

# Risk Assessment for Animal Contact

## Animal Contact Medical Monitoring Program

- Select
- Initial
- Renewal
- Change in Animal
- Program Removal

Please visit the [Animal Contact Program](#) website for detailed instructions on filling out this form.  
Personal medical health issues can **only** be discussed with **OCCMED CLINIC personnel** at (352) 294-5700.

Participant Name	UFID Number	Date of Birth	Male	Female
Participant ufl.edu Email	Position Title	Cell/Primary Phone Number		
Department/Division	Position Number	Work Phone		
Supervisor/PI Name	Supervisor Phone	Supervisor Email		

Has the [Payment Authorization Form](#) been submitted?      Yes      No      Not Required (*Animal Contact Type 1 or 2 only - see below*)  
*Failure to submit the Payment Authorization form, if required, may delay processing.*

Fiscal Contact Name \_\_\_\_\_ Fiscal Contact Phone: \_\_\_\_\_ Fiscal Contact Email: \_\_\_\_\_

**Select Type of Animal Contact:**

1. **Only** listed on a current IACUC project. **No animal contact and does not visit** animal facilities

**OR**

2. **No longer active on** an approved IACUC project and will **not** be **entering** animal facilities

**Supervisor ACTION REQUIRED** → *If contact type 1 or 2 apply, STOP HERE, SIGN & SUBMIT* → **Supervisor Sign Here:** \_\_\_\_\_  
*If contact type 3,4,or 5 apply, participants and supervisors must continue filling out form completely.*      [Click to submit via e-mail](#)

3. Observes animals or enters animal facility only. No direct animal contact: IACUC inspector, maintenance personnel, UPD security, etc.  
4. Does not conduct procedures on live animals but handles animal waste, "unfixed" animal tissues, or body fluid  
5. Handles, restrains, collects specimens from, or administers substances to live vertebrate animals.

**Frequency of contact:**    Daily (5x/week)    Weekly (1-3x/week)    Monthly (1-3x/month)    Rarely (1-3x/every 3-6 months or less)

**Briefly describe your contact with or exposure to animals:**

**If working with all of the animals listed below, select "ALL Animals".**

Otherwise, select **each** animal that you may be in contact with or exposed to - not just the added or new types.

<b>ALL Animals</b> Live Animals      Tissue/Body Fluids <b>ONLY</b>	<b>Non-Human Primates</b> Live Animals      Tissue/Body Fluids <b>ONLY</b>	<b>Other</b> Live Animals      Tissue/Body Fluids <b>ONLY</b> Wild animals or their tissue/body fluids <b>Must specify type/species:</b>  <b>Describe your rabies risk level according to the CDC recommendations:</b>  <b>No rabies risk</b>  <b>Cat 2:</b> Frequent contact w/bats and/or frequent necropsies w/potential rabies infected neural tissue  <b>Cat 3:</b> >3 years of expected exposure to potentially rabid animals  <b>Cat 4:</b> <= 3 years of expected exposure to potentially rabid animals
<b>Bats</b> Live Animals      Tissue/Body Fluids <b>ONLY</b>	<b>Pigs</b> Live Animals      Tissue/Body Fluids <b>ONLY</b>	
<b>Birds</b> Live Animals      Tissue/Body Fluids <b>ONLY</b>	<b>Rabbits</b> Live Animals      Tissue/Body Fluids <b>ONLY</b>	
<b>Cats</b> Live Animals      Tissue/Body Fluids <b>ONLY</b>	<b>Reptiles &amp; Amphibians</b> Live Animals      Tissue/Body Fluids <b>ONLY</b>	
<b>Cattle</b> Live Animals      Tissue/Body Fluids <b>ONLY</b>	<b>Rodents</b> ( <i>Guinea pigs, hamsters, gerbils, mice, rats, etc.</i> ) Live Animals      Tissue/Body Fluids <b>ONLY</b> Wild rodents or their tissue/body fluids	
<b>Dogs</b> Live Animals      Tissue/Body Fluids <b>ONLY</b>	<b>Sheep/Goats</b> Live Animals      Tissue/Body Fluids <b>ONLY</b> Housed indoors for Biomedical Research ( <i>N95</i> )	
<b>Fish</b> Live Animals      Tissue/Body Fluids <b>ONLY</b>	<b>Zoo/Exotic</b> Live Animals      Tissue/Body Fluids <b>ONLY</b> <b>Must specify type/species:</b>	
<b>Horses</b> Live Animals      Tissue/Body Fluids <b>ONLY</b>		

**Supervisor ACTION REQUIRED** → Supervisor Sign Here: \_\_\_\_\_ Date: \_\_\_\_\_      **Supervisor SAVE & EMAIL TO:** → Participant: \_\_\_\_\_ E-mail: \_\_\_\_\_

Participant Name: \_\_\_\_\_ UFID: \_\_\_\_\_ Phone: \_\_\_\_\_



**Complete both pages of the Immunization/Screening History & Health Questionnaire**

<b>Immunization/Screening History</b> - Call the VETMED Clinic at 352-294-5700 to obtain any of these services.	<b>Date (MM/YY)</b>
Tetanus Immunization. <i>Required of all, every 10 yrs. (MM/YY)</i>	
Rabies vaccines only required if possible contact with rabies infected mammals or their materials. <i>Include dates of past vaccines and/or titers. Include official records with form.</i>	
Tuberculosis screening. <i>Required annually for contact with nonhuman primates, elephants &amp; rhinos. Include official records with form.</i>	
Q Fever Titer. <i>Required annually for contact with sheep and goats as specified by the <a href="#">Q Fever Policy</a>.</i>	

1. Are you allergic to any animal(s)?	Yes	No	Don't Know
If yes, list animals that cause your allergy symptoms:			
2. Do you have any other known allergies?	Yes	No	Don't Know
If yes, what? List cause(s) of allergies:			
List symptoms that occur when you are suffering from your allergies:			
List any treatment that you received to relieve your allergies:			
3. Are you allergic or possibly allergic to the animals that you currently work with?	Yes	No	Don't Know
If yes, have you been seen by a physician for this?			
4. Do you have asthma caused by or related to allergies?	Yes	No	Don't Know
If yes, list cause(s) (if you do not know, write "unknown"):			
5. Do you have asthma related to the animals that you currently work with?	Yes	No	Don't Know
If yes, have you been seen by a physician for this?			
6. Do you experience shortness of breath at work?	Yes	No	Don't Know
If yes, explain:			
7. Do you have any skin problems related to work? (e.g. reactions to latex, dry/cracked skin, rashes)	Yes	No	Don't Know
If yes, describe:			
8. Do you have any chronic medical condition which might suppress your immune system (e.g. heart disease, lung disease, cancer, lupus, rheumatoid arthritis, multiple sclerosis, leukemia, lymphoma, diabetes, HIV/AIDS, tuberculosis, renal disease, splenectomy, alcoholism)?	Yes	No	Don't Know
If yes, describe:			
9. Have you recently taken any medications, which might suppress your immune system? (e.g. prednisone, cortisone, chemotherapy, methotrexate, etc.)	Yes	No	Don't Know
10. Do you take any medications (prescribed or over the counter) on a regular basis?	Yes	No	Don't Know
If yes, list:			

Participant Name: \_\_\_\_\_ UFID: \_\_\_\_\_ Phone: \_\_\_\_\_

Health Questionnaire - *continued*

11. Do you wear a fit-tested respirator (including N95) to perform any work activities?							Yes	No	
If yes, date of last respirator training & date of last supervised fit-testing:									
12. Do you have any health or workplace concerns not covered by the questionnaire that you feel may affect your occupational health and would like to confidentially discuss with the Occupational Health Consulting Physician (e.g. questions regarding immunity or medical conditions)							Yes	No	
13. Have you developed any new symptoms or illnesses from exposure to animals at work or home?							Yes	No	Don't Know
If yes, describe:									
<b>Initial: Skip Q.14 only</b>					<b>Renewals/Change in Animal: Answer Q. 14, Skip Q.15 and Q.16</b>				
14. Have you developed any new medical problems since your last evaluation?							Yes	No	
If yes, describe:									
15. Prior to your current job, have you been previously exposed to animals in any of the following setting:							Yes	No	
If yes, please indicate:		Mice or Rats	Rabbits	Cats	Dogs	Guinea Pigs or Hamsters	Other		
University									
Pharmaceutical Lab									
Hospital									
Research Lab									
Veterinary School									
Veterinary Clinic									
Pet Store									
16. If you were exposed to any lab animal, did you have any symptoms?							Yes	No	Don't Know/NA
If yes, symptoms with which animal?									
Skin									
Nose/Eyes									
Chest									
17. If you were exposed to any animal, did you avoid or stop working with any animal because you thought you were allergic to it?							Yes	No	



I, \_\_\_\_\_ *Participant's Name* affirm have answered the questions on this form truthfully and to the best of my recollection

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

1. Save this completed .pdf file
2. [Click here to SUBMIT](#) OR email to [OccMedClinic-RiskAssessment@ahc.ufl.edu](mailto:OccMedClinic-RiskAssessment@ahc.ufl.edu)

**OCCMED CLINIC USE ONLY**

No Restrictions for Animal Contact      Follow-Up Due:    1 year    3 Year    Other \_\_\_\_\_

Yes, Specific restrictions for Animal Contact. Restrictions are detailed below:

MD/ARNP/PA or other licensed healthcare professional:

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_