

BSL- 3 Plant Questionnaire

University of Minnesota
Occupational Health Clinic
Boynton Health Service
401 Church St SE
Minneapolis, MN 55455
612-626-9423

For Office Use Only:

Date Reviewed: _____

Action:

OK Call Appt

Date Review Completed: _____

PURPOSE

The purpose of this form is to obtain information about your personal health and work exposures to biological and chemical agents and personal health information from you to help the University to assess your ability to work in a BSL-3 laboratory. You must be seen by the designated occupational health provider for an initial health assessment prior to starting to work in a BSL 3 lab. The University Office of Occupational Health and Safety has contracted for occupational health services through Boynton Health Service. You will also be asked to complete the attached questionnaire periodically to assess ongoing risks and fitness for duty. A health care professional at the Occupational Health Clinic at Boynton Health Service will evaluate the information on this form and document for you and your supervisor any work restrictions or protective measures to be followed.

PRIVACY STATEMENT

The following information requested on the form is private: date of birth, sex, home address (unless listed in the campus directory) and all items under *Medical History*.

The Occupational Health Clinic at Boynton Health Service will maintain health and treatment information about you in a confidential medical record to ensure your privacy. The Occupational Health Clinic will not release private information about you without your written consent, except as required by law. The Occupational Health Clinic will however notify your supervisor at the University of work restrictions or protective measures to be followed and whether you have completed all occupational health requirements applicable to you.

DIRECTIONS

Please fill out the enclosed questionnaire. BE SURE TO PRINT CLEARLY. Return the form in a sealed envelope to: Attn: Occupational Health, c/o Boynton Health Service, 410 Church St. S.E., Minneapolis, MN 55455 or fax to 612-624-3310. For inter-office mail: use mail code MMC188. If you have questions regarding this form, please call 612-626-9423.

PARTICIPANT INFORMATION

Date: _____ Email Address: _____ U of M Employee ID#: _____

Name: *Last* _____ *First* _____ *Middle* _____

Sex: _____ Date of Birth: ____ mm ____ dd _____ yyyy

Job Title: _____ Department: _____

BSL-3 Lab where you will be working: _____

Supervisor: _____

Principal Investigator (if different from supervisor above): _____

Home Mailing Address:

Street: _____ City: _____

State: _____ Zip: _____ Home Phone: _____

Campus Mailing Address:

Street: _____ City: _____

State: _____ Zip: _____ Work Phone: _____

MEDICAL HISTORY

1. Have you had any of the following medical conditions or diseases within the last year? (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Dizziness or fainting spells | <input type="checkbox"/> Heart disease or condition |
| <input type="checkbox"/> Mental health problems | <input type="checkbox"/> Angina or heart related chest pain |
| <input type="checkbox"/> Seizures, epilepsy | <input type="checkbox"/> Chronic infectious disease |
| <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Chemical dependency or alcohol abuse |
| <input type="checkbox"/> Shortness of breath, lung problems | <input type="checkbox"/> Sleep disorder, narcolepsy, sleep apnea |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Irregular heart beat or arrhythmia | <input type="checkbox"/> Attention Deficit Disorder (ADD) or
Attention Deficit Hyperactivity Disorder (ADHD) |

2. Do you have any diseases that suppress your immune system (such as lupus, cancer, etc.) Yes No
If yes, please list:

3. Do you currently take any medications that may suppress your immune system? (For example prednisone, steroids or chemotherapy) Yes No
If yes, list medications:

4. Do you have any other health conditions that you think could be adversely affected by your work? Yes No
If yes, please list the condition(s)

5. Are you currently on any work restrictions or activity limitations? Yes No
If yes, please describe:

6. Do you have any known allergies? Yes No
If so what are you allergic to?

MEDICAL HISTORY (CONTINUED)

7. Have you ever had allergy testing (skin testing or blood lab work) Yes No
If yes, please list allergens you had positive test for:

8. Do you have any concerns or questions about occupational health and safety issues related to your job? Yes No
If yes, please describe below:

9. For Females:
Are you pregnant or do you anticipate becoming pregnant in the next 12 months? Yes No

EXPOSURE ASSESSMENT:

1. Total numbers of hours in an average week that you will be working in a BSL-3 lab:

- Less than 3 hours/week 3-10 hrs/week 11-24 hrs/week
 25 hrs or more/week
 Occasional/Irregular/Non-scheduled (i.e. maintenance, inspections)

2. Please describe, in your own words, your job duties in the BSL-3 lab:

3. Do you wear a mask or respirator at work for the University of Minnesota? Yes No

If yes, please answer the questions below:

Do you work in areas where you are required to wear a respirator? Yes No

Do you or will you be required to wear a respirator in the BSL-3 areas? Yes No

For what reason/hazard are you wearing a respirator? _____

What type of respirator do you wear?

N-95 Air Purifying Respirator (APR) Powered Air Purifying Respirator (PAPR)

Cartridge Respirator Other _____

EXPOSURE ASSESSMENT (CONTINUED):

5 : Please check the agents you will be exposed to while working in the BSL3 lab:

Infectious agents such as virus, bacteria, fungus, parasite, etc.
Please list: _____

Radioactive materials, please list radioactive material:
1. Radioactive material
2. Radiation generating equipment

Specify type of radiation or equipment: _____

Toxin
specify type: _____

Plant toxin or infectious agent
Please list type of toxin or agent: _____

Hazardous chemicals, including anesthetics , please list chemicals:

SIGNATURE OF PARTICIPANT

The above information is accurate and complete to the best of my knowledge

Signature

Date

The University of Minnesota Office of Occupational Health and Safety encourages employees to contact the Occupational Health Clinic at Boynton Health Service (612) 626-9423 with any questions about how their health might be affected by exposure to workplace hazards.