Clear Form

UNITED STATES DEPARTMENT OF AGRICULTURE
ANIMAL AND PLANT HEALTH INSPECTION SERVICE
EMERGENCY MANAGEMENT SAFETY AND SECURITY

OCCUPATIONAL MEDICAL MONITORING PROGRAM

OCCUPATIONAL EXPOSURES

SPECIAL INSTRUCTIONS: Read SECTION VIII 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)* / I. PHONE NUMBER (HOME) (optional)
CITY / STATE / ZIP CODE	J. FAX NUMBER *(required)* / K. 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)*
CITY / STATE / ZIP CODE	F. FAX NUMBER *(required)* / G. EMAIL ADDRESS *(required)*

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

☐ SAME AS ABOVE

☐ ALTERNATE ADDRESS *(enter new address in the fields to the right)*

STREET 1

CITY / STATE / ZIP CODE

SECTION II - RESPIRATOR USE

4A. WILL YOU BE REQUIRED TO USE A RESPIRATOR?

☐ NO. GO TO SECTION III.

☐ YES. COMPLETE ITEM 4B.

B. TYPE OF RESPIRATOR(S) *(select all that apply)*

☐ SELF-CONTAINED BREATHING APPARATUS

☐ POWERED AIR PURIFYING RESPIRATOR

☐ ELASTOMERIC HALF OR FULL FACE RESPIRATOR

☐ 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?

☐ NO. GO TO SECTION IV.

☐ YES. HOW?

B. RECEIVED RABIES VACCINATION? ☐ NO ☐ YES	C. DATE OF LAST TITER	D. DATE OF LAST VACCINE

SECTION IV - TUBERCULOSIS

6. DO YOU NEED A TUBERCULOSIS TEST? ☐ NO ☐ YES

SECTION V - TRAVEL MEDICINE CONSULTATION

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

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

☐ NO. GO TO SECTION VI.

☐ 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.

9. TRAVEL MEDICINE CONSULTATION FORMS:

BRING ANY AND ALL IMMUNIZATION RECORDS TO THE CONSULTATION

EMPLOYEE NAME	DATE

SECTION VI - OCCUPATIONAL EXPOSURES AND CHARACTERIZATIONS

10. (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

SECTION VII - GENERAL COMMENTS / REQUESTS

11.

SECTION VIII - 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 Adobe Acrobat Professional DC. Adobe Acrobat Reader DC will not work. For help with software issues, contact ATAC at help@usda.gov.

Option 1. If you have Adobe Acrobat Professional DC, follow steps a - d below. Otherwise, see Option 2.

a) Save the downloaded form to your desktop (or other secure location) and use it for your submission.

b) After completing the form, but before digitally signing it, save it with a unique name, and then encrypt it by selecting Tools > Protect > Protect 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.

c) 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.

d) 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 Adobe Acrobat Professional DC, complete the entire form in full and send it to gerald.houvener@aphis.gov as an encrypted email.

SECTION IX - 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.

12. EMPLOYEE SIGNATURE	DATE
13. SUPERVISOR SIGNATURE	DATE

SECTION X - PRIVACY ACT NOTIFICATION

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.