A. You will be contacted by VA Personnel Health with a scheduled appointment for an Animal Allergy Physical.

B. Please take this completed questionnaire with you to the appointment.

C. Have Personnel Health staff sign the last page (17).

D. Return page 17 to the Research Office.

Louis Stokes Cleveland VA Medical Center
Personnel Health
Laboratory Animal Allergy Questionnaire – Initial

Demographic Information

1. Name: _____ _____ _____
   Last First Middle Initial
2. Social Security Number: _____

3. Date of Birth: _____/ _____/ _____ 4. Age: _____ 5. Sex: M F (circle one)
   Month Day Year

6. Today's Date: _____/ _____/ _____
   Month Day Year

7. Race: (Circle one) Asian Black Hispanic/Latino White Other: _____

8. Current Job Title: _____

Where do you work? (Specific Location) _____
Building: _____
Floor: _____ Room number: _____

Telephone number: _____ _____ _____
Area Code Telephone number Extension

Pager/Cell Number: _____

Date you began this job: _____/_____ Date you began with this organization: _____ / _____
Month Year Month Year

Work Status: (Circle one) VA Paid Employee WOC Contractor Student CWRU employee

* Are you enrolled in the Case Western Reserve University/UH health services for animal research? Yes No Not Sure

Hours employed: (Circle one) Full-Time Part-Time PRN

Current Allergic Symptoms

9. Please complete the below table for any symptoms you have experienced on a regular basis to include year of onset, whether the symptom is present now, and the times at which you are most troubled by the symptom? If you have NOT experienced any of the symptoms below please proceed to question 10.

(Please EXCLUDE any symptoms that are associated with a cold, flu or other illness)

	Year of onset	Present now	Spring	Summer	Fall	Winter	No particular Season	Home	Work	No Difference
Watery or itchy eyes										
Runny or stuffy nose										
Sneezing spells										
Frequent cough										
Difficulty swallowing										
Sputum production (excessive mucous)										
Sinus problems										

Frequent colds										
Hives										
Swelling of lips or eyes										
Eczema										
Wheezing/Chest tightness										

If you answered "YES" to the following questions, please complete the additional questions in the enclosed boxes. Thank you.

Atopic History

10. Do you think you have ALLERGIES? **YES / NO**

If YES:

To what are you allergic: _____

What symptoms do you have when your allergies act up? _____

_____

11. Have you ever had HAY FEVER? **YES / NO**

If YES:

At what age did you first develop hay fever? _____

When was the last time you were troubled by hay fever? _____/_____

Month Year

12. Has a physician ever told you that you have ALLERGIES? **YES / NO**

13. Have you ever had a SKIN TEST for allergens (not TB)? **YES / NO**

If YES:

If you were tested, to what were you allergic? _____

_____

14. Have you received ALLERGY SHOTS? **YES / NO**

15. Have you ever taken MEDICATIONS FOR ALLERGIES? **YES / NO**

If YES:

What medications? _____

How Often? _____

16. Has a physician ever told you that you have ASTHMA? **YES / NO**

17. Have you ever had an attack of wheezing that made you short of breath? **YES / NO**

If YES:

At what age did you have your first attack? _____

Are you still occasionally troubled by these attacks? YES / NO

Do you currently take medications for these attacks? **YES / NO**

18. Are you allergic or sensitive to things that cause skin rashes? **YES / NO**

If YES:

What causes rashes? _____

_____

19. Is there anyone in your immediate family with ALLERGIES or ASTHMA? **YES / NO**

IF YES: (circle all that apply)

Father	**Allergies**	**Asthma**	**Both**
Mother	**Allergies**	**Asthma**	**Both**
Sister	**Allergies**	**Asthma**	**Both**
Brother	**Allergies**	**Asthma**	**Both**
Child	**Allergies**	**Asthma**	**Both**

Home Environment

20. Have you EVER had HOUSE PETS? **YES / NO**

If YES:

Which animals? **For how long?**

_____ **Dogs** _____

_____ **Cats** _____

_____ **Other (specify):**

_____ _____

_____ _____

Are you (or were you) allergic to them? **YES / NO**

Do you have house pets now? **YES / NO**

21. Do you smoke cigarettes or cigars?

If YES:

On average, how many do you smoke per day? _____

How many years have you smoked? _____

If NO:

Did you smoke cigarettes or cigars in the past? **YES / NO**

For how many years? _____

When did you quit? (Month/Year) _____

22. **Do other members of your household smoke?** **YES / NO**
23. **Did your parents smoke when you were living at home?** **YES / NO**

24. **Are you taking any medications on a regular basis?** **YES / NO**

Please list ALL medications (including herbal and vitamin supplements) you are Currently taking on a regular basis and how often you take them.

_____
_____
_____
_____
_____
_____

Occupational History / Current exposure Information

25. **Have you worked with laboratory animals before this job?** **YES / NO**

If YES:

For how long? (total years) _____
What types of animals? _____

Were you allergic to any of the animals with which you worked? YES / NO

If YES, what type of animal(s)? _____

When was the onset of allergy? (Year or Month/Year) _____

26. **In your current job do you handle animals or their tissue, body fluids, or cages?** **YES / NO**

27. **Do you work in the animal room at least once a week?**

If YES:

How many days per week do you work with the lab animals or their cages? (circle one)
<1 1 2 3 4 5 More _____

During these days**, how many hours per day (on the average)** do you work with lab animals or their cages? (circle one)
<1 1 2 3 4 5 6 7 8 More _____

If NO:

Over the past 24 weeks (about six months) **during how many weeks** have you had lab animal contact?
_____

During these weeks, **how many days per week** have you worked with lab animals? (circle one)
<1 1 2 3 4 5 More _____

On these days, **how many hours per day** have you worked with lab animals? (circle one)
<1 1 2 3 4 5 6 7 8 More _____

28. **How many hours per week** do you usually have contact with the following species? (circle one choice for each listing)

	How many hours per week						
Guinea Pig	0	<1	1-5	6-10	11-15	16-20	21 or more
Hamster	0	<1	1-5	6-10	11-15	16-20	21 or more
Dogs	0	<1	1-5	6-10	11-15	16-20	21 or more
Cats	0	<1	1-5	6-10	11-15	16-20	21 or more
Rat	0	<1	1-5	6-10	11-15	16-20	21 or more
Rabbit	0	<1	1-5	6-10	11-15	16-20	21 or more
Marmosets	0	<1	1-5	6-10	11-15	16-20	21 or more
Primates	0	<1	1-5	6-10	11-15	16-20	21 or more
Mice	0	<1	1-5	6-10	11-15	16-20	21 or more
Other_____ (specify)	0	<1	1-5	6-10	11-15	16-20	21 or more

29. **How many hours per week** are you usually involved in the following activities? (circle one choice for each listing)

	How many hours per week						
Handle dirty cages	0	<1	1-5	6-10	11-15	16-20	21 or more
Return clean cages	0	<1	1-5	6-10	11-15	16-20	21 or more
Receiving animals	0	<1	1-5	6-10	11-15	16-20	21 or more
Breeding Room	0	<1	1-5	6-10	11-15	16-20	21 or more
Holding Room	0	<1	1-5	6-10	11-15	16-20	21 or more
Gavage or other dosing	0	<1	1-5	6-10	11-15	16-20	21 or more
Weighing	0	<1	1-5	6-10	11-15	16-20	21 or more
Sacrifice/Necropsy	0	<1	1-5	6-10	11-15	16-20	21 or more
Isolators	0	<1	1-5	6-10	11-15	16-20	21 or more
Change bedding	0	<1	1-5	6-10	11-15	16-20	21 or more
Other animal room housekeeping	0	<1	1-5	6-10	11-15	16-20	21 or more
Isolated organ or tissue experiments	0	<1	1-5	6-10	11-15	16-20	21 or more
Using animals or tissues/fluids	0	<1	1-5	6-10	11-15	16-20	21 or more
Outside animal facility	0	<1	1-5	6-10	11-15	16-20	21 or more

30. **When working with lab animals or their cages how often do you do the following?**
(Check one choice for each item)

	Never	**Less then <1/2 time**	**Most of the time**	**Always**
Wear gloves	_____	_____	_____	_____
Wear a dust/mist respirator	_____	_____	_____	_____
Wear other respirator	_____	_____	_____	_____
Wear a gown/Tyvek unit	_____	_____	_____	_____
Wear hair bonnets	_____	_____	_____	_____
Wear show covers	_____	_____	_____	_____
Wash hands after handling animals'	_____	_____	_____	_____
Wear eye protection	_____	_____	_____	_____

31. Do you get any of the following symptoms from working with laboratory animals or their cages? (Or have you ever had any of the symptoms in the past from working with laboratory animals or their cages. In other words, if you were not able to wear personal protective equipment, would you probably get these symptoms?). **If No**, go to question #32.

If YES:

Which of the symptoms do you have? (Please check all that apply)

Sneezing spells _____
Runny nose or Stuffy Nose _____
Watery or itchy eyes _____
Coughing spells _____
Wheezing/Chest tightness _____
Shortness of breath _____
Skin rashes or hives _____

Does personal protective equipment eliminate these symptoms? YES / NO

Which of the following species causes any of these problems?

Guinea pig _____
Hamster _____
Dogs _____
Cats _____
Mouse _____
Rat _____
Rabbit _____
Marmosets _____
Primates _____

(Type: _____)

Other: _____

(Specify: _____)

How soon after exposure to lab animals do these symptoms start? (Circle one)

Less than 10 minutes 10 minutes to 1 hour 1 to 8 hours More than 8 hours

How long do they last?

Less than 10 minutes 10 minutes to 1 hour 1 to 8 hours More than 8 hours

Do you take any medications for these symptoms? YES / NO

32. **Are there any lab animals with which you cannot work because of allergy problems? YES / NO**

If YES:

Which animal species? _____

How long have you been allergic to this (these) species? _____

33. Have you ever changed jobs or working habits because of symptoms from handling animals? YES / NO

Please explain: _____

34. Aside from your own work, are lab animals used by others in the same room where you work? YES / NO

35. Have you ever had Tuberculosis disease (TB)? YES / NO
Have you been tested for TB in the past year? YES / NO
Results: Positive / Negative When was the test performed? _____

Are you receiving immunosuppressive therapy such as prednisone, steroids or anti-cancer drugs? YES / NO
If yes, please list with amount: _____

Some people have been immunized against TB with a vaccine called BCG. This may make your skin test positive forever.

Have you received BCG? YES / NO Don't know

36. Have you received a Tetanus booster in the past 10 years? YES / NO

If yes, when did you receive the tetanus booster? _____

37. Have you received a Rabies vaccination (if applicable)? YES / NO

If yes, please list date: _____

When was your last Rabies titer? Date: _____
Results of your last Rabies titer? Immune: _____ Not Immune: _____

38. Have you ever received Hepatitis B vaccine? YES / NO Don't know

If you have already received the vaccine, please sign the following statement:

I have received the Hepatitis B vaccine. I do not need immunization.

_____
Signature Date

39. Have you ever received Hepatitis A vaccine? YES / NO Don't know

40. Do you ever smoke, eat drink, apply cosmetics or handle contact lenses in animal handling rooms? YES / NO

When working with animals, do you always wear:

Gloves	**Yes**	**No**
Mask	**Yes**	**No**
Protective eyewear	**Yes**	**No**
Gown/lab coat	**Yes**	**No**

41. Do you perform the following after handling animals at work?

Wash hands	**Yes**	**No**		
Shower/change clothing	**Yes**	**No**		
Have you been issued & do you wear a respirator?	**Yes**	**No**	**Yes**	**No**

Risk of injury-Which animals will you have contact with *(check all that apply)?*

Low Risk		**Fish or amphibians**
Mild Risk		**Rats, Mice, Rabbits, guinea pigs, hamsters, gerbils, birds, and swine with mild risk of injury (primary bites, and scratches, zoonotic disease, but significant potential for allergies.)**
Moderate Risk		**Dogs, cats, sheep, cattle, goats and wild rodents with moderate risk of injury (primarily bites, scratches, kicks, and crushing), zoonotic disease (rabies, Q fever, Hanta Virus, bacterial and fungal infections), and significant potential for allergies.**
Marked Risk		**Non-human primates with marked risk of injury (primarily bites and scratches). Zoonotic disease (herpes B virus, tuberculosis, viral hepatitis, bacterial infections), bacterial or viral infections (class 2 or greater) used in research, and some potential for allergies.**

I certify that the information provided above is true to the best of my knowledge. I understand this review is a generalized review aimed for ensuring a safe working environment. I understand I must immediately notify my supervisor and go to Personnel Health or Urgent Care if I have a reaction/bite/scratch to any animal or agent within the Louis Stokes Cleveland VA Medical Center Research animal handling area.

I understand that I am expected to adhere to Federal Research/Occupational Health & Safety regulations and failure to do so will result in administrative action. I understand that I must re-submit the Animal Questionnaire and provide documentation upon changes to my health status.

I have received training by Research Services that included the use of personal protective equipment and counseling as to the potential risk of zoonotic diseases:

Print Name:_____Signature:_____

Date:_____

Employee Health Provider or Medical Representative Signature: _____

Date: _____

Personnel Health

Patient Data Sheet

Name: _____
(Please Print) Last First MI

Social Security Number: _____

Home Street Address _____

_____
City State Zip Code

Telephone
Home: ( ) _____ Mobile: ( ) _____

Date of Birth: _____
Month / Day / Year

Place of Birth: _____
City & State (or Country)

Father's Name: _____
Last First MI

Mother's Name: _____
Last First MI

Mother's Maiden Name: _____
Last First MI

Current Occupation: _____

Employment Status:

◯ Full-Time ◯ Part-Time ◯ PRN ◯ Not Employed

Marital Status:

◯ Never Married ◯ Married ◯ Widow ◯ Divorced

Emergency Contact

Name: _____

Relationship: _____

Telephone Number: _____

Address: _____

_____
City State Zip Code

NOTE TO EXAMINING PHYSICIAN: The person you are about to examine will have to cope with the functional requirements and environmental factors circled side of this form. Please take them, and the brief description of job duties above them, into consideration.

1. HEIGHT: _____ FEET, _____ INCHES WEIGHT: _____ POUNDS BMI

2. EYES:
(A) Distant vision (Snellen) without glasses: **right** 20 **left** 20 ;with glasses, if worn: **right** 20 **left** 20

(B) What is the longest and shortest distance at which the following specimen of Jaeger No. 2 type can be read by the applicant? Test each eye separately.

Jaeger No. 2 Type
Employees in the Federal classified service as may be requested by the Civil Service Commission or its authorized representative. This order will supplement the Executive Orders of May 29 and June 18, 1923 (Executive

without glasses:
right _____ in to _____ in
left _____ in to _____ in

with glasses, if used:
right _____ in to _____ in
left _____ in to _____ in

(C) Color vision: Is color vision normal when Ishihara or other color plate test is used? ☐ YES ☐ NO
If not , can applicant pass lantern, yarn, or other test? ☐ YES ☐ NO

3. EARS: (Consider denominators indicated here as normal. Record as numerators the greatest distance heard.)
Ordinary conversation:WHISPER

RIGHT EAR _____ LEFT EAR _____
20 FT 20 FT

Audiometer *(if given)* :

250	500	1000	2000	3000	4000	5000	6000	7000	8000

4. OTHER FINDINGS: In items a through l briefly describe any *abnormality* (including diseases, scars, and disfigurations). Include briefly history, if pertinent. If normal, so indicate.

a. Eyes, ears, nose, and throat *(including tooth and oral hygiene)*

b. Head and back *(including face, hair, and scalp)*

c. Speech *(note any malfunction)*

d. Skin and lymph nodes *(including thyroid gland)*

e. Abdomen

f. Peripheral blood vessels

g. Extremities

h. Urinalysis *(if indicated)*
Sp. gr. _____ **Sugar** _____ **Blood** _____
Albumin _____ **Casts** _____ **Pus** _____

l. Respiratory tract *(X-ray if indicated)*

j. Heart *(size, rate , rhythm, function)*
BP:
Pulse:
T
EKG *(if indicated):*

k. Back *(special consideration for positions involving heavy lifting and other strenuous duties)*

l. Neurological and mental health

CONCLUSIONS: Summarize below any medical findings which, in your opinion, would limit this person's performance of the job duties and/or would make him a hazard to himself or others. If none, so indicate.

☐ **No limiting conditions for this job**

☐ **Limiting conditions as follows:**

Personnel Health Data Base & Infectious Disease Information

Please fill in or circle all appropriate responses. Your assistance is needed to complete this mandated questionnaire. Thank you for your cooperation.

Name:_____ Date of Birth:_____

Social Security #:_____ Service:_____

Address:_____ Job Title:_____

City:_____ Extension:_____

Zip Code:_____ Home Phone:_____

In case of emergency, please NOTIFY:_____

Relationship:_____ Phone:_____

THE INFORMATION IN THIS QUESTIONNAIRE IS CONFIDENTIAL AND WILL REMAIN IN YOUR PERONNEL HEALTH FILE.

MUMPS

Mumps is a common disease of children, which is preventable by immunization. It usually causes fever, headache and swelling of the salivary glands. It is much more serious in adolescents and adults, in whom it may cause hearing loss and problems with male fertility.

Have you ever had Mumps? **YES_____NO_____Don't know_____**

Have you ever been immunized against Mumps? **YES_____NO_____Don't know_____**

TUBERCULOSIS

Tuberculosis (TB) is a serious infectious lung disease, which is increasing in the population. Hospital workers are at risk from exposure to untreated patients. Exposure is diagnosed by a positive TB skin test (PPD), symptoms, or an abnormal chest X-Ray.

Have you ever had TB? **YES_____NO_____Don't know_____**

When was your last TB skin test? **Date_____Don't know_____**

Was the skin test: **Positive_____Negative_____Don't know_____**

Hospital employees should have annual skin tests, if previously negative. If previously positive and at any time you experience some of the following symptoms, you need to be evaluated.

Weight Loss Fever, particularly at night Night sweats

Decreased appetite Persistent cough Coughing up blood

Some people have been immunized against TB with a vaccine called BCG. This may make your skin test positive forever. Your situation requires special attention if problems occur.

Have you received BCG? **YES_____NO_____Don't know_____**

MEASLES (Rubeola)

Measles (Rubeola) is the most serious of the common childhood diseases. Usually it causes a rash, high fever, cough, runny nose and watery eyes, lasting 1 to 2 weeks. Sometimes it causes much more serious problems such as ear infections, pneumonia, deafness and very rarely, an inflammation of the brain.

Have you ever had measles? **YES_____NO_____Don't know_____**

Have you ever been immunized against measles? **YES_____NO_____Don't know_____**

If yes, **before** 1980_____, or **after** 1980_____?

Persons immunized between 1957 and 1980 should be re-immunized. This vaccine is offered to employees at no cost, through Personnel Health.

CHICKEN POX/SHINGLES (Varicella Zoster)

Chicken Pox/Shingles is a viral infection that is highly contagious. The virus is found in respiratory secretions and fluid from the blisters of infected individuals. There is no vaccine for Chicken Pox at present. If you believe you have not had Chicken Pox or are unsure if you have had it, you should avoid contact with any individual with this infection. Testing to determine whether you have had Chicken Pox is offered through Personnel Health.

Have you ever had Chicken Pox or Shingles? **YES_____NO_____Don't know_____**

RUBELLA

Rubella (German Measles, Three Day Measles) is a common disease of children. It may also affect adults. Usually it is very mild and causes a light fever, rash and swelling of the glands in the neck. It lasts about 1 day. Very rarely, it can cause inflammation of the brain (encephalitis) and cause a temporary bleeding disorder. The most serious problem with Rubella is that if a pregnant woman gets this disease, there is a good chance that she may have a miscarriage or that the baby will be born blind or with other birth defects. This vaccine is offered to employees at no cost, through Personnel Health.

Have you ever had Rubella? **YES_____NO_____Don't know_____**

Have you ever been immunized against Rubella? **YES_____NO_____Don't know_____**

TETANUS (Lockjaw)

Tetanus is a fatal disease entirely preventable by immunization every 8-10 years. Diphtheria is another childhood disease also preventable by immunization. There is a combination vaccine that immunizes against both diseases. If it has been 10 years or more since your last booster, we recommend you receive a booster. The booster is offered to employees through Personnel Health at no cost.

Have you received Tetanus/Diphtheria Immunization? **YES_____NO_____Don't know_____**

When was your last immunization booster?_____

I UNDERSTAND THAT, WHEN INDICATED, APPROPRIATE VACCINES ARE AVAILABLE TO ME. ALL IMMUNIZATIONS ARE VOLUNTARY AND ARE NOT REQUIRE FOR EMPLOYMENT. HOWEVER, I UNDERSTAND THAT THEY ARE STRONGLY RECOMMENDED FOR HIGH RISK PERSONNEL. IF I WANT TO RECEIVE ANY OF THESE VACCINES, I WILL CONTACT THE PERSONNEL HEALTH CLINIC AT WADE PARK: EXT. 3813 OR BRECKSVILLE: EXT. 6864.

HEPATITIS

Hepatitis B is a disease caused by a viral infection. The virus is found in blood and body fluids of infected individuals. The Hepatitis B virus attacks the liver. It may cause serious liver disease and, rarely, death. Sometimes people who contract Hepatitis B remain carriers of the virus. Approximately 25% of carriers develop chronic active Hepatitis, which often progresses to cirrhosis. Furthermore, Hepatitis B carriers have a higher risk of developing liver cancer. Certain jobs in the medical center place you at greater risk of exposure to Hepatitis B. Some of these include:

- Exposure to blood, tissues or other bodily fluids.
- Administration of medications or vaccines using syringes or needles.
- Taking blood samples for laboratory tests.
- Inserting or maintaining intravascular devices.
- Collecting filled needle containers and contaminated wastes.

Some employees considered at great risk for exposure to Hepatitis B are:

Environmental Management Staff Nurses Dentists Physicians
Laboratory Staff OR Personnel Health Aides Laundry Staff
Dental Hygienists Radiology Techs Physician Extenders

Have you ever had Hepatitis? **YES_____NO_____Don't know_____**

If not, immunization with Hepatitis B vaccine is the most effective means of preventing Hepatitis B virus infection and its consequences. As an employee at the V.A. Medical Center, vaccination is highly recommended. No substances of human origin are used in the manufacture of the vaccine, so there is no risk of Hepatitis B or H.I.V. infection from the vaccination. Immunization

involves 3 intramuscular injections given over six months. (Hepatitis B vaccine was not available until the early 1980's. Please do not confuse it with Hepatitis B immune globulin.)
Have you ever received Hepatitis B vaccine? **YES_____NO_____Don't know_____**

If you have already received the vaccine, please sign the following statement:
I have received Hepatitis B vaccine. I do not need immunization.

_____

Signature Date

If you do not know if you received Hepatitis B vaccine check here:_____

If you have not received the vaccine, do you wish to receive it? **YES_____NO_____**

If you want the Hepatitis B vaccine, please contact the Personnel Health Department. Wade Park: ext. 3813, Brecksville: ext. 6864 or the CMO's office at Canton or Youngstown.
OSHA requires that anyone declining the Hepatitis B vaccine read the following statement and sign below to acknowledge your declination.

HEPATITIS B VACCINE DECLINATION

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B viral (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B. If at anytime I change my mind and would like to receive the Hepatitis B vaccine, I may contact my Personnel Health Department and receive the Hepatitis B vaccine at no cost to myself.

_____

Signature Date

CONSENT FOR RELEASE OF INFORMAITON

I hereby authorize **DEPARTMENT OF VETERANS AFFAIRS - PERSONNEL HEALTH**

Name of Doctor/Hospital: 10701 EAST BLVD., CLEVELAND, OHIO 44106

TEL: (216) 791-3800 EXT. 6365/3813/4411

FAX: (216) 231-3262

To release information from the records of:

Name of Patient: _____

Social Security #: _____

Date of Birth: _____

To be released to: ◯ SELF

◯ _____

_____

_____

_____

This information will be used to assist our medical staff in the examination and/or treatment of the patient named above. The information to be released is:

◯ Final Summary or report of hospitalization _____ Date

◯ Brief report of examination or treatment _____ Date

◯ X-ray films and/or reports (X-ray filmls and lab slides will be returned after review.

◯ Psychiatric Evaluation _____ Date

◯ Drug/Alcohol abuse

◯ Other: _____

_____

_____ _____

Signature of Patient Date

_____ _____

Witness Date

I autthorize you to release the medical information requested above to the Department of Veterans Affairs. I understand that I may revoke this authorization at any time except to the extent that action has already been taken to comply with it. Without my expressed revocation this consent will automatically expire after the requested information has been supplied to the Department of Veterans Affairs. Re-disclosure of my medical records by those receiving the information authorized above may not be accomplished without further consent.

LICENSED HEALTH CARE PRACTITIONER OPINION

Part A. TO BE COMPLETED BY APPLICANT OR EMPLOYEE		
1. Name (Last, First, Middle Initial)		
2. Federal Employee Number	3. Sex ☐ Male ☐ Female	4. Birth Date *(month, day, year)*
6. Address (including City, State, Zip Code)		
7. E-mail Address	8. Telephone Numbers (with Area Code)	

FOR AGENCY USE ONLY	
Part D. TO BE COMPLETED BY AGENCY MEDICAL OFFICER (if one is available) NOTE: Review the attached certificate of medical examination and make your recommendations in item 1 below.	
1. Recommendation: ☐ Hire or retain; describe limitations, if any, here. ☐ Take action to separate or do not hire; explain why.	
2. Agency Medical Officer's Name	3. E-Mail Address
4. Address (Including Street, City, State and ZIP Code)	5. Telephone Number
6. Signature of Agency Medical Officer	7. Date (Month, Day, Year)

The above recommendation from the Agency Medical Officer applies to the following program:

_____ Animal Allergy

_____ Driver Exam

_____ Other - specify: _____

MEDICAL CLEARANCE WILL EXPIRE ONE YEAR FROM THE DATE OF THE AGENCY MEDICAL OFFICER'S RECOMMENDATION UNLESS OTHERWISED NOTED.

☐ RENEWAL OF MEDICAL CLEARANCE CAN BE COMPLETED WITHOUT IN-OFFICE VISIT THROUGH COMPLETION OF ANNUAL QUESTIONNAIRE, PLEASE SEND TO PERSONNEL HEALTH 170(W)

☐ APPLICANT IS DUE FOR NEXT IN-OFFICE MEDICAL EVALUATION ON: _____

Louis Stokes Cleveland VA Medical Center
Personnel Health
Laboratory Animal Allergy Clearance – Initial

Employee Name: _____
Last **First** **Middle Initial**

PI/Supervisor: _____

Date of Physical: _____

_____ _____
Print Name **Signature**
Personnel Health Medical Staff **Personnel Health Medical Staff**

Please return this page to: **Medical Research Service 151(W)**
Room K115
Louis Stokes Cleveland
Veterans Affairs Medical Center
10701 E. Blvd
Cleveland, Ohio 44106