

**Department of
Veterans Affairs**

Memorandum

Date: May 12, 2011

From: Chief of Staff (11)

Subj: Occupational Health and Safety Program

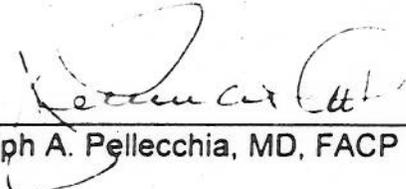
To: Addressees

1. Most staff involved with research has the option of enrolling in VA's Occupational Health and Safety program. **Please note:** you must enroll to work on an approved Animal Component of Research protocol. This program is free and includes a physical exam and an annual health survey. Enrolling in the program is just one way you can protect your health and ensure your safety while performing your tasks.

2. Because the Occupational Health and Safety program that covers WOC employees while they are at the University of Kentucky does not meet public health standards, we cannot accept this program. Therefore, we encourage all WOC employees and VA paid employees to enroll in our program.

3. Please follow the directions on the attached confidential health questionnaire and return a completed copy to Leon Bargo (11E-CD). If you are not working with animals and choose to decline, we still need you to sign the attached form and return it to Mr. Bargo.

4. Please direct any questions to Jenna Sansone, Supervisor, Veterinary Medical Unit, at ext. 5946.



Joseph A. Pellecchia, MD, FACP

Attachment

Animal Exposure Baseline History

1. Name: _____ S.S.#: (Last 4) _____
2. Date of Birth: _____ Male Female Pregnant?
3. Service: _____ Job Title: _____
4. Extension: _____ Pager: _____ E-mail: _____
5. Routing Symbol: _____ Building and Room #: _____
6. Supervisor's Name: _____ Supervisor's Phone: _____
7. Animal contact within VAMC (check all that apply):

<input type="checkbox"/> Dogs	<input type="checkbox"/> Pigs
<input type="checkbox"/> Cats	<input type="checkbox"/> Sheep
<input type="checkbox"/> Nonhuman Primates	<input type="checkbox"/> Rodents
<input type="checkbox"/> Rabbits	<input type="checkbox"/> Guinea Pigs
<input type="checkbox"/> Other: _____	
8. Total amount of contact time with animals (include contact with animal tissues, waste, body fluids, carcasses or animal quarters):
 - More than one hour / week
 - One or less hour / week
 - Other (explain): _____
9. Does your work with animals involve any human or animal pathogens or infectious diseases?
 - Yes No
 - If yes, please list pathogens or diseases: _____
 - _____
10. If you are in contact with nonhuman primates:
 - a. Have you ever had Tuberculosis (TB)? Yes No
 - If yes, please list medications and how long you took them: _____
 - _____
 - b. Have you been vaccinated with BCG for TB? Yes No _____ Year
 - c. Have you ever had a positive reaction to a TB test (Tine Test, PPD, Mantoux)?
 - Yes No

If yes, please name any medications you took and the length of time you took them.

11. Are you receiving immunosuppressive therapy such as prednisone, steroids or anti-cancer drugs? Yes No

12. How often do you wear Personal Protective Equipment when working with animals? (Check the appropriate responses.)

<u>Type of PPE</u>	<u>Sometimes</u>	<u>Always</u>	<u>Never</u>	<u>Rarely</u>
Gloves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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"/>
Cap	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Goggles/Glasses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. Do you smoke, eat or drink in the animal areas? Yes No

14. How often do you do the following after handling animals at work?

	<u>Sometimes</u>	<u>Always</u>	<u>Never</u>	<u>Rarely</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"/>

15. Do you have a history of the following conditions? (Check those you have or have had.)

- Hay fever Asthma Allergic Skin Problems Eczema
 Sinusitis Other Chronic Respiratory Infections

16. Has anyone in your family ever had hay fever, asthma, eczema or allergic skin problems?

Yes No

17. Do you have sneezing spells, runny or stuffy nose, watery or itchy eyes, coughing, wheezing, or shortness of breath, skin rash or hives, or difficulty swallowing after working with laboratory animals or their cages? (Circle those you have.)

_____ Yes _____ No

18. Which animals cause the above problems?

19. How frequently are you bothered by the symptoms below?

<u>Symptoms</u>	<u>Never</u>	<u>Monthly</u>	<u>Weekly</u>	<u>Daily</u>
Watery, itchy eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Runny or stuffy nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sneezing spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent dry cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing in chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rash or hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

20. Do you have any house pets? Yes No

If yes, what type of animals do you have? _____

21. Do you have any symptoms with your pets? Yes No

If yes, what type of symptoms do you have? _____

22. Do you have a chronic respiratory disease? Yes No

If yes, please explain: _____

23. Have you ever had a hernia (rupture)? Yes No

If yes, please explain: _____

24. Have you ever had back trouble or pain that required treatment, surgery or loss of time at work? Yes No

If yes, please explain: _____

25. Do you have joint problems or any form of arthritis? Yes No

If yes, please describe: _____

26. Do you work with chemicals? Yes No

Do you have symptoms from the chemicals? Yes No

Comments: _____

27. Please note any other health history you consider significant:

28. Immunization / TB Screening History:

<u>Vaccine/Test</u>	<u>Date</u>	<u>Side Effect/Reaction</u>	<u>Other</u>
Tetanus (most recent)	_____	_____	_____
Rabies Series, Initial	_____	_____	_____
Rabies Booster	_____	_____	_____
Rabies Immune Globulin	_____	_____	_____

Hepatitis B Series, Initial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B, 2 nd Series	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculin Mantoux (PPD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest X-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature of Employee: _____ Date _____

Print Name: _____

Signature of Interviewer: _____ Date _____

Print Name: _____

27. Please note any other health history you consider significant.

Comments: _____

28. Immunization \ TB Screening History:

Vaccine/ Test	Date	Site / Observation	Other
Tetanus (most recent)	_____	_____	_____
Rabies Series (initial)	_____	_____	_____
Rabies Booster	_____	_____	_____
Rabies Immune (Globulin)	_____	_____	_____

Periodic Animal Exposure Questionnaire

Name: _____ SS#: (Last 4) _____

Job Title: _____ Extension: _____ Bldg/Room #: _____

1. I no longer work with animals (including animal tissues, waste, body fluids, carcasses or animal quarters) at the VAMC. YES NO (if YES, skip to #4).
2. Show any **CHANGE** in animal contact within the VAMC in the past year. Write a plus (+) for continuing contact; (++) for new animal contact; (-) for animals no longer working with.

_____ Dogs	_____ Pigs
_____ Cats	_____ Sheep
_____ Rabbits	_____ Rodents
_____ Guinea Pigs	_____ Nonhuman Primates
_____ Other	

3. Check total amount of contact time with animals in the past year (include contact with animal tissues, waste, body fluids, carcasses or animal quarters):

_____ More than one hour / week

_____ One hour or less / week

_____ Other (explain) _____

4. List any additions or deletions of human or animal pathogens or infectious diseases you have worked with in the past year:

Additions: _____

Deletions: _____

5. List the date of your last TB screening: (Mantoux or TB Symptoms Checklist): _____

6. List date of Hepatitis B, Tetanus or Rabies immunizations received this past year:

Tetanus _____ Rabies _____ Hepatitis B _____

7. Circle any condition(s) you have developed over the past year:

- Hay fever Asthma
- Sinusitis Other Chronic Respiratory Infection
- Allergic skin problems Eczema

Comments: _____

8. Check symptoms you developed this past year and how often you have them:

Symptoms	Never	Monthly	Weekly	Daily
Watery, Itchy Eyes				
Runny, Stuffy Nose				
Sneezing Spells				
Frequent Dry Cough				
Wheezing In Chest				
Rash or Hives				
Shortness of Breath				
Trouble Swallowing				

9. Do animals cause the above symptoms? If so, please list the animals.

10. List any NEW pets you obtained in the past year and symptoms you have with them.

New Pets	Symptoms

11. List any medical problems, pregnancies, hospitalizations or surgeries this past year.

Signature of Employee: _____ Date: _____

Print Name _____

Signature of Reviewer _____

Print Name _____

Physical Examination: Recommended _____ Not Recommended _____

10. List any NEW pain you obtained in the past year and symptoms you have with them.

New Test	Symptoms

11. List any medical problems, procedures, hospitalizations or surgeries this past year.

Signature of Employee: _____ Date: _____

Print Name: _____

Signature of Reviewer: _____

Print Name: _____

Physical Examination: Recommended _____ Not Recommended _____