Animal Workers Medical Surveillance
Consent for Medical Screening/Evaluation

Completed Consent Form should be submitted to IACUC@uidaho.edu or delivered to Office of Research Assurances, Morrill Hall.

Directions: *Complete this form to authorize a medical history screening/medical evaluation as part of the University of Idaho's Animal Workers Medical Surveillance Program.*

I, _____, agree to provide my medical history and/or make myself available for a medical evaluation, in accordance with the University of Idaho Animal Workers Medical Surveillance Program ("AWMSP"). I understand that a medical history screening and/or medical evaluation will be performed by the University of Idaho's provider under contract for this program (contractual medical provider)*, at the direction and expense of University of Idaho. I understand that my medical history and the results of the medical evaluation will become a confidential part of my medical record to be retained by the contractual medical provider.

I understand that my medical history and records of my medical evaluation, including any medical conditions, will not be disclosed to the University and will not become a part of my personnel file or educational record, as applicable, at the University of Idaho. The contractual medical provider will, upon my request, provide me with access to my medical records in its possession as a result of my participation in the AWMSP.

I understand and agree that the contractual medical provider may use my medical history and/or medical evaluation for identification of possible health conditions that may impact my work with animals and/or for the identification of health and safety measures deemed necessary for my work with animals at the University.

I understand that the contractual medical provider, after undertaking screening of my medical history and/or a medical evaluation as part of the AWMSP, will communicate to the University its recommendations regarding health and safety measures it deems necessary for my work with animals, and I consent to such disclosures.

Any additional expense for personal medical diagnosis or treatment of conditions discovered through this medical surveillance program and not related to my work with animals shall be my responsibility. Any medical treatment of conditions identified shall be my responsibility.

I hereby grant the contractual medical provider permission to perform such screenings, examinations, and medical tests as may be deemed professionally necessary or advisable relating to University sanctioned animal work and my participation in the AWMSP.

*For purposes of this consent "contractual medical provider" includes the University-contracted provider as well as your personal medical provider of choice, to the extent that your provider is involved in any follow-up screening or treatment in connection with the AWMSP.

Employee's Signature:_____ Date:_____/_____/_____

E-Mail (UI Preferred):_____ V Number:_____

Home Phone:_____ Work Phone:_____

Address:_____ City/State/Zip:_____

Department:_____ Billing Index:_____

Supervisor (Print & Sign):_____