortness of breath that interferes with your job [ ] Y [ ] N
   g) Coughing that produces phlegm (thick sputum) [ ] Y [ ] N
   h) Coughing that wakes you early in the morning [ ] Y [ ] N
   i) Coughing that occurs mostly when you are lying down [ ] Y [ ] N
   j) Coughing up blood in the last month [ ] Y [ ] N
   k) Wheezing [ ] Y [ ] N
   l) Wheezing that interferes with your job [ ] Y [ ] N
   m) Chest pain when you breathe deeply [ ] Y [ ] N
   n) Any other symptoms that you think may be related to lung problems [ ] Y [ ] N

5. Have you ever had any of the following cardiovascular or heart problems?
   a) Heart attack [ ] Y [ ] N
Appendix D

b) Stroke Y[ ] N[ ]
c) Angina Y[ ] N[ ]
d) Heart failure Y[ ] N[ ]
e) Swelling in your legs or feet (not caused by walking) Y[ ] N[ ]
f) Heart arrhythmia (heart beating irregularly) Y[ ] N[ ]
g) High blood pressure Y[ ] N[ ]
h) Any other heart problem that you’ve been told about Y[ ] N[ ]

6. Have you ever had any of the following cardiovascular or heart symptoms?
   a) Frequent pain or tightness in your chest Y[ ] N[ ]
   b) Pain or tightness in your chest during physical activity Y[ ] N[ ]
   c) Pain or tightness in your chest that interferes with your job Y[ ] N[ ]
   d) In the past two years, have you noticed your heart skipping or missing a beat Y[ ] N[ ]
   e) Heartburn or indigestion that is not related to eating Y[ ] N[ ]
   f) Any other symptoms that you think may be related to heart or circulation problems Y[ ] N[ ]

7. Do you currently take medication for any of the following problems?
   a) Breathing or lung problems Y[ ] N[ ]
   b) Heart trouble Y[ ] N[ ]
   c) Blood pressure Y[ ] N[ ]
   d) Seizures (fits) Y[ ] N[ ]

8. If you’ve used a respirator, have you ever had any of the following problems? (If you’ve never used a respirator, check the following space and go to question 9:)
   a) Eye irritation Y[ ] N[ ]
   b) Skin allergies or rashes Y[ ] N[ ]
   c) Anxiety Y[ ] N[ ]
   d) General weakness or fatigue Y[ ] N[ ]
   e) Any other problem that interferes with your use of a respirator Y[ ] N[ ]

9. Do you have any muscle or skeletal problem that interferes with using a respirator Y[ ] N[ ]

10. Would you like to talk to the health care professional who will review this questionnaire about your answers in this questionnaire Y[ ] N[ ]

Part B

Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen Y[ ] N[ ]
   If “yes”, do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you’re working under these conditions Y[ ] N[ ]

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g. gases, fumes, or dust), or have you come into skin contact with hazardous chemicals? Y[ ] N[ ]
   If “yes” name the chemicals if you know them

3. Have you ever worked with any of the materials, or under any of the conditions listed below?
   a) Asbestos Y[ ] N[ ]
   b) Silica (e.g. in sandblasting) Y[ ] N[ ]
   c) Tungsten/cobalt (e.g. grinding or welding this material) Y[ ] N[ ]
   d) Beryllium Y[ ] N[ ]
Appendix D

e) Aluminum [Y] [N]
f) Coal (for example, mining) [Y] [N]
g) Iron [Y] [N]
h) Tin [Y] [N]
i) Dusty environments [Y] [N]
j) Any other hazardous exposures [Y] [N]

If “yes” describe these exposures:

4. List any second jobs or side business you have

5. List your previous occupations:

6. List your current and previous hobbies:

7. Have you been in the military services? [Y] [N]
   If “yes” were you exposed to biological or chemical agents (either in training or combat) [Y] [N]

8. Have you ever worked on a HAZMAT team? [Y] [N]

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications): [Y] [N]
   If “yes” name the medications if you know them:

10. Will you be using any of the following items with your respirator(s):
    a) HEPA Filters [Y] [N]
    b) Canisters (for example, gas masks) [Y] [N]
    c) Cartridges [Y] [N]

11. How often are you expected to use the respirator(s) (circle “yes” or “no” for all answers that apply to you)
    a) Escape only (no rescue) [Y] [N]
    b) Emergency rescue only [Y] [N]
    c) Less than 5 hours per week [Y] [N]
    d) Less than 2 hours per day [Y] [N]
    e) 2 to 4 hours per day [Y] [N]
    f) Over 4 hours per day [Y] [N]

12. During the period you are using the respirator(s), is your work effort
    a) Light (less than 200 kcal per hour) [Y] [N]
       If “yes” how long does this period last during the average shift
       _____________ hrs _____________ min
       Examples of a light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1-3 lbs.) or controlling machines
    b) Moderate (200-350 kcal per hour) [Y] [N]
       If “yes” how long does this period last during the average shift
       _____________ hrs _____________ min
       Examples of moderate work effort are sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work or transferring a moderate load (about 35 lbs.) at trunk level; walking on a level surface about 2 mph or down a 5 degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 100 lbs.) on a level surface.
Appendix D

c) Heavy (above 350 kcal per hour)  Y[ ] N[ ]
If “yes” how long does this period last during the average shift

<table>
<thead>
<tr>
<th>hrs</th>
<th>min</th>
</tr>
</thead>
</table>

Examples of heavy work are lifting a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you’re using your respirator  Y[ ] N[ ]
If “yes” describe this protective clothing and/or equipment

14. Will you be working under hot conditions (temperature exceeding 77º F)  Y[ ] N[ ]

15. Will you be working under humid conditions  Y[ ] N[ ]

16. Describe the work you’ll be doing while you’re using your respirator(s)

17. Describe any special or hazardous conditions you might encounter when you’re using your respirator(s)
(for example, confined spaces, life-threatening gases)

18. Provide the following information, if you know it, for each toxic substance that you’ll be exposed to when you’re using your respirator(s):

<table>
<thead>
<tr>
<th>Name of the first toxic substance</th>
<th>Estimated maximum exposure level per shift</th>
<th>Duration of exposure per shift</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of the second toxic substance</td>
<td>Estimated maximum exposure level per shift</td>
<td>Duration of exposure per shift</td>
</tr>
<tr>
<td>Name of the third toxic substance</td>
<td>Estimated maximum exposure level per shift</td>
<td>Duration of exposure per shift</td>
</tr>
<tr>
<td>The name(s) of any other toxic substances that you’ll be exposed to while using your respirator</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

19. Describe any special responsibilities you’ll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security)

Complete next page to allow Champlain Medical review.
Appendix D

Occupational Health Surveillance Program for Employees Working with Animals

General Consent for Review and Release of Medical Information

I certify that the above statements are true, complete, and correct to the best of my knowledge and belief.

I consent to review of this information by Champlain Medical on behalf of the University of Vermont. I understand that this review is undertaken for my safety in the job environment and understand that I may be further contacted by Champlain Medical either for clarifications or further evaluation. Further evaluation may include, but is not limited to, a physical examination, blood tests, an evaluation of lung function, and other diagnostic tests as necessary. Costs for evaluation and testing will be covered by the University.

I further understand that this information and the results of subsequent tests or treatments that relate to my job and the performance of essential job functions may be released to my supervisor.

Employee Signature: ___________________________________________________
Employee Printed Name: ___________________________________________________
Date Signed: ___________________________________________________________

OR

I understand that if I decline participation in the Occupational Health and Safety Program, my employment status might change to meet acceptable safety and wellbeing standards.

Employee Signature: ___________________________________________________
Employee Printed Name: ___________________________________________________
Date Signed: ___________________________________________________________

Submission Instructions:

**Option 1:** Complete, scan into PDF and then email the form to iacucrpo@uvm.edu. While we cannot completely ensure confidentiality of the information contained utilizing this option, there is only one person in our office who will reference the information on the first page only to record your name as having completed the requirement.

**Option 2:** Place completed form in a sealed envelope, legibly write your name and “CONFIDENTIAL- OCC HEALTH FORM”. Forward the sealed envelope by campus mail to the IACUC office at the address below.

Research Protections Office - IACUC
213 Waterman Building, 85 South Prospect Street
Burlington, VT 05405

The form is then forwarded to Champlain Medical for review. You will be contacted by Champlain Medical directly if applicable sections are not complete.

*You must sign the last page to allow Champlain Medical review.*

Champlain Medical Use Only:

Reviewed by _____________________________________________________________
Date ____________________