University of Idaho
Environmental Health and Safety

Employee Name: ______________________________________

Once completed, please place this form in a sealed envelope marked "Confidential", with your name, email address, and "Attention: AWMSP" on it. You may hand deliver the forms to EHS or mail the forms to:

Environmental Health and Safety
875 Perimeter Drive
MS 2030
Moscow, ID 83844

Date of Birth: ____________________ Gender: M / F

E-mail:___________________________ Work Phone:______________________

Home/Cell Phone:__________________

Address: ______________________________City/State/ZIP:_____________________

1) List the animal species you will be working with:

2) List the duties you will be performing:

3) List any other hazardous activities or duties you may be doing as part of your animal work:

Vaccination History:

VACCINATION	DATE OF RECEIPT
Tetanus	
Hepatitis B	
Rabies Series	

This form is submitted by the University to and kept on file with the medical provider.
No copies of this form will be maintained by the University.

Instruction for Medical Provider: Do not return this form to the University of Idaho.
Only return the "Health Care Provider's Animal Worker Recommendation" to the University.

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Employee Name: ______________________________________

Directions: *Please place a check to the left of each item indicating whether you have ever had this condition. For each item checked "yes" indicate if this condition exists now, in the past and what treatment you receive(d) in the space is provided. If more space is needed, please use the back of the page.*

Are you allergic or sensitive to any of the following?

YES	NO	CONDITION	NOW	PAST	TREATMENT
		Pollens			
		Dust			
		Animal dander, feathers, or fur			
		Wood shavings or sawdust			
		Straw or hay			
		Medications or vaccines			
		Latex			
		Metal			
		Sunlight or cold			
		Cleaning soaps or detergents			
		Other factors not listed above			

YES	NO	CONDITION	NOW	PAST	TREATMENT
		Allergic Reaction			
		Vision Problems			
		Hearing Problems			
		Skin Disease or Rash			
		Sinusitis			
		Hay Fever			
		Chronic Cough			
		Asthma			
		Tuberculosis			
		Diabetes			
		Neurological Disease			
		Heart Disease			
		Gastrointestinal Disease			
		Liver Disease			
		Kidney Disease			
		Reproductive Problems			
		Arthritis			
		Back Pain			
		Bone or Joint Problems			

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		Anemia or Blood Problems			
		Tumor or Cancer			
		Other Medical Conditions (please specify)			

Do you have difficulty in any of the following areas?

YES	NO	CONDITION	NOW	PAST	TREATMENT
		Sensitivity to chemical, dust, sunlight or other factor			
		Performing certain motions			
		Other medical difficulties (if yes, please explain)			

Are you currently taking or have you taken any of the following within the past month?

YES	NO	MEDICATION	DOSAGE	FREQUENCY
		Antihistamines		
		Immunosuppressive drugs (such as cortisone, etc)		
		Allergy desensitization injections		
		Other medication taken routinely List:___________________		

Are you exposed to the following?

YES	NO	CONDITION	NOW	PAST	COMMENTS
		Have you ever been a smoker?			
		If yes, average amount per day?			
		Do you work around loud noises?			
		Do you wear hearing protection?			
		Do you work around respiratory hazards?			
		Do you wear respiratory protection?			
		Do you have animals at home?			
		If yes, please list number and species.			

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Employee Name: ___________________________________

I certify that I have reviewed the information supplied by me, and that it is accurate and complete to the best of my knowledge.

________________________________ ______/______/______

Employee's Signature *Date*

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