ADDENDUM # One (1) TO RFP # 0056039

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY (Virginia Tech)
Procurement Department (MC 0333)
North End Center, Suite 2100
300 Turner Street NW
Blacksburg, Virginia 24061

DATE	New DUE DATE AND HOUR
Monday, July 9, 2018	Thursday, July 26, 2018

ADDRESS ALL INQUIRIES AND CORRESPONDENCE TO: Kimberly Dulaney, Assistant Director & Contracts Manager
E-MAIL ADDRESS: kdulane@vt.edu TELEPHONE NUMBER (540) 231-8543
FAX NUMBER (540) 231-9628 AFTER HOUR MESSAGES (540) 231-6221

Occupational Health Medical Services Partner

1. The following questions have arisen for the aforementioned RFP;

   Question 1. The table of services references a History Form and Animal Handler/Infectious Disease Surveys. Please provide a copy of all forms to be processed.

   Virginia Tech Answer: These are attached for your reference (Attachment D). There are other forms used when required by OSHA for persons exposed to asbestos or lead materials. Please note that the first four pages of the Animal Handlers form are used by EHS to identify medical services needed based on their reported hazard exposures.

   Question 2. Is the expectation that the contractor's clinic be located within 5 miles of the Virginia Tech's main campus located in Blacksburg, Virginia? Does Virginia Tech desire that Occupational Health Medical Services be offered in close proximity to any of Virginia Tech's other off-campus locations or are services restricted to the Blacksburg campus?

   Virginia Tech Answer: The clinic needs to be close enough to the main campus that our on-campus client's travel back-and-forth will not overly burden their time, hence the 5 miles. If services can be offered at other off-campus locations that would be helpful but it is not required as a condition of this contract. We may, however, elect to use those off site service locations if convenient to our clients.

   Question 3. Is the expectation that the contractor's clinic will schedule the block of time in four continuous hours or at intervals throughout the Monday thru Friday, 8am-5pm work week?

   Virginia Tech Answer: It's actually preferred if we can schedule a block of time on a set day per week. If we do not fill all 'slots', we would release them back to you as quickly as possible. We would appreciate flexibility, however, as urgent issues do sometimes arise.

   Question 4. Please provide guidance as to the services to be provided at the current site and the services to be provided off-site. What services will the OHAP staff provide and what services will the contractor provide?

   Virginia Tech Answer: For main campus clients, OHAP staff provide audiograms, pulmonary function tests, respirator fit testing, and blood draws for titers and similar. We desire to add vaccinations. If the physician is serving out of our clinic, we would add blood pressure, temperature screening, and whatever else the physician needs or requires to conduct a physical where one is required. Persons receiving medical services based on work exposures to asbestos, lead and silica would only occur on the main campus, not

offsite locations. Services received by offsite personnel would typically be limited to vaccinations, titers, pulmonary function testing (for respirator fit testing) and audiograms.

Question 5. Please provide more information as to the expectation concerning Department of Transportation drug and alcohol testing programs for CDL holders and FAA pilots? Specifically the randomization process.

Virginia Tech Answer: Virginia Tech employs about 150 employees that are subject to DOT drug and alcohol testing. These employees are CDL drivers, Police Officers or Pilots. There is a random sample, drawn each quarter, of approximately 10-20 individuals. The randomization is handled by our conviction check vendor TruScreen. Once the random list is sent to us along with chain of custody forms, Virginia Tech notifies the employee and their department. The employee is then required to report for testing. Once testing is completed at the Occupation Health Medical Services Partner facility, the results and billing are sent to TruScreen which then takes over their part in reporting back to Virginia Tech.

Question 6. Define Tier 1 select agents.

Virginia Tech Answer: Please see https://www.selectagents.gov/selectagentsandtoxinslist.html

Question 7. Please provide more information concerning how medical charts will be secured during transport?

Virginia Tech Answer: They are hand delivered from our office to the physician. When carried away from the main campus, they are kept in a locked box.

Question 8. Please provide more information concerning the expectations for consultative services in response to unusual service needs, employee exposure issues, or as needed to support national and international travel?

Virginia Tech Answer: The circumstances vary widely. Examples include:

- Employees who are pregnant or who are thinking about becoming pregnant who are concerned about their work exposure to either chemicals or biological agents and their effect on an embryo.
- Employees who report being exposed to chemicals, biological agents, asbestos, lead or other air contaminants and who request a consultation with our physician on potential health effects. The physician may order tests as needed to address or allay their concerns. In some cases, these evaluations may fall under Workers' Compensation and will need to be billed as such. (We would work with Human Resources so the chosen physician is added as an approved panel physician.)
- For international travel, a travel consult could include providing guidance on things to avoid in the destination location (hygiene issues), and issuing prescriptions for medications including those not usually addressed by the CDC but which may be needed based on work location (for example, antibiotics, antidiarrheals, antimalarial, etc. if working in remote areas where medical assistance will not be readily available)
- Coordination of services with the Department of Health on providing services overseas when outbreaks occur which affect our personnel. (This happened recently with a plague outbreak in Madagascar.) This is an extremely rare occurrence.
- For international travel by persons not covered by Workers Compensation, the physician may be asked to provide direct services if the person becomes ill upon return and it is related to their work exposures.
- Consultations and providing prophylaxis for needle stick injuries based on the physician's evaluation of risk.

Question 9. Please provide more information concerning the biosafety research protocols and any expectations related to the scope of input required?

Virginia Tech Answer: The physician may be asked to provide input on medical services needed based on the organisms being used in the research. This happens infrequently (several times per year). There is no expectation that every research protocol would be reviewed.

Question 10. Is the expectation that the contractor's clinic provide a Special Immunization Program (SIP) to include an Investigational New Drug (IND) Program?

Virginia Tech Answer: This is possible, yes, as we have researchers who may in the future use pathogens covered by SIP. We would work in close coordination with the Department of Health and the selected physician if this need arises.

Question 11. Could Virginia Tech provide more information concerning the Institutional Biosafety Committee, including how often the committee meets and where and time commitment?

Virginia Tech Answer: There is no expectation that every research protocol would be reviewed or that the physician attend all meetings. Rather, the IBC may request direct input on specific protocols. This happens infrequently (at best, a few times per year). More frequent would be OHAP staff seeking guidance on what services should be provided based on the exposure.

Question 12. What is the expectation of the contractor of integration with preexisting OHAP staff? Will the contractor be providing onsite supervision for Virginia Tech OHAP staff for standing orders?

Virginia Tech Answer: It is our desire that OHAP staff be authorized to work under standing orders, but there is no expectation that staff will be directly supervised by the physician.

Question 13. Could Virginia Tech provide a complete listing of lab tests and immunizations and titers? Will the lab tests and immunizations be billed as all-inclusive or pass through as needed?

Virginia Tech Answer: Note that any testing performed will vary based on the person's work-related exposures, i.e. there is no 'standard list' of services provided to every participant. For persons who are provided medical services for an exposure covered by an OSHA standard, that standard will dictate the minimum testing that must be performed supplemented by any other tests dictated by the physician. Ex: asbestos, lead, silica, respirator use, bloodborne pathogens, formaldehyde. Services could expand to cover cotton dust, chromium, cadmium, beryllium, etc. if persons with such exposures are identified. For exposures covered by OSHA, OHAP personnel have a list of required services from which they normally operate based on the standards. Services provided might include, for example, blood lead and zinc protoporphyrin, complete blood chemistry, fecal occult blood screening, urinalysis, urine cytology, complete blood count, chest X-ray, pulmonary function test, blood mercury, etc. Typically all blood draws are performed by OHAP personnel. In all cases, all lab results are to be reviewed by the physician and are to be addressed in the Physicians Written Opinion.

Vaccinations: Tetanus, Rabies, Hepatitis A, Hepatitis B, any required based on the organism being worked with where vaccines are available, any required based on work location and per CDC for travel vaccinations (some vaccines are only available through the Health Department)

Titers: Rabies, tuberculosis, others as warranted based on hazard exposure

OHAP desires to continue collecting, sending all samples directly to the testing laboratory and to be billed directly by that company, hence the request for Standing Orders. Where testing is performed at the physician's office, it could be billed as pass-through or cost plus to cover oversight/handling.

2. Attachment D, Sample Forms, is hereby attached to this RFP

3. No further inquiries will be accepted for this solicitation
4. All other terms, conditions and descriptions remain the same.
5. The due date and hour is changed from **Friday, July 13, 2018, 3pm** TO **Thursday, July 26, 2018 3pm**.

I acknowledge that I have read and understand this addendum in its entirety.

_____ _____

Signature Date

Revised 01/01/2018

Medical Questionnaire

All information is part of your confidential medical record.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

PLEASE ANSWER ALL QUESTIONS

Name: _____ _____ _____
First Name Middle Initial Last Name

Gender: ☐ Male ☐ Female DOB: ____/____/_____ Age: _____

Height: _____ Ft. _____ In. Weight: _____ lb. Email/PID: _____

Phone Number: (_____) _____ VT/Hokie ID: _____

Department: _____ Job Title: _____

Supervisor: _____ Supervisor Phone #: (____) _____

Please describe your primary job duties:

What types of personal protective equipment have you been told you will use during your job?
Please check all that apply:
☐ Respirator ☐ Hearing Protection ☐ Chemical resistant gloves ☐ Eye/Face Protection

Yes	No	Please check Yes or No for each of the questions below.
☐	☐	1. Have you ever spent time in the hospital as a patient? If "YES", what kind of problem were you having, and when did the problem occur?
☐	☐	2. Have you been under the care of a physician during the past year? If "YES", for what condition(s)?
Yes	**No**	3. Have you ever been told you had any of the following:
☐	☐	a. Asthma, hayfever, or sinusitis?
☐	☐	b. Emphysema, bronchitis, or other respiratory problem?
☐	☐	c. Hepatitis?
☐	☐	d. Cirrhosis?
☐	☐	e. Cancer?
☐	☐	f. Arthritis or Joint Pain?
☐	☐	g. High Blood Pressure?

Yes	No	Please check Yes or No for each of the questions below.
☐	☐	4. Have you ever had a heart attack or heart trouble?
☐	☐	5. Has there been a change in your general health in the last year? If "YES", please describe:
☐	☐	6. Has there been a change in your breathing in the last year? If "YES", please describe:
☐	☐	7. Have you ever smoked? If "YES", then how many cigarettes per day and for how long? #Per Day: _____ #Years: _____ If you quit, when did you quit: _____
☐	☐	8. Do you drink alcohol? If "YES", in what quantity per week?
☐	☐	9. Do you wear glasses or contact lenses?
☐	☐	10. Do you consider your job to have a high level of stress? If "YES", explain:
Yes	**No**	11. Do you have any of the following symptoms?
☐	☐	a. Shortness of breath?
☐	☐	b. Persistent Cough? (more than 3 months out of the year)
☐	☐	c. Feeling of smothering, not able to take a deep breath?
☐	☐	d. Wheezing?
☐	☐	e. Burning, tearing, redness of eyes at work?
☐	☐	f. Sore, burning, or itching throat or nose at work?
☐	☐	g. Stuffiness or dryness of nose?
☐	☐	h. Swelling of eyelids or face?
☐	☐	i. Jaundice?
☐	☐	j. Frequent headaches?
☐	☐	k. Frequent episodes of nervousness or irritability at work?
☐	☐	l. Trouble concentrating or remembering?
☐	☐	m. Dizziness, light-headedness, or drowsiness at work?
☐	☐	n. Blurred vision at work?
☐	☐	o. Numbness or tingling hands, feet, or other body parts?
☐	☐	p. Chronic fatigue or weakness?
☐	☐	q. Heartburn or indigestion?
☐	☐	r. Itching, dryness, or peeling of the skin on your hands?
☐	☐	s. Swelling of the hands or feet?
☐	☐	t. Difficulty in walking?
☐	☐	u. Easy bruising?
☐	☐	v. Bone or joint problems?
☐	☐	w. Back trouble?
☐	☐	x. Problems with urination?
☐	☐	y. Blood in urine?
☐	☐	z. Change in bowel habits?
☐	☐	aa. Habitual constipation?
☐	☐	bb. Blood in stools?
☐	☐	cc. Black or tarry stools?
☐	☐	dd. Any symptoms not mentioned here? If "YES", please list your symptoms:

Yes	No	Please check Yes or No for each of the questions below.
☐	☐	12. Do you feel that any of the above symptoms may be related to your work? If "YES", please describe:
☐	☐	13. Do you get any regular physical exercise? If "YES", what type and how often?
☐	☐	14. Do you do any activities outside of work that may bring you into contact with chemicals, such as furniture stripping, sand blasting, insulation installation, etc.? If "YES", list the activities and the exposures:
☐	☐	15. Do you do any activities outside of work where you may be exposed to very loud noise, such as shooting firearms, work with power tools, etc.? If "YES", please list the activities:
☐	☐	16. Do you have any medical complaints today? If "YES", please describe:
☐	☐	Do you take any medications (prescribed or over-the-counter)? If yes, please list:

Medication Name/Dose:	Used for:	How long have you been taking this medication?

If you have any additional comments, please enter them here:

Employee Signature: _____ Date: _____

PHYSICIAN'S WRITTEN OPINION

To Physicians: Please check "yes" "no" or "NA" beside the following statements and include any detailed comments or notes in the space provided below.

Name of Employee: _____

Yes	No	NA	
☐	☐	☐	According to my review of this employee's medical chart, it is my opinion that this employee has detectable medical conditions that would increase the risk of material health impairment through the performance of the job functions. These conditions are described below.
☐	☐	☐	I recommend that limitations be placed on this employee's use of personal protective equipment, such as respiratory protection. Limitations are described below.
☐	☐	☐	I have reviewed the Respirator Fitness Questionnaire and have determined that this employee is medically able to wear the respiratory protection devices assigned, in the workplace conditions described.
☐	☐	☐	I recommend that special protective measures be provided to the employee as described below.
☐	☐	☐	It is my opinion that additional medical opinion be sought as described below.

COMMENTS AND NOTES (**please do not provide non-work related comments on this form**):

_____

_____

_____

_____

_____

Signature of Physician: _____

VirginiaTech
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Environmental, Health and Safety Services

Medical Survey Questionnaire

Progress: 1 | 2 | 3 | 4 | 5

The purpose of this questionnaire is to obtain an individual health history for employees working with animals and/or potentially infectious material, including toxins of biological origin, unfixed tissue and microorganisms. It will be used in conjunction with individual protocol risk assessments to evaluate appropriate medical survey needs and to determine appropriate individual personal protective equipment (PPE) needs.

CONFIDENTIALITY STATEMENT: This form asks that you provide personal health information that is protected by University policy and State and Federal law. Your rights to the confidentiality of your personal health information will be strictly maintained by Environmental Health and Safety. Your information will be used or disclosed in accordance with those policies and laws only to the minimal extent necessary for your treatment or business operations. You have the right to review and obtain a copy of your medical or health record. This is a secure website. Information that is electronically transmitted on this form will be maintained in a secure environment.

If you are a minor, this questionnaire will **not** collect a medical history and the information you provide will **not** be reviewed by the Occupational Physician. Rather, EHS will need a parent or legal guardian to provide written authorization for this information to be collected by us. You will be contacted directly by us if it is determined that you are a minor.

All fields in this form are required.

First Name:	Zack	
Last Name:	Adams	
Sex:	Male	
Email:	adamsz@vt.edu	user@domain.com
Date of Birth:	1979-04	YYYY-MM
Virginia Tech ID:	909999991	90XXXXXXX
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Current Employment/Academic Status (check all that apply):

☑ Faculty	☐ Visiting Faculty	☐ Student
☐ Classified Lab Technician / Staff	☐ Animal Care Staff / Herdsman	☐ Volunteer
☑ Other (please specify)		

Job Title:	asdfa
Provide the name of the faculty member or supervisor to whom you report.	asdf
Your supervisor's email address (include full address)	lance3@vt.edu user@domain.edu
Your supervisor's Phone Number	540-231-5985 555-555-5555
In which College are you employed?	College of Science
In which Department are you employed?	Psychology
Where is your primary work location? (Building)	asdfas
Room Number	123
Mail Code	1233
Your Phone Number	540-231-5985 555-555-5555

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RHA: You are listed in a Respirator Hazard Assessment (RHA). Please use the prompts, to guide your answers below.

I am potentially exposed to: (check all that apply)

- ☑ **Invertebrates/Microbes/Cell Lines** — RHA: An RHA indicates you work with Invertebrates.
- ☑ **Vertebrates/Animals** — RHA: An RHA indicates you work with Animals.
- ☑ **Chemicals** — RHA: An RHA indicates you work with Chemicals.
- ☑ **Noise**
- ☑ **Dust/Particulates** — RHA: An RHA indicates you work with Particulates.

Are you currently or will you be listed on a IBC protocol(s)?

◉ Yes ○ No

PI Name: asdfasdf	PI PID:	IBC Number:	
PI Name:	PI PID:	IBC Number:	
PI Name:	PI PID:	IBC Number:	
PI Name:	PI PID:	IBC Number:	
PI Name:	PI PID:	IBC Number:	

Do you conduct field work (e.g, observing/handling wild animals, working outdoors)?

◉ Yes ○ No

Please describe the ecosystem and specific geographic location: sdfasdf

Are you exposed to animals at home?

◉ Yes ○ No

What type of animals are you exposed to *at home*? (Check all that apply):

☐ Amphibians	☑ Birds/Poultry	☐ Cats	☐ Cattle	☐ Dogs
☐ Fish/Other Aquatics	☐ Guinea pigs	☐ Hamsters	☐ Horses	☐ Mice
☐ Rabbits	☐ Rats	☐ Reptiles	☐ Sheep/Goats	☐ Swine
☐ Wild Mammals	☐ Other:			

Do you perform work with infectious organisms (e.g., bacteria, viruses, rickettsial organisms, fungal organisms, or parasites), animals known to be infected with transmissible infectious organisms or in which the experiment involves infecting the animals?

RHA: An RHA indicates you work with infectious organisms. [Yes].

◉ Yes ○ No

Please list the organisms that you currently or plan to manipulate and, if known, organisms that others manipulate in the same work area (common names are acceptable, but please do not use acronyms):

RHA: An RHA indicates you work with the following: Agents List, some weird bacteria, Viruses, Bacteria, Worms,

pseudomonas sp.

Are all manipulations of these animals and organisms done exclusively in a Biosafety Cabinet?

RHA: An RHA indicates your work is performed in a Biosafety Cabinet. [Yes].

◉ Yes ○ No

Which Biosafety Cabinet are you using?

RHA: An RHA indicates you work with the following Biosaefty Cabinet: Type III (Biosafety Cabinet), I work in my unventilated garage.,

Type II, A2

Which of the following activities do you perform as part of your job (*check all that apply*):

- [x] Culturing / propagating the organisms
- [ ] Inoculating animals with the organisms
- [x] Collecting blood or other samples from living animals
- [ ] Handling animals, caging, or soiled bedding (husbandry, or transport to PI's lab)
- [ ] Animal Care staff / herdsman
- [ ] Performing euthanasia of the animals
- [ ] Collecting postmortem tissues or samples
- [ ] None of the above
- [ ] Other:

Please name and describe the invertebrates/microbes/cell lines you are working with:

111

Are you currently or will you be listed on a IACUC protocol(s)?

(•) Yes ( ) No

PI Name: asdfsdf	PI PID:	IACUC Number:
PI Name:	PI PID:	IACUC Number:
PI Name:	PI PID:	IACUC Number:
PI Name:	PI PID:	IACUC Number:
PI Name:	PI PID:	IACUC Number:

Indicate below the species that you are *working with or potentially exposed to as part of your duties for Virginia Tech*. Include work with tissues/fluids that have not been treated with chemical preservatives.

RHA
An RHA indicates you work with these animals: **Amphibians, Bats, Other:Other Animal,**

- [ ] Amphibians
- [ ] Bats
- [x] Birds or Poultry
- [ ] Cats
- [ ] Cattle
- [ ] Dogs
- [ ] Fish/Aquatics
- [ ] Guinea Pigs
- [ ] Hamsters
- [ ] Horses
- [ ] Humans
- [ ] Mice
- [ ] Rabbits
- [ ] Rats
- [ ] Reptiles
- [ ] Sheep/Goats
- [ ] Swine
- [ ] Wild Animals
- [ ] Other:

Indicate the *level of contact* for each group. Enter less than whole values as decimals.

Level I - No direct contact, but enters animal facility.
Level II - Does not conduct procedures on live animals but handles "unfixed" animal tissues and fluids.
Level III - Minor exposures: changes cages, bedding, water bottles, handles or transports occupied cages.
Level IV - Major exposures: handles, restrains, collection of specimens (blood, urine, feces) or administers substances to live animals (via injection, gavage, dosed feed, dosed water), performs invasive procedures (such as surgery or necropsy).

Animal Exposures	Level I	Level II	Level III	Level IV	Avg # hours/day	Avg exposure
Birds	(•)	( )	( )	( )	1	1 days/week

Do you trap, handle or house *WILD* rodents (e.g., deer mice ? Peromyscus spp.), or come into contact with burrows or equipment contaminated with their urine and feces?

( ) Yes (•) No

Please name the chemicals you are working with that are causing you to complete this survey:

RHA
An RHA indicates you work with these chemicals: **Chemical Names, stuff,**

formaldehyde, ethanol, propanol, sodium azide

Please estimate how often your work with these chemicals occurs:

RHA
An RHA indicates you work with these chemicals: **1 Minutes per day. 2 Days per Week, 2 Minutes per day. 2 Days per Week,**

6 Minutes per day, 1 Days per (•) Week ( ) Month

Are all manipulations of these chemicals done exclusively in a Fume Hood, Biosafety Cabinet, or other engineering control?

RHA
An RHA indicates you work with these engineering controls: **Biosafety Cabinet, Fume Hood, Other Engineering Control,**

- [x] Fume Hood
- [ ] Biosafety Cabinet
- [ ] Other Engineering Control
- [ ] No

Please describe the source of noise:

My office mates are very loud (and abrasive)

Please estimate how often your exposure to this noise occurs:

4 Minutes per day. 5 Days per (•) Week ( ) Month

Do you wear hearing protection (plugs or muffs) for this work related noise exposure?

(•) Yes ( ) No

What are the dusts, mists, fumes, or particulates? Please describe:

RHA

An RHA indicates you work with these chemicals: **Dust Description,**

Dandar from my office mates

Please estimate how often your work with these particulates occurs:

RHA

An RHA indicates you work with these chemicals: **3 Minutes per day. 4 Days per Month, 9 Minutes per day. 9 Days per Month,**

2 Minutes per day. 2 Days per (•) Week ( ) Month

Are all manipulations of these particulates done exclusively in a Fume Hood, Biosafety Cabinet, or other engineering control?

RHA

An RHA indicates you work with these engineering controls: **Fume Hood, Biosafety Cabinet,**

☐ Fume Hood ☐ Biosafety Cabinet ☑ Other Engineering Control ☐ No

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VirginiaTech *Invent the Future* | **Environmental, Health and Safety Services**

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Do you work with any of the following gases?

Halothane	◉ Yes	○ No
Isoflurane	◉ Yes	○ No
Carbon Dioxide	◉ Yes	○ No
Sevoflurane	◉ Yes	○ No
Ether	◉ Yes	○ No
Nitrous Oxide	○ Yes	◉ No

For what purpose are you using Sevoflurane, Halothane, Isoflurane and Ether?

anesthetize animals

How many times a day/how many hours do you perform this task with Sevoflurane, Halothane, Isoflurane and Ether?

2 hours per day

Do you or someone else refill vaporizers containing Sevoflurane, Halothane, Isoflurane and Ether? If so, how often?

myself; daily

What engineering controls are available to prevent personal exposure to Sevoflurane, Halothane, Isoflurane and Ether? (fume hood, BSC, local exhaust, etc.)

none

Are you using Sevoflurane, Halothane, Isoflurane and Ether in a lab or non-lab environment?

non-lab

Have you been trained on potential exposure risks of Sevoflurane, Halothane, Isoflurane and Ether and the use of the anesthesia machine. If so, who provided the training?

no

☑ I have read and understand the guidelines stated in the Waste Anaesthetic Gas Fact Sheet.

Does your work involve any of the following (check all that apply):

Recombinant DNA	◉ Yes	○ No
Human Blood, Tissue, Cells, or Cell Lines	◉ Yes	○ No
Caustic, Flammables, or Cryoagents	◉ Yes	○ No
Radiation	◉ Yes	○ No
Class 3b, 3r or 4 Lasers	◉ Yes	○ No
Drugs/Pharmaceuticals	◉ Yes	○ No
Chemotherapeutic Agents	○ Yes	◉ No

Heavy Metals	(•) Yes	( ) No
Carcinogens	(•) Yes	( ) No
Formalin/Formaldehyde	( ) Yes	(•) No
Biological or Chemical Toxins	(•) Yes	( ) No
Nanomaterials	(•) Yes	( ) No

Please list the Biological or Chemical Toxins you use and its application:

red fish fin toxin

Have you been told you will need to wear respiratory protection for your work (e.g, research protocol, work duties, emergency use, lab SOP, etc.)?

(•) Yes ( ) No

Please enter the PID of the PI or Supervisor that has told you to wear a respirator:

lance3

Are there others in your work group who wear a respirator?

( ) Yes (•) No

Please check if you use any of the devices below to protect yourself from potential airborne contaminants in your workplace. Examples

RHA

An RHA indicates you use these respirators: **Full Face, Half Face, Loose-fitting PAPR, Tight-fitting PAPR, 2-strap N95/100 disposable, One-strap dust mask,**

[ ] Full face respirator [x] Half face respirator [ ] Loose-fitting PAPR [x] Tight-fitting PAPR [ ] 2-strap N95/100 disposable [ ] One-strap dust mask [ ] None

How often are you using respiratory protection?

RHA

An RHA indicates you use these respirators: **3 Minutes per day. 4 Days per Month, 8 Minutes per day. 8 Days per Week,**

1 Minutes per day. 1 Days per (•) Week ( ) Month

What contaminants are you potentially exposed to that requires the use of a respirator?

coal dust from that stupid power plant

Persons who use respirators **must** be enrolled in Virginia Tech's Respiratory Protection Program.
Training and fit testing are ANNUAL requirements.

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VirginiaTech *Invent the Future*

Environmental, Health and Safety Services

Medical Survey Questionnaire

Progress: 1 2 3 4 5

Please have your medical records handy as many of the following questions may require detailed answers.

Note: The following questions relate to your current health status, and are designed to help the Occupational Health Nurse and/or Physician determine if there are additional risk factors that should be considered in relation to the work you perform for Virginia Tech. They also help us assure that you are offered vaccinations, titers and other medical services that are appropriate for your work-related exposures. You can choose to decline to provide this information; however, by doing so, you will not be enrolled in the Occupational Health Assurance Program and will not be offered vaccinations, titers or other medical services that may be recommended based on your work-related exposures. If you choose to decline, please click here.

By completing and submitting this form you are providing consent to and authorize employees of the Occupational Health Assurance Program of Environmental Health and Safety at Virginia Tech, including nursing, medical service technician/coordinators, contracted Occupational Health Physician (OHP) and other staff members to render medical services/evaluations which include health history collection, specimen collection/testing, physical exam and other occupational health testing as requested by my employer, as is necessary in the judgment of the OHP. The duration of this consent is indefinite and continues until revoked in writing. The following information will become a part of your **CONFIDENTIAL** medical records maintained by the department of Environmental Health and Safety.

Please list any and all prescription or over the counter medication, along with dosing, you are currently taking. Enter "None" if none.

none

Have you traveled outside the U.S. in the last year?

(●) Yes ( ) No

Please describe your travel including dates and locations.

Brazil on 2/12/13

Have you received a vaccination for travel outside the U.S.?

(●) Yes ( ) No

Please describe your travel vaccinations:

everything I needed and some that I didn't need

Will you be traveling outside the U.S. for work related business?

(●) Yes ( ) No

Please describe your work related travel plans including dates and locations.

Spain in September

Have you had a Tetanus booster in the last 10 years?

(●) Yes ( ) No

What was the year of the last Tetanus booster you received?

2010 YYYY

Have you had a Tuberculosis (TB) test?

(●) Yes ( ) No

What was the year of the last TB test?

2010 YYYY

What were the results of your last TB test?

○ Positive ◉ Negative

Have you ever been vaccinated against Rabies?

◉ Yes ○ No

What was the year the intial series of your Rabies vaccination was completed?

2016 YYYY

What year was your most recent Rabies titer?

2018 YYYY or N/A

Based on your last Rabies titer result, did you require a rabies booster vaccination?

Yes ○ No ◉ N/A ○

Have you ever been vaccinated against Polio?

◉ Yes ○ No

Have you had a Yellow Fever booster in the last 10 years?

◉ Yes ○ No

What was the year of the last Yellow Fever booster you received?

2010 YYYY

Have you ever been vaccinated against Measles/Rubeola?

◉ Yes ○ No

What was the year of your last Measles/Rubeola booster?

1999 YYYY

Have you ever been vaccinated against Hepatitis B?

○ Yes ◉ No

Have you ever been diagnosed with any of the following (*check all that apply*):

☐ Pneumonia	☐ Recurrent Bronchitis	☐ Tuberculosis
☐ Heart Disease	☐ Rheumatic Fever	☑ Heart Murmur & Valve Disease
☐ Diabetes	☑ Kidney Disease	☐ Liver Disease
☐ Cancer	☑ Gastrointestinal Disorder	☐ Loss of Consciousness
☐ Seizures	☑ Arthritis	☑ Chronic Back or Joint Pain
☐ Cystic Fibrosis	☐ Emphysema or Chronic Lung Condition	☐ None

Are working with ruminants?

◉ Yes ○ No

Please contact EHS at 231-8733. For more information on this issue, click here.

Has your health status changed in the last year?

(●) Yes ( ) No

Please explain the change in your health.

got older

Have you ever smoked?

(●) Yes ( ) No

Are you currently smoking?

(●) Yes ( ) No

Do you currently have or have you had a history of allergies?

(●) Yes ( ) No

To which are you allergic? *(check all that apply):*

☑ Pollen/Grasses/Etc. ☑ Food

☐ Latex ☐ Iodine or Disinfectant Chemicals

☐ Other (please describe):

Are you allergic to household pets?

(●) Yes ( ) No

What species of household pets are you allergic to?

cats

Do you have any allergic symptoms when working with or near animals or their bedding/cages at work?

(●) Yes ( ) No

About when did the work related animal exposure allergic symptoms begin?

2011 YYYY

Are the symptoms worse than one year ago?

(●) Yes ( ) No

What are your symptoms? *(Please complete all fields all that apply to your allergic symptoms or select "Never" under Frequency)*

Symptoms	Frequency	Severity	Primary Animal Species Causing Problem
Sneezing	Every Time	Moderate	Cats
Watery/Itchy Eyes	Most Times	Severe	Horses
Runny Nose (Nasal Dripping)	Rarely	Severe	Rabbits
Shortness of Breath	Never	N/A	N/A
Chest Tightness	Never	N/A	N/A
Coughing Spells	Never	N/A	N/A
Skin Rash	Never	N/A	N/A
Hives	Sometimes	Moderate	Wild Mammals

Do you have any additional comments about animal species that are causing you to experience allergic symptoms, or allergic symptoms in general that are not addressed above?

Have you ever changed jobs/working habits because of symptoms from handling animals?

(•) Yes ( ) No

Have you had to wear a respirator, goggles or protective clothing to protect yourself from allergies (e.g., hay fever [rhinitis], eye symptoms, hives or asthma) at work?

( ) Yes (•) No

Do you take prescription drugs that suppress your immune system?

(•) Yes ( ) No

What drugs are you taking?

abstain

If you prefer not to answer, just enter "abstain".

You should seek the advice of your personal physician before continuing animal exposure or exposure to/work with infectious agents.

Note: Any employee who has an autoimmune disease (no matter how well managed) or is taking immune suppressing medications or is pregnant or planning conception should be aware that working with mutagenic, teratogenic and/or infectious agents poses a special risk to them or a fetus. See NIOSH guides Effect of Workplace Hazards on Female Reproductive Health and Effect of Workplace Hazards on Male Reproductive Health for more information. In addition, employees should consult with their Primary Care Physician or Obstetrician regarding their work and the implications to their health or that of their unborn child. If an employee chooses to communicate this medical information to his/her supervisor, there are several options that can be offered to the employee. These options include:

1. Consultation with EHSS and Virginia Tech's Occupational Health Physician regarding the hazards in the employee's work place, evaluation of work practices, upgrades in PPE, changes to duties.
2. Consultation between the Occupational Health Physician and the employee's PCP or Obstetrician to thoroughly analyze the specific medical concerns for the employee in relation to the workplace hazards in order to make recommendations for accommodating the employee.
3. Consultation with Human Resources as needed to facilitate implementation of recommendations made by the medical providers or EHSS .

If submitting, please enter the phrase in the box to the right.  =

< Back | Save without submitting | Save and Submit

VirginiaTech

Environmental Health and Safety
www.ehss.vt.edu

ANNUAL MEDICAL SERVICES

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

All of your answers will be kept confidential, as is all medical information.

PLEASE ANSWER ALL QUESTIONS

Name: _____ Date: _____

Job Title: _____ Hokie ID No. _____

Phone No: _____ Mail Code: _____ Supervisor: _____

Department: Number of Years in Current Position:

What types of personal protective equipment do you use during your job? (Check all that apply)	
☐ Respirator:	Type(s): ☐ Disposable Dust Mask ☐ Disposable Half Mask (N95, N100) ☐ Half-Mask ☐ Full Face ☐ PAPR ☐ SCBA
☐ Hearing Protection:	Type(s): ☐ Plugs ☐ Muffs ☐ Both ☐ Other
☐ Eye/Face Protection	Type(s): ☐ Welding ☐ Laser ☐ Safety Eyeglasses/Goggles

Please describe your primary job duties:

_____

_____

_____

_____

_____

_____

Exam Date: _____

TO BE EXAMINED "☒"	TESTS AND EXAMINATIONS	NORMAL	ABNORMAL	NOT PERFORMED	RESULTS/ COMMENTS
☐	Tier 1	☐	☐	☐	
☐	Bloodwork	☐	☐	☐	
☐	Audiometric Test	☐	☐	☐	
☐	Chest Roentgenogram	☐	☐	☐	
☐	Audiological Evaluation	☐	☐	☐	
☐	Hemoglobin & Hematocrit	☐	☐	☐	
☐	Medical History	☐	☐	☐	
☐	OSHA Respiratory Questionnaire	☐	☐	☐	
☐	Physical Exam:	☐	☐	☐	
☐	Pulmonary Function Test	☐	☐	☐	
☐	PPD (Tuberculosis Screen)	☐	☐	☐	
☐	Urinalysis/Urinary Cytology Exam	☐	☐	☐	
☐	Vision Test	☐	☐	☐	

PHYSICIAN'S WRITTEN OPINION

To Physicians: Please check "yes" "no" or "NA" beside the following statements and include any detailed comments or notes in the space provided below.

Name of Employee: _____

Yes	No	NA	
☐	☐	☐	According to the finding of this examination/evaluation, it is my opinion that this employee has detectable medical conditions that would increase the risk of material health impairment through the performance of the job functions. These conditions are described below.
☐	☐	☐	I recommend that limitations be placed on this employee's use of personal protective equipment, such as respiratory protection. Limitations are described below.
☐	☐	☐	I have reviewed the Respirator Fitness Questionnaire and have determined that this employee is medically able to wear the respiratory protection devices assigned, in the workplace conditions described.
☐	☐	☐	I recommend that special protective measures be provided to the employee as described below.
☐	☐	☐	It is my opinion that additional medical opinion be sought as described below.
☐	☐	☐	According to my medical determination, this employee is subject to "Medical Removal", as mandated by OSHA. This determination is based on: ☐ The employee has been referred to a hematologist/internist due to abnormalities from Benzene exposure in excess of 0.5 ppm. ☐ The employee has a blood-lead level in excess of 50 µg/100g. ☐ The employee has a condition that will increase the risk of material health impairment from continued exposure to lead concentrations 30 $\mu g/m^3$ of air. ☐ Other
☐	☐	☐	I have informed the employee of the increased risk of lung cancer attributable to the combined effect of smoking and asbestos exposure.

COMMENTS AND NOTES (**please do not provide non-work related comments on this form**):

_____

_____

_____

_____

_____

I have informed the employee of the results of the medical examination, test(s) performed and any medical condition which requires further examination or treatment.

Signature of Physician: _____

VirginiaTech

Environmental Health and Safety Services
540/231-2509 Fax: 540/231-3944
E-mail: respirators@vt.edu
www.ehss.vt.edu

Respirator Medical Evaluation Questionnaire

Because your job tasks at Virginia Tech may subject you to occupational exposures that require the use of a respirator, our contract physician will help us determine your ability to use a respirator without compromising your health. Our contract physician for all annual medical evaluations is Scott Jamison, MD in Christiansburg.

All of your answers will be kept confidential, as is all medical information.

PLEASE ANSWER ALL QUESTIONS

Name: _____ Date: _____

Sex: (check one) ☐ Male ☐ Female Height: _____ Ft. _____ In.

Age: _____ Weight: _____ lbs

Job Title: _____ Phone No: _____

Department: _____

Have you worn a respirator before? ☐ Yes ☐ No

Type(s) of respirator:
- ☐ Disposable (for example: N95, N99, N100)*
- ☐ Half-mask negative pressure (*Approximately .75-1 lb.)*
- ☐ Full face negative pressure *(Approximately 2 lbs.)*
- ☐ Powered Air Purifying Respirator (PAPR) *(Approximately 3.5-5.0 lb)*
- ☐ Other, Describe:_____

** Note: Single-strap dust masks and comfort masks are not respirators.*

Duration of Use
- ☐ 1-2 hours
- ☐ 3-5 hours
- ☐ 6-8 hours
- ☐ 10-12 hours
- ☐ 13-15 hours
- ☐ 16-18 hours
- ☐ 19-24 hours
- ☐ Not Applicable

Frequency of Use
- PER ☐ Day
- PER ☐ Week
- PER ☐ Month

Physical Effort Required: ☐ Mild ☐ Moderate ☐ Strenuous
Temperature Extreme: ☐ Low ☐ High
Humidity Extreme: ☐ Low ☐ High

Additional PPE Required? Please describe: _____

Yes	No	Please check Yes or No for each of the questions below.
☐	☐	**1. Do you *currently* smoke tobacco, or have you smoked tobacco in the last month?**
Yes	**No**	**2. Have you ever had any of the following conditions?**
☐	☐	a. Seizures (fits)
☐	☐	b. Diabetes (sugar)
☐	☐	c. Allergic reactions that affect your breathing
☐	☐	d. Claustrophobia (fear of closed-in places)
☐	☐	e. Trouble smelling odors
Yes	**No**	**3. Have you ever had any of the following pulmonary or lung problems?**
☐	☐	a. Asbestosis
☐	☐	b. Asthma
☐	☐	c. Chronic bronchitis
☐	☐	d. Emphysema
☐	☐	e. Pneumonia
☐	☐	f. Tuberculosis
☐	☐	g. Silicosis
☐	☐	h. Pneumothorax (collapsed lung)
☐	☐	i. Lung cancer
☐	☐	j. Broken ribs
☐	☐	k. Any chest injuries or surgeries
☐	☐	l. Any other lung problem that you've been told about? Please describe:
Yes	**No**	**4. Do you currently have any of the following symptoms of pulmonary or lung illness?**
☐	☐	a. Shortness of breath
☐	☐	b. Shortness of breath when walking fast on level ground or walking up a slight hill
☐	☐	c. Shortness of breath when walking with other people at an ordinary pace on level ground
☐	☐	d. Have to stop for breath when walking at your own pace on level ground
☐	☐	e. Shortness of breath when washing or dressing yourself
☐	☐	f. Shortness of breath that interferes with your job
☐	☐	g. Coughing that produces phlegm (thick sputum)
☐	☐	h. Coughing that wakes you early in the morning
☐	☐	i. Coughing that occurs mostly when you are lying down
☐	☐	j. Coughing up blood in the last month
☐	☐	k. Wheezing
☐	☐	l. Wheezing that interferes with your job
☐	☐	m. Chest pain when you breathe deeply
☐	☐	n. Any other symptoms that you think may be related to lung problems? Please describe:

Yes	No	
		5. Have you ever had any of the following cardiovascular or heart problems?
☐	☐	a. Heart attack
☐	☐	b. Stroke
☐	☐	c. Angina
☐	☐	d. Heart failure
☐	☐	e. Swelling in your legs or feet (not caused by walking)
☐	☐	f. Heart arrhythmia (Irregular heart beat)
☐	☐	g. High blood pressure
☐	☐	h. Any other heart problem that you've been told about
Yes	**No**	**6. Have you ever had any of the following cardiovascular or heart symptoms?**
☐	☐	a. Frequent pain or tightness in your chest
☐	☐	b. Pain or tightness in your chest during physical activity
☐	☐	c. Pain or tightness in your chest that interferes with your job
☐	☐	d. In the past two years, have you noticed your heart skipping or missing a beat
☐	☐	e. Heartburn or indigestion that is not related to eating
☐	☐	f. Any other symptoms that you think may be related to heart or circulation problems
Yes	**No**	**7. Do you currently take medication for any of the following problems?**
☐	☐	a. Breathing or lung problems
☐	☐	b. Heart trouble
☐	☐	c. Blood pressure
☐	☐	d. Seizures (fits)
Yes	**No**	**8. If you've used a respirator, have you ever had any of the following problems?**
☐	☐	a. Eye irritation
☐	☐	b. Skin allergies or rashes
☐	☐	c. Anxiety
☐	☐	d. General weakness or fatigue
☐	☐	e. Any other problem that interferes with your use of a respirator? Please describe:
☐	☐	**9. Would you like to talk to the health care professional who will review this questionnaire about your answers?**

Answer the following questions ONLY if you wear either a full facepiece respirator or self-contained breathing apparatus (SCBA)

Which type of respirator do you use? ☐ Full Facepiece ☐ SCBA

Yes	No	Please check Yes or No for each of the questions below.
☐	☐	**1. Have you *ever lost* vision in either eye (temporarily or permanently)?**
		2. Do you currently have any of the following vision problems?
☐	☐	a. Wear contact lenses
☐	☐	b. Wear glasses
☐	☐	c. Color blind
☐	☐	d. Any other eye or vision problem?
☐	☐	**3. Have you ever had an injury to your ears, including a broken ear drum?**
		4. Do you currently have any of the following hearing problems?
☐	☐	a. Difficulty hearing
☐	☐	b. Wear a hearing aid
☐	☐	c. Any other hearing or ear problem
☐	☐	**5. Have you ever had a back injury?**
		6. Do you currently have any of the following musculoskeletal problems?
☐	☐	a. Weakness in any of your arms, hands, legs, or feet
☐	☐	b. Back pain
☐	☐	c. Difficulty fully moving your arms and leg
☐	☐	d. Pain or stiffness when you lean forward or backward at the waist
☐	☐	e. Difficulty fully moving your head up or down
☐	☐	f. Difficulty fully moving your head side to side
☐	☐	g. Difficulty bending at your knees
☐	☐	h. Difficulty squatting to the ground
☐	☐	i. Climbing a flight of stairs or a ladder carrying more than 25 lbs.
☐	☐	j. Any other muscle or skeletal problem that interferes with using a respirator? Please describe:

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Environmental Health and Safety
www.ehss.vt.edu

MEDICAL HISTORY UPDATE

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

All of your answers will be kept confidential, as is all medical information.

PLEASE ANSWER ALL QUESTIONS

Name: _____		Date: _____	
Birth Date: _____		Hokie ID No. _____	
Job Title: _____		PID/email: _____	
Department:		Phone No: _____	
Supervisor: _____		Height:	Weight:

Yes	No	Please check Yes or No for each of the questions below.
☐	☐	1. Has your general health changed in the last year? If "YES", what kind of problem were you having, and when did the problem occur?
☐	☐	2. Have you been under the care of a physician during the past year? If "YES", for what condition(s)?
☐	☐	3. Have any of your medicines changed in the last year? If "YES", what are you currently taking?
☐	☐	4. Has there been a change in your breathing in the last year?
☐	☐	5. Are you a smoker? ☐ Yes ☐ No
☐	☐	6. In the past year, have you had any chest illnesses that have kept you off work, indoors at home, or in bed?
☐	☐	7. In the past year, how many such illnesses with (increased) phlegm did you have which lasted a week or more?
☐	☐	8. Have there been any changes in your alcohol consumption, use of tobacco products, exercise routine, or other wellness factors? If "YES", please describe:
☐	☐	9. Do you have any other comments? If "YES", please write them here:

Employee Signature: _____

VirginiaTech

Environmental Health and Safety

Occupational Health Clearance for Work with Select Agents

To Physician: Please check "yes" or "no" beside the following statements. Any forms for personnel who must be referred to EHS for follow up must be faxed to **1-866-460-0028** and discussed with the Occupational Health Nurse as soon as possible.

Employee Name: _____

Yes	No	
☐	☐	Reports use of tobacco, alcohol, controlled substances, illicit drugs
☐	☐	Reports admission for mental health evaluation, treatment of a mental health disorder, treatment for depression, suicide attempt
☐	☐	Reports change in sleep or eating habits, weight change
☐	☐	Reports major life change: marriage, new baby, divorce, job change, loss of parent or spouse, other significant life event:
☐	☐	Reports a general sense of well being
☐	☐	Reports being comfortable with the type of research he/she is doing
☐	☐	Reports being overwhelmed by the pressures of research and/or coursework
☐	☐	Reports concerns regarding colleagues or his/her hierarchy
☐	☐	Reports having pulled off an attached tick in the last year or has had a diagnosis of Lyme disease

☐	Discuss medical history
☐	Discuss medications/review titer results
☐	Physical exam

_____ _____

Occupational Health Provider Signature Date

VirginiaTech
Environmental Health and Safety

Occupational Health Clearance for Work with Select Agents
Tier 1 BSAT

Employee Name:	
VT ID:	
Department:	
Supervisor:	

Status:

☐ Cleared to perform work in the Tier 1 BSAT program

☐ Conditional clearance to perform work in the Tier 1 BSAT program

☐ NOT cleared to perform work in the Tier 1 BSAT program:

☐ Indefinitely ☐ Temporarily

If "Conditionally Cleared" or "Temporarily Not Cleared" please provide relevant information as it pertains to employee's job duties in the Tier 1 BSAT program (do not include medical information):

_____

_____

_____

This decision was based on health information obtained during this assessment. Future changes in health status could lead to a change in occupational health clearance and will need to be re-assessed by occupational health.

_____ _____

Occupational Health Provider Signature **Date**

Medical Services Documentation	
Copy Provided to RO/ARO	
Completed by:	Date: