UF Environmental Health and Safety UNIVERSITY of FLORIDA

BioPath: Biohazard Medical Monitoring Authorization Form

☐ Initial Enrollment
☐ Change in biohazard exposure
Specify_____
☐ Annual Renewal

Department, Complete section below and send to EH&S BSO@ehs.ufl.edu

Participant Name _____	UFID _____	DOB _____	Male ☐ Female ☐
Dept/Division _____	Pos Title _____	Pos # _____	Email _____

Work Duties: ☐ Climbing/Working on ladder ☐ Lifting over 25lbs ☐ Lifting over 25lbs overhead ☐ Certifying/Repairing equipment ☐ Inspections ☐ Emergency Response ☐ In shared space with other agents ☐ Prolonged (over 4hrs) work in containment areas

Physical Work Location of Participant: _____

Anticipated Biohazard Exposure
List Direct Exposure Agents: _____
List Indirect Exposure Agents: _____

Fiscal Contact _____	Fiscal Phone _____	Fiscal Email _____

Has the Payment Authorization Form been submitted? ○ Yes ○ No

PI/Spvr Name _____	Phone _____	Email _____

This information is accurate. I understand the above named individual requires participation in the Biohazard Medical Monitoring Program and have reviewed the Program information. (http://www.ehs.ufl.edu/programs/bio/biopath_program/)

PI/Supervisor Signature:_____ Date:_____ Submit to EH&S: **Submit Form**

EH&S will notify the Supervisor once the BioPath Authorization form had been uploaded to Occupational Health. Participant must then send completed Biohazards Medical Assessment Questionnaire to UF OCCMED Clinic at OccMedClinic-RiskAssessment@ahc.ufl.edu

Environmental Health & Safety Authorization: Complete and Share with SHCC

Respirator Recommendation: ☐ N95 ☐ N99 ☐ N100 ☐ PAPR ☐ Other _____

Additional PPE Requirements: ☐ Cut-proof gloves ☐ Double Gloves (latex/nitrile) ☐ Tyvek Gown ☐ Tyvek Coveralls ☐ Safety Goggles

Agent Exposure: ☐ Room/Equipment Chemically Deconned ☐ Surfaces Disinfected ☐ Agents Secured ☐ Works with agents or infected animals directly

EH&S Monitoring Recommendations: ☐ Vaccination ☐ Initial and annual blood tests ☐ Initial Physical ☐ Initial and/or annual review of questionnaire

EH&S Signature_____(Print_____) Date _____

UF OCCMED Clinic Use

Diagnostic Testing: ☐ TB TST Test (Initial) ☐ TB TST Test (Annual) ☐ TB Annual Symptom Review
Other_____

Immunization: Hep B: #1_____ #2_____ #3_____
Influenza _____ Small Pox_____ Other _____

Respirator Medical Clearance: ☐ N95 ☐ N99 ☐ N100 (EH&S fit testing is required after medical clearance) ☐ PAPR

Other:

UF OCCMED Clinic Statement

Follow-Up Due

☐ No Restrictions ☐ Specific Restrictions _____

Licensed Healthcare Provider_____Date _____

☐ 1 yr _____

☐ Other _____