THE UNIVERSITY OF ALABAMA AT BIRMINGHAM
OH&S Employee Health

ARP RENEWAL FORM

YOUR RESPONSES ARE STRICTLY CONFIDENTIAL

Place the completed Employee Health Program Enrollment form in a *Confidential Envelope* and bring it with you when you receive your yearly TB Skin Test.

General Information:

1. If you have ever been diagnosed with or had symptoms of the following, you may be at increased risk of injury or health problems when conducting research at UAB.

Skin rashes	Glove Allergies/rashes	Allergies to animals, dander, and/or hair
Asthma	Muscle or bone problems	Allergies to pollen, food, etc.
Latex Allergy	Mitral valve prolapse	Repetitive motion injury (i.e., carpal tunnel)
Diabetes	Repeated episodes of diarrhea	Problems with visual acuity, hearing ability
Hernia	Splenectomy (missing spleen)	Allergic skin problems, eczema
Seizure disorder	Drug or alcohol dependency	Family history of hay fever, asthma

2. If you are pregnant or if your immune system is suppressed, you may be at increased risk. Please make sure your private/personal physician knows about your job duties.
3. Personnel working with certain animals may require immunizations specific to that species.
4. If you have any disability (limitation) for which you believe an accommodation is needed for you to perform your job, it is your responsibility to inform your supervisor and request a workplace accommodation.
5. To minimize risks to personnel, health screening at the beginning of the job and at periodic intervals is recommended for certain job categories.
6. An annual tuberculosis (TB) screen is required for those in contact with nonhuman primates. Vaccination against TB by Bacillus Calmette-Guerin (BCG), does not exclude one from annual TB screening requirements.

Demographic Information:

Please complete **ALL** of the following information:				**DATE:**	
Check all that apply: ☐Mr. ☐Mrs. ☐Ms. ☐Dr. ☐ Male ☐ Female				Are you employed by UAB? ☐ Yes ☐ No	
Last Name		First Name		MI	
Job Title		Work Address		Blazer ID	
Birth Date		Best way to contact you		Dept.	
Work Phone		Alt. Phone		Email	
Supervisor Name					

In the space below, please provide a brief job description (use back of form if more space is required):

Work Area:

Lab Location (Bldg and Room):______________________________

Animal Facilities (Bldg and Room):______________________________

Other Areas (Bldg and Room):______________________________

Have your work exposures changed? ☐ NO ☐ YES

Immunizations:

Have you had any immunizations from another healthcare facility/provider since your last enrollment form?

☐ NO ☐ YES If so, please list:

Immunization	Date of Immunization

Medical History:

Have you had any of the following (check all that apply)?		
☐ Pneumonia	☐ Recurrent Bronchitis	☐ Tuberculosis
☐ Heart Disease	☐ Rheumatic Fever	☐ Heart Murmur or Valve Disease
☐ Diabetes	☐ Kidney Disease	☐ Liver Disease
☐ Cancer	☐ Gastrointestinal Disorder	☐ Loss of Consciousness
☐ Seizures	☐ Arthritis	☐ Chronic Back or Joint Pain

Allergy	Symptoms*			Frequency of Symptoms**			Treatment
	A	B	C	X	Y	Z	Please Describe Here
Animal Specify:__________							If so, do you have plans to work with these animals in your research?
Chemicals: Specify:__________							
Medications: Specify:__________							
Latex							
Other: (pollen, food, talc, etc.) Specify:__________							

***Symptoms:**
A – itchy eyes, runny nose, sneezing
B – wheezing, shortness of breath, asthma
C - hives

****Frequency:**
X – less then 1 time per year
Y – more than 1 time per year
Z – seasonal only

Please answer the following:	NO	YES	If YES, explain or list
Do you have any ongoing medical problems?			
Have you ever contracted a disease from animals or experienced an animal-related injury (including bites, scratches, etc.)?			
Have you ever been told by a physician that you have an immune-compromising medical condition or are you taking medication that might impair your immune system (e.g., steroids, immunosuppressive drugs, chemotherapy)?			
Are you currently under a physician's care for allergies or asthma?			
Are you currently taking any medications?			
For women: Are you pregnant, or planning to be come pregnant in the next two years?			Explanation not necessary

Assurances:

I certify that information provided is true and complete to the best of my knowledge. I understand that any intentional false statement or omission of facts may place me or my coworkers at increased risk of health-related injury/illness and may be grounds for disciplinary action.

I have read the information in this form. I am aware that some health conditions may increase my risk of injury or illness when working with research animals. I understand that I should make my physician aware of these conditions and my duties.

Signature ______________________ Date ______________________

Based on the information provided in this form, if you are concerned that you may be at increased risk and wish to schedule an appointment to discuss this information, please provide your contact information and check here____.

(work)________________________ (home)___________________________ (mobile)_________________________