Lehman College Animal Use Occupational Safety & Health Program

Baseline Health Questionnaire

This Baseline Health Questionnaire is designed to provide the following:

- Information about occupational exposure and risks associated with the position (identified in Section 1.1 – Job Information);
- Employee medical information related to ability to safely perform work-related functions;
- Baseline employee medical history for ongoing medical surveillance purposes.

PART A of this Questionnaire should be completed as follows:

1) New Hires: By *Manager or Supervisor* and provided to newly-hired employees.

2) Existing Employees: By existing employee with assistance of Manager or Supervisor to ensure accuracy of occupational exposure and risk.

PART B of the Questionnaire will be completed by the *Employee*. **Do not share any information in Part B of this questionnaire with anyone, including managers, supervisors, or Human Resources**. All personal health and medical information provided in PART B is privileged and confidential. After Part B is completed, the individual MUST SIGN THE QUESTIONNAIRE.

Submission Instructions: The completed form can be mailed via interoffice mail to Lehman College Student Health Services (Nursing Bldg/T3, room 118).

PART A: to be completed by hiring manager or supervisor of new employee or candidate, or, with the assistance of manager or supervisor if position below is being performed by an existing employee.

Section 1.0: Occupational Exposure

Section 1.1: Job Information					
Employee Name					
Employee email address					
Department					
Today's date					
Title					
Principal Investigator (PI)					
PI campus phone number					
PI email address					
Position Description (Check all that apply)					
Principal Investigator		Animal Care Technician		Visitor	
Researcher		IACUC Member		Postdoctoral	
Veterinary		Volunteer		Graduate student	
Other (please describe):					

Section 1.2: Workplace Description (Check All that Apply)							
Animal Care Facility		Research Laboratory		Teaching Laboratory			
Other (please describe):							
Biosafety Level		BSL 1		BSL 2		N/A	

Section 1.3: Workplace Environment (Check All that Apply)					
Animals		Class 3b or 4 laser		Radioactive material	
Unfixed tissue:		Human cells, tissue, or blood		Unfixed Nonhuman Primate (NHP) tissue	
Hazardous chemicals		Recombinant (rDNA)		Field studies	
Other (please describe):					

Section 2.0: Risk Assessment

Section 2.1: Exposure to Animals							
Does this position require contact with animals?				YES		NO	
If YES, please identify the type(s) of animal species below:							
Mice		Prairie Voles		Fish, frogs, or other aquatics			
Other species:							
Rats							
Hamsters							
Gerbils							
Other (please describe):							

Section 2.2: Exposure to Infectious Agents							
Does this position require work with infectious agents?				YES		NO	
If 'YES', please identify the type(s) of infectious agents below:							
Risk Group 2:							
Burkholderia cepacia		Human immunodeficiency virus		Neisseria meningitidis			
Chlamydia trachomatis		Influenza		Plasmodium falciparum			
Clostridium Difficile		Japanese encephalitis virus vaccine strain		Polio virus			
Cryptosporidium parvum		Klebsiella pneumoniae		Rabies virus			
Dengue virus		La Cross virus		Salmonella typhimurium			
Entamoeba histolytica		Measles virus		Streptococcus pyogenes (Group A)			
Enterovirus 71 (Sarawak serotype b)		Methicillin-Resistant Staphylococcus aureus		Vancomycin-Resistant enterococci			
Escherichia coli (EHEC strain)		Mumps virus		Vibrio cholera Pacini (strain N16961)			
Haemophilus influenzae		Mycobacterium bovis BCG		Yellow fever virus vaccine strain			
Herpes B virus		Neisseria gonorrhoea		Yersinia enterocolitica			
Other (please describe):							

PART B: To be completed by employee. Please answer all questions completely.

Section 3.0: Medical Health History							
Section 3.1: Personal Information							
Full Name							
Sex	Male		Female				
Date of Birth							
Home Address							
Home phone							
Employer (Lehman College, CUNY, Other)							
CUNY First Employee ID Number							
Email							
Campus phone number							
Cell phone number							
Emergency Contact							
Relationship to emergency contact							
Emergency contact phone							
Section 3.2: Review of Systems: Allergy and Respiratory System Health History							
Asthma or other chronic respiratory disease				YES		NO	
Allergic skin reactions such as hives, rash or itching. If yes, please explain				YES		NO	
Skin conditions such as eczema, psoriasis, dermatitis				YES		NO	
Known or suspected animal allergies. Please check off any animal-related reaction(s):							
Runny/stuffy nose		Wheezing		Hives			
Sneezing		Chest tightness		Skin rash			
Coughing		Shortness of breath		Throat swelling			
If yes, please list animal(s):							
Known or suspected allergies to chemicals, latex, food or environment				YES		NO	
If yes, please list:							
Are you currently using respiratory protection or a mask?				YES		NO	
If yes, have you been fit-tested? Please list type or respirator/ mask you are using:							

Immune/Metabolic System Health History

Chronic health conditions such as diabetes	YES		NO	
Valvular heart disease	YES		NO	
Reproductive health counseling available – Would you like to speak with an occupational health provider?	YES		NO	
Kidney or liver disease	YES		NO	
History of spleen problems or absence of spleen	YES		NO	
Immune system deficiencies or other limitations to your ability to fight off disease or infection? If yes, please list:	YES		NO	
Do you have any questions concerning your health as it relates to the workplace that you would like to discuss with an occupational health professional?	YES		NO	

Section 3.3: Immunizations					
Please check the boxes to indicate which immunizations you have received in the past:					
Tetanus/diphtheria or Tdap		Rubella (German measles)		Varicella (Chicken pox)	
Measles		Mumps		Hepatitis B	
Other (please describe):					

Section 3.4: Tuberculosis Screening	
Date of your last TB test:	
If history of positive TB test, please indicate date:	

Employee Signature: my signature below indicates that I have answered the questions above truthfully, completely, and to the best of my ability.

Employee Signature:
Date:

Section 4.0: Important Information

Federal law prohibits employers from requesting genetic information of an employee or an employee's family member unless an exception applies. "Genetic information" includes your family medical history, the results of your or your family member's genetic tests, and the fact that you or your family member sought or received genetic services. Please do not provide such information when completing this questionnaire. The medical records created as a result of services performed by the health care professionals employed or contracted by Lehman College Student Health Services. Your medical records will be maintained by your private physician or Lehman College Student Health Services. Your consent

will be requested when medical records are needed by other medical institutions to perform diagnostic tests or examinations related to fitness for duty or medical surveillance. Certain disclosures of your protected medical records such as records relating to drug and alcohol treatment, mental health, AIDS/HIV, and genetic testing requires a separate written authorization by you. Prior authorizations for disclosing such records may be withdrawn by written request.

Past medical records may have been created as a result of services performed by health care professionals employed by or contracted by Lehman College Student Health Services related to and during the term of your employment with Lehman College. As historical medical records are an important consideration in the performance of medical surveillance, evaluations, and provision of appropriate medical care, it is important for the health care professionals at Lehman College Student Health Services to be able to review these records.

Section 5.0: Consent for Examination and Authorization for Disclosure

I hereby authorize the health care professionals employed or contracted by the Lehman College Student Health Services to examine me and maintain medical records created as a result of such medical examination. This authorization includes:

(a) Permission to review health information maintained by Lehman College Student Health Services.

(b) Permission to obtain routine diagnostic tests, if necessary, to provide me with any immunizations which may be required, and to perform a physical examination to assess my ability to perform my job.

I understand that this evaluation has been requested by Lehman College and hereby authorize the health care professionals employed or contracted by Lehman College Student Health Services to provide a comprehensive report to my employer relating to my fitness for duty. I understand that such a report may include information on my medical history and medical conditions to the extent this information is relevant to an assessment of my ability to safely perform the duties of my position. I acknowledge that my health information may also be released to others for purposes of treatment, payment, or health care operations and for other purposes as required or permitted by workers compensation law or other applicable law. I understand that I may request a copy of my medical record by submitting a written request.

Employee Signature:
Date:

For Lehman College Student Health Services Use

Lehman College Student Health Services Health Care Provider Signature:
Date:
Provider notes: