

**SPECIAL INSTRUCTIONS: Read SECTION VII in full before proceeding.**

**SECTION I - EXPOSED EMPLOYEE INFORMATION**

**1. EMPLOYEE INFORMATION**

A. NAME (last, first, MI)			B. EQS ID NUMBER	C. DATE OF BIRTH	D. SEX	E. PROGRAM
F. WORK ADDRESS				G. TITLE, SERIES, GRADE		
STREET 1				H. PHONE NUMBER (OFFICE) (required)		
STREET 2				I. PHONE NUMBER (HOME) (optional)		J. PHONE NUMBER (CELL) (optional)
CITY	STATE	ZIP CODE	K. FAX NUMBER (required)		L. EMAIL ADDRESS (required)	

**2. SUPERVISOR INFORMATION**

A. NAME (last, first, MI)			C. TELEPHONE NUMBER (OFFICE) (required)			
B. WORK ADDRESS			D. TELEPHONE NUMBER (HOME) (optional)			
STREET 1			E. TELEPHONE NUMBER (CELL WORK) (required)			
STREET 2			F. TELEPHONE NUMBER (CELL PERSONAL) (optional)			
CITY	STATE	ZIP CODE	G. FAX NUMBER (required)		H. EMAIL ADDRESS (required)	

**3. CONFIDENTIAL CORRESPONDENCE (Enter address where all confidential correspondence is to be sent.)**

<input type="checkbox"/> SAME AS ABOVE			STREET 1			
<input type="checkbox"/> ALTERNATE ADDRESS (enter new address in the fields to the right)			CITY		STATE	ZIP CODE

**SECTION II - RESPIRATOR USE**

4A. WILL YOU BE REQUIRED TO USE A RESPIRATOR?		B. TYPE OF RESPIRATOR(S) (select all that apply)			
<input type="checkbox"/> NO. GO TO SECTION III.		<input type="checkbox"/> SELF-CONTAINED BREATHING APPARATUS		<input type="checkbox"/> POWERED AIR PURIFYING RESPIRATOR	
<input type="checkbox"/> YES. COMPLETE ITEM 4B.		<input type="checkbox"/> ELASTOMERIC HALF OR FULL FACE RESPIRATOR		<input type="checkbox"/> FILTERING PAPER RESPIRATOR	

**SECTION III - RABIES VIRUS EXPOSURE**

5A. DURING THE COURSE OF YOUR DUTIES, IS THERE A LIKELY OR ACTUAL EXPOSURE TO THE RABIES VIRUS?				
<input type="checkbox"/> NO. GO TO SECTION IV.				
<input type="checkbox"/> YES. HOW?		B. RECEIVED RABIES VACCINATION?	C. DATE OF LAST TITER	D. DATE OF LAST VACCINE
		<input type="checkbox"/> NO <input type="checkbox"/> YES		

**SECTION IV - TRAVEL MEDICINE CONSULTATION**

6. DO YOU HAVE IMMUNIZATION RECORDS?  NO  YES (See note in Item 8, below)

7. AS PART OF YOUR OFFICIAL DUTIES, WILL YOU BE TRAVELLING TO AN INTERNATIONAL DESTINATION?

NO. GO TO SECTION V.

YES. BE MINDFUL THAT A TRAVEL MEDICINE CONSULTATION IS HIGHLY RECOMMENDED FOR YOUR SAFETY AND HEALTH. THIS SHOULD BE SCHEDULED AS SOON AS POSSIBLE, PREFERABLY SIX (6) WEEKS PRIOR TO TRAVEL. COMPLETING THE FORMS BELOW AND SUBMITTING THEM TO FEDERAL OCCUPATIONAL HEALTH (FOH) WILL START THIS PROCESS.

8. TRAVEL MEDICINE CONSULTATION FORMS:  
BRING ANY AND ALL IMMUNIZATION RECORDS TO THE CONSULTATION

EMPLOYEE NAME

DATE

**SECTION V - OCCUPATIONAL EXPOSURES AND CHARACTERIZATIONS**

9. (1) ACTUAL AND POTENTIAL OCCUPATIONAL EXPOSURES	(2) WORK USE	(3) ROUTE OF ENTRY	(4) FREQUENCY	(5) DURATION
A.				
B.				
C.				
D.				
E.				
F.				
G.				
H.				
I.				
J.				
K.				
L.				
M.				
N.				
O.				
P.				
Q.				
R.				
S.				
T.				
U.				
V.				
W.				
X.				
Y.				
Z.				

EMPLOYEE NAME	DATE
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**SECTION VI - GENERAL COMMENTS / REQUESTS**

10.

**SECTION VII - PII AND PREPARING THE FORM FOR ELECTRONIC SUBMISSION**

This form contains personally identifiable information (PII). If the information is provided, the completed form must be password encrypted when emailed. To encrypt the form, you must complete it using Acrobat Professional DC. Acrobat Reader DC will not work. For help with software issues, contact ATAC at help@aphis.usda.gov.

**Option 1.** If you have Acrobat Professional DC, follow steps a - e below. Otherwise, see Options 2 and 3.

- a. Save the downloaded form to your desktop (or other secure location) and use it for your submission.
- b. To turn off highlighted fields, type CTRL+K and under Forms > Highlight Color, uncheck "Show border hover color for fields".
- c. After completing the form, but before digitally signing it, save it with a unique name, and then encrypt it by selecting Tools > Protect > Encrypt > Encrypt with password. Select a password you will share with your supervisor and the FOH office. Save the password, and your newly encrypted form, in a secure place.
- d. Digitally sign and save the form, then send it to your supervisor for review and electronic signature. Provide him or her the password separately. If you cannot provide it in person or verbally, send it by another email.
- e. Email the completed form, with electronic signatures and encryption, to APHIS FOH at APHIS@FOH.HHS.gov. Send the password to open the file to the same address using a separate email.

**Option 2.** If you do not have Acrobat Professional DC and you are not a new employee, do not provide PII information on the form. Provide only the last 4 digits of your social security number in Item 1B, skip telephone Items 1I, 1J, 2D, and 2F, and skip Item 3. Email the completed form to APHIS FOH at APHIS@FOH.HHS.gov.

**Option 3.** If you do not have Acrobat Professional DC and you are a new employee, or a current employee and want to provide PII, complete the entire form in full and fax it to APHIS FOH at (415) 436-7913. DO NOT EMAIL IT.

**SECTION VIII - SIGNATURES**

Our signatures below affirm the employee has read the Privacy Act Statement on the following page and that this form is completed fully and accurately.

11. EMPLOYEE SIGNATURE	DATE
12. SUPERVISOR SIGNATURE	DATE

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## SECTION VIII - PRIVACY ACT NOTIFICATION

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The collection and use of this information is authorized by 5 U.S.C. 7901 (Health Service Programs) and 29 U.S.C. 657 (Occupational Safety and Health; Recordkeeping). The information will become part of your official Employee Medical File, and will be used to assist Federal Occupational Health in carrying out its occupational health services responsibilities under one or more interagency agreements with your employing agency, and for other official purposes and routine uses as described in Privacy Act systems notice OPM/GOVT-10 (Employee Medical File System Records). Providing the requested information is voluntary. Not providing the information may affect the availability and quality of health services rendered to you, and may also affect the completeness of information used by your agency in making determinations of medically-related employment decisions.

The Medical Review Officer (Federal Occupational Health/Department of Health and Human Services) is authorized by the Occupational Safety and Health Act of 1970 and by 5 U.S.C. 301 to obtain personal medical information from APHIS employees.

The purpose of this collection is to protect Agency employees from actual or potential occupational exposures in their work environment and to reduce these actual/potential exposures. The medical information collected is necessary in making accurate medical determinations and conclusions about the impact on employees of actual or potential exposure to possible biological, chemical, or other physical threats. Medical records maintained will document health status, changes in physical conditions through the years, and provide an account of any care rendered, advice given, and consultations recommended. The physical examination and laboratory test provided by this program are not intended to substitute for the care provided by a personal physician.

The information may be disclosed to authorized medical professionals to determine unusual susceptibility to illness or injury from exposures in the work environment, to determine medical suitability of assignments, to permit identification of potentially harmful effects of toxicants used, and to provide medical treatment and advice. It may be disclosed to appropriate public health agencies to conduct epidemiological studies and research.