Bowdoin College Occupational Health and Safety Program
Animal Use Questionnaire

The questionnaire should be completed within 30 days prior to the date you will begin working directly and repeatedly with vertebrate animals or vertebrate animal tissues under the auspices of the College in the next year. Advisors should distribute this to their students who qualify. The questionnaire is required annually.

Students should email the form to Health Services - healthservices@bowdoin.edu Bowdoin Health Services will reach out to students to set up a short appointment to review the AUQ information.

Faculty and staff should email forms to Occupational Health Associates - support@ohamaine.com

Faculty and staff will need to fill out one additional authorization form, Authorization to Release Results, required by Occupational Health Associates. Students do not need to fill out this form.

If you have questions or comments regarding this questionnaire, please contact Charly Wojtysiak at cwojtysi@bowdoin.edu.

If the confidential medical review indicates that an individual may require special equipment, immunizations, further medical examination, etc., Human Resources or Health Services (for students) will contact the individual to make the necessary arrangements. This information may be used in cases of public health emergencies or emergency medical treatment as allowed by law. If advisors, supervisors, or the Animal Care and Facilities Manager need to be notified of any special requirements, they will only be told of the requirements (for example, the need to use a respirator) and will not be given the medical reason for the request.

Questionnaire

Instructions: Please fill out this form if you will have direct and repeated contact (more than one day) with vertebrate animals or vertebrate animal tissues during the pending semester or session, and if you have not filled out an Animal Use Questionnaire in the last year.

Name: ______________________________ Bowdoin ID: ____________

Supervisor: ______________________________ Date: ____________

Department: ______________________________ Semester: ____________

Email: ______________________________ Phone: ____________

The applicant is (CIRCLE ONE): *Faculty/Staff* *Student*

Please note that the information you provide as part of this confidential questionnaire will be used only for the Occupational Health and Safety Program. Information may also be used in cases of public health emergencies or if emergency medical treatment is necessary.

General Information (Faculty or Staff/Student)

1. Job/Course Title ____

2. Years at Bowdoin /Class Year ____

3. Brief Description of Animal Activities (if known) ____

4. To your knowledge, are you pregnant, immunocompromised, or have any preexisting medical condition that could be of potential health concern regarding the direct and repeated handling of vertebrate animals or animal tissues?

   □ No □ Yes If yes, please describe: ________________________

5. Have you previously worked with any vertebrate animals? □ No □ Yes
   If yes, what animal and with what frequency/duration?

Animal	No	Yes	Frequency/Duration of Contact
Rats	□	□	________________________
Mice	□	□	________________________
Birds	□	□	________________________
Frogs	□	□	________________________
Fish	□	□	________________________
Other ________	□	□	________________________

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6. Are you allergic to any animals? ☐ No ☐ Yes
   If yes, what animal(s)? ____

7. Do you have animals at home? ☐ No ☐ Yes
   If yes, what animal and for how long?

	1-2 years	2-3 years	3-4 years	over 4 years
Dogs	☐	☐	☐	☐
Cat	☐	☐	☐	☐
Other (Type) ___________	☐	☐	☐	☐

8. Have you or do you currently use any of the following items when working with animals?

Mask/Respirator	☐ No	☐ Yes
Eye Protection	☐ No	☐ Yes
Gloves	☐ No	☐ Yes
Protective Clothing	☐ No	☐ Yes

9. Please check all symptoms that apply to you in the list below, and give the year of onset:

Symptom	No	Yes	Date of Onset	Symptoms present at:		
				Home	Work	All
Cough (persistent)	☐	☐	____________	☐	☐	☐
Dizziness	☐	☐	____________	☐	☐	☐
Fainting	☐	☐	____________	☐	☐	☐
Blurred vision	☐	☐	____________	☐	☐	☐
Shortness of breath	☐	☐	____________	☐	☐	☐
Wheezing	☐	☐	____________	☐	☐	☐
Chest tightness	☐	☐	____________	☐	☐	☐
Asthma	☐	☐	____________	☐	☐	☐
Nasal congestion (persistent)	☐	☐	____________	☐	☐	☐
Runny nose (persistent)	☐	☐	____________	☐	☐	☐
Sneezing (persistent)	☐	☐	____________	☐	☐	☐
Itchy eyes	☐	☐	____________	☐	☐	☐
Hay fever	☐	☐	____________	☐	☐	☐
Frequent colds	☐	☐	____________	☐	☐	☐
Hives	☐	☐	____________	☐	☐	☐
Skin rash	☐	☐	____________	☐	☐	☐
Swelling of eyes or lips	☐	☐	____________	☐	☐	☐
Eczema	☐	☐	____________	☐	☐	☐

Comments: ____

10. Do you have any allergies? ☐ No ☐ Yes If yes, to what?

☐ Ragweed	☐ Grass	☐ Trees	☐ Mold	☐ Dust
☐ Latex	☐ Cat	☐ Dog	☐ Mouse	☐ Other____________

11. Have you ever received allergy (desensitization/immunotherapy) shots?
□ No □ Yes

12. If you have asthma:
A. When did your asthma start ______________(year)
B. Are you currently taking any medicine (prescription or over the counter) to control your asthma? □ No □ Yes If yes, please list: ________________

13. In the last 4 months have you had any surgeries or taken any medications that:
□ Lower your body's immune system
□ Increases/decreases your heart rate
□ Alters your normal breathing pattern

If yes to any of the above, has your Doctor cleared to return to work and/or to work with animals? □ No □ Yes

14. Please provide information for the most recent immunization date for the following:
- Tetanus: ___________________
- Hepatitis B: _________________
- Other:_____________________

Please sign, date, and forward to Occupational Health Associates: support@ohamaine.com (staff) or Health Services: healthservices@bowdoin.edu (student).

I hereby certify that the information contained in this document is true and complete. I understand that false statements or misrepresentations on this document may result in the inability to work with animals.

_______________________________________ _______________
(Signature) (Date)

____
(Print Name)

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Completion of this form is required by the terms of Bowdoin's Assurance Number **A4502-01**, on file with the Office of Laboratory Animal Welfare (OLAW), a division of the United States Public Health Service (PHS), a division of the Department of Health and Human Services. Compliance with the terms of the Assurance is required under the PHS Policy on Humane Care and Use of Laboratory Animals, revised 2011, and the following federal statutes:

> The Act of August 24, 1966 (PL 89-544), commonly known as the Laboratory Animal Welfare Act, as amended by the Act of December 24, 1970 (PL 91-579), the Animal Welfare Act of 1970; the Act of April 22, 1976 (PL 94-279), the Animal Welfare Act Amendments of 1976; and the Food Security Act of December 23, 1985 (PL 99-198), the Animal Welfare Act Amendments of 1985, and the Public Health Service Act (PHS Act) mandated by the Health Research Extension Act of 1985 (PL 99-158).

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INITIAL/ANNUAL ANIMAL USE MEDICAL REVIEW FORM

Applicant Name_____________________________________ Bowdoin ID# _______________

The applicant is (CIRCLE ONE): *Faculty/Staff* *Student*

My review of the provided medical questionnaire DATED ___________________ regarding the patient's proposed direct and repeated contact with vertebrate animals or animal tissues indicated the following (CHECK ONLY ONE):

□ Applicant is **approved** without additional restrictions or recommendations beyond normal laboratory precautions.

□ Applicant is **conditionally approved**, with the following restrictions/recommendations (COMPLETE ALL THAT APPLY):

- □ Use of specialized protective equipment SPECIFY: ____________________________
- □ Use of special controls or procedures SPECIFY: ____________________________
- □ Prior immunizations/vaccinations SPECIFY: ____________________________
- □ Approval of personal physician or Occupational Health Specialist SPECIFY: ____________________________
- □ Other restrictions/recommendation s SPECIFY: ____________________________

□ Applicant is **denied** based on the information provided, and should be contacted by the College for further actions.

Medical Provider ____________________________ Affiliation ______________________

Signature ____________________________ Date ______________________

Reviewer Notes:

This completed form should be sent back to Charly Wojtysiak, Director of EHS cwojtysi@bowdoin.edu

AUTHORIZATION TO RELEASE
EXAMINATION RESULTS

This authorization is for use or disclosure of protected health information (PHI) pertaining to:

Name:____
Address: ____
____

DOB : _________________________Phone:_____________________________________

I hereby authorize the following health care provider:

Occupational Health Associates of Maine, P.A.
270 State Rd West Bath, Maine 04530

To *release* my protected health information to:

Name of Employer: Bowdoin College-Occupational Health And Safety Program
Address: _________3500 College Station, Brunswick, ME 04011

Purpose of disclosure:
Required examination. Animal Use Questionnaire Results

Protected health information to be released:
Examination results pertaining to the ability to do my job.

Expiration:
This authorization becomes effective immediately and shall expire on: One (1) year from signature date.

This consent to release information does not extend to Mental Health, HIV or Substance Abuse information.

- I understand that I am not required to sign this form; however, *Occupational Health Associates* may condition eligibility for the examination service on whether I sign this form. I understand that my refusal to sign may result in adverse consequences.
- I understand that PHI released pursuant to this authorization may include records generated by another healthcare provider or facility.
- I understand that I have the right to access or copy the PHI described in this form by making a written request to the Privacy Officer.
- I understand that I have the right to withdraw my authorization at any time except to the extent that action has been taken in reliance on this authorization. I understand that I may revoke this authorization by submitting a written revocation to the Privacy Officer at *Occupational Health Associates*.
- I understand that PHI used or disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer be protected by confidentiality laws.
- I understand that I have a right to receive a copy of this authorization.

Signed:____Date:__________________

Print name: ____

If signed by other than patient, indicate legal relationship_________________________________