

# Risk Assessment for Animal Contact

## Animal Contact Medical Monitoring Program

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.

Select

Initial  
 Renewal  
 Change in Animal  
 Program Removal

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: \_\_\_\_\_

Choose **ONLY ONE** of the following:

**No Animal Contact**

- Listed on a current IACUC project, but no animal contact or facility access.
- Not listed on a project and will not enter any animal facility.

*If you choose "No Animal Contact" - Stop here, ensure signatures are signed at the bottom and submit form.*

**Indirect Contact Only**

- Enter facilities or observe animals without touching them.  
(e.g., inspector, maintenance, UPD, etc.)
- Handle animal waste, tissues, or fluids -- but no live animals.

**Direct Contact Only**

- Work directly with live animals.  
(e.g., restrain, collect specimens, administer substances)

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>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> (Guinea pigs, hamsters, gerbils, mice, rats, etc.) 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 (N95)	
<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>		

**Describe your rabies risk level according to the [CDC recommendations](#):**

**No rabies risk**

**Cat 2:** Frequent contact w/bats and/or frequent necropsies w/potential rabies infected neural tissue

**Cat 3:** >3 years of expected exposure to potentially rabid animals

**Cat 4:** </= 3 years of expected exposure to potentially rabid animals

Supervisor  
**ACTION REQUIRED**

Supervisor  
Sign Here: \_\_\_\_\_ Date: \_\_\_\_\_

Supervisor  
**SAVE & EMAIL TO:**

Participant: \_\_\_\_\_  
E-mail: \_\_\_\_\_

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

Participant  
ACTION REQUIRED

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

Immunization/Screening History - Call the VETMED Clinic at 352-294-5700 to obtain any of these services.	Date (MM/YY)
Tetanus Immunization. Required of all, every 10 yrs. (MM/YY)	
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. Required annually for contact with nonhuman primates, elephants & rhinos. <i>Include official records with form.</i>	
Q Fever Titer. Required annually for contact with sheep and goats as specified by the <a href="#">Q Fever Policy</a> .	

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:								
Initial: Skip Q.14 only				Renewals/Change in Animal: Answer Q. 14, Skip Q.15 and Q.16				
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	Other
If yes, please indicate:	Mice or Rats	Rabbits	Cats	Dogs	Guinea Pigs or Hamsters	Other Explained		
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	

Participant  
ACTION REQUI

→ I, \_\_\_\_\_ affirm have answered the questions on this form  
Participant's Name  
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: \_\_\_\_\_