

Instructions on Application for Observer/Trainee (OTVS)

The University of Texas Health Science Center at Houston (UTHealth) welcomes visiting colleagues and students from across the United States and around the world for research and educational collaboration, observation, and study.

A **Visitor** is an individual who, though **uncompensated by UTHealth**, may be given access to UTHealth property, facilities and/or information systems, at the discretion of UTHealth, for a specific period of time for collaborative or educational purposes. Visitors may not perform any patient care. Visitors are **not considered, employees, and are not entitled to wages or benefits**. There are five categories of Visitors to UTHealth: Guest, Observer, Pre-Baccalaureate Trainee, Professional Trainee, and Visiting Student Trainee.

- A **Guest** is a Visitor who is at UTHealth **for a short term** (generally less than one week) and **for a specific event** (e.g., serving as a guest lecturer, site visitor or similar event) at the invitation of UTHealth. The intake and supervision of Guests is a school responsibility. Schools are not required to submit an application to the UTHealth administration for Guests. Guests may **not** be issued an access badge and must be escorted by UTHealth employees while on campus. The host department should inform the guest of possible exposure risks, protective measures, and personal responsibility for any costs of needed healthcare.

To apply for one of the following Visitor categories, the Applicant must first identify a Faculty Sponsor at UTHealth. The Applicant and Faculty Sponsor must complete this Application, receive departmental and school approvals, and submit it to the UTHealth administration for review and approval:

- An **Observer** is a Visitor who observes UTHealth operations for educational purposes. The observer's experience is strictly to watch, listen and learn. Observers may not provide clinical care and may not participate in or perform research, data collection or other hands-on activities. The duration of the observation period is limited to no more than two months in any one department/division. Observers may observe in up to three different divisions/departments, for a cap of six months in any five-year period. A non-refundable \$750 USD (\$775 USD if paid by wire transfer) application processing fee is required for a foreign* Observer.
- A **Pre-Baccalaureate Trainee** is a Visitor who is a high school or undergraduate student seeking non-clinical hands-on training at UTHealth. The main purpose of the training is to learn how to conduct research, data collection, and participate in other non-clinical hands-on activities, appropriate to their educational qualifications. Pre-Baccalaureate Trainees may observe clinical practices but *cannot* provide patient care or have any type of direct patient contact (i.e., taking patient history, etc.). The duration of training is limited to no more than four months in any one division/department. Pre-Baccalaureate Trainees may train in up to three different divisions/departments, for a cap of twelve months in any five-year period.
- A **Professional Trainee** is a Visitor who holds an undergraduate or higher degree and is seeking additional non-clinical hands-on training. The Professional Trainees' experience is mainly to receive specific training in research and health education, appropriate to their educational qualifications, such as to learn how to conduct research, data collection, and participate in other non-clinical hands-on activities. Professional Trainees may observe clinical practices but *cannot* provide patient care or have any type of direct patient contact (i.e., taking patient history, etc.). The duration of training is limited to no more than four months in any one division/department. Professional Trainees may train in up to three different divisions/departments, for a cap of twelve months in any five-year period. A copy of the applicant's diploma (highest degree) must be submitted with the application. A non-refundable \$750 USD (\$775 USD if paid by wire transfer) application processing fee is required for a foreign Professional Trainee.
- A **Visiting Student Trainee** is a Visitor who is currently enrolled in an undergraduate, graduate, or professional degree program at another institution of higher education while seeking non-clinical hands-on training at UTHealth, *and who is not registered and enrolled in an official course at UTHealth.* The training at UTHealth must

fulfill an educational requirement of the program in which the visiting student trainee is enrolled. The main purpose of the training is to learn how to conduct research, data collection, and participate in other non-clinical hands-on activities. Visiting Student Trainees may observe clinical practices but *cannot* provide patient care or have any type of direct patient contact (i.e., taking patient history, etc.). A letter from the applicant's home institution confirming the applicant's enrollment, good standing and educational requirement must be submitted with the application. An Agreement may be required before the visit can begin. UTHealth will make this determination during the application review process and will advise if required. The duration of training is limited to no more than one year in any one department/division.

* *"Foreign"* in this document refers to individuals who are not U.S. citizens or U.S. permanent residents.

In addition, please note:

- UTHealth conducts security background checks on all applicants.
- Approval of this application is at the discretion of the Executive Vice President & Chief Academic Officer (EVPCAO) of UTHealth. An Applicant in any of the above categories **may not begin their visit at UTHealth until the application is approved by the Office of the EVPCAO, and all intake processes are complete.**
- **It is the responsibility of non-U.S. citizens/permanent residents to have a visa appropriate for the visitor category they are applying for.**
- Foreign nationals, who are not U.S. citizens or U.S. permanent residents, must **check-in with the UTHealth Office of International Affairs with all original immigration documents to obtain appropriate written clearance to begin appointment.**
- Minors (individuals under the age of 18) must submit additional paperwork to be considered, as described in UTHealth's policy on Minors in the Workplace (<https://www.uth.edu/hoop/policy.htm?id=1448176>). **Applicants must be at least 16 years old on the start date.**
- Any Visitor participating in human subjects or animal research must complete the applicable, required UTHealth training.
- It is mandatory that all applicants submit the appropriate UT Health Form(s) fully completed and signed (with supporting documentation as requested on the form(s), including English translations, if applicable).
- All applicants who will be in a clinical setting and/or have access to patient information/records shall read and acknowledge the "[HIPAA Overview and Information Safeguards](#)" at: www.uth.edu/evpara/otvs.
- UTHealth schools and departments may charge separate fees to participate in the visitor program.

This process does not apply to individuals seeking an official medical elective or to current students who are enrolled through the Registrar of UTHealth.

IMPORTANT NOTICE – Application Fees for foreign Observers and foreign Professional Trainees:

- A processing fee of \$750 USD (if paid by money order) or \$775 USD (if paid by wire transfer) per application will be required to all foreign Observers and foreign Professional Trainees.
- This fee is non-refundable and non-transferable.
- The fee must be paid with the application in order to process the application. It can be paid using a money order drawn on a U.S. bank and made payable to "UTHSC-H." Wire transfers can be done upon request; please contact the administrative coordinator for your Faculty Sponsor in order to receive the instructions. Applicants shall be responsible for payment of any wire transfer's fees.

Required documents for Observer/Trainee (OTVS)

The Office of the EVPCAO requires at least eight (8) weeks to review and process applications. Please note that incomplete applications will not be processed until all required documents are received. Application should be submitted no more than six (6) months prior the proposed dates.

Applicant - Required Documents Checklist	
<i>Please submit the following documents to your sponsoring department.</i>	√
A completed applicant section of this application typed (pages 1-4)	
Copy of photo identification:	
For U.S. citizens: Copy of federal or state-issued photo identification	
For U.S. permanent residents: Copy of Permanent Resident Card (Green Card)	
For non-U.S. citizens/permanent residents: Copy of passport identification page, U.S. visa stamp, Immigration forms (I-20, DS-2019, I-797, etc.) and Form I-94 (if applicable)	
Résumé or C.V. (in English, listing academic history, certifications, licensures, employment, and training experience)	
Health form(s) (with supporting documentation as requested on the form, including English translations, if applicable)	
<i>For Professional Trainee:</i>	
Copy of diploma (highest degree, with English translation if applicable)	
<i>For Visiting Student Trainee:</i>	
A letter, from the Applicant's home institution, confirming enrollment, good standing and educational requirement (on official letterhead, dated and signed)	
<i>For Applicants under the age of 18:</i>	
Clearance Request for Minors in the Workplace (form available from the sponsoring department)	
**FOREIGN Observer & Professional Trainee: non-refundable \$750 USD application processing fee (\$775 USD by wire transfer)	

If you have questions concerning the status of your application at any time, please contact the administrative coordinator for your Faculty Sponsor.

Department - Required Documents Checklist	
<i>Please submit the following documents to the Office of the EVPCAO.</i>	√
The Applicant's completed section (pages 1-4) with the required supporting documents.	
Faculty section (pages 5-6), typed and signed	
<i>For Pre-Baccalaureate Trainee and Professional Trainee:</i> Trainee Plan	
Health Clearance Email (see page 7 for instructions)	



For Office Use Only	Application #: _____
Additional Agreement Required: Yes No	
Export Control _____ OIA _____ Privacy Officer/MHH _____	
Animal Care _____ Human Subjects _____ Minor _____	

Application for Observer / Trainee (OTVS): Applicant Section

Applicant Section

Must be typed and all fields filled-out.

APPLICANT'S NAME:

Last (Family, Surname)

First (Given)

Middle

PROPOSED APPOINTMENT DATES:

FROM:

TO:

month/day/year

month/day/year

(start date should be at least eight (8) weeks from the day that the application is submitted)

UTHealth SCHOOL: _____

UTHealth DEPARTMENT/DIVISION: _____

UTHealth FACULTY SPONSOR: _____

Please select your citizenship status: *(check only one)*

U.S. Citizen

U.S. Permanent Resident (Green Card)

Country of Citizenship: _____

Foreign nationals (non-U.S. Citizen, non-U.S. Permanent Resident, Asylum, U.S. visa holders, etc)

Country of Citizenship: _____

Please check the category of your desired association (see "Instructions" for category definitions): *minimum 16 years old*

Observer

Two (2) month limit *(processing fee required for foreign observer**)*

Professional Trainee

Four (4) month limit *(processing fee required for foreign professional trainee**)*

Pre-Baccalaureate Trainee

Four (4) month limit

Visiting Student Trainee

Name of educational institution in which you are currently enrolled as a student:

This institution is: public or private Degree: _____ Graduation Date _____

Biographical Information

Full Legal Name: _____
Last (Family, Surname) First (Given) Middle

Gender: Male Female Date of Birth: _____
month / day year

Permanent Mailing Address: _____
No. and Street Apartment No.

City State/Province Zip/Postal Code Country

Phone E-mail Address

Houston Area Address: _____
(if known, and if different from Permanent Address) No. and Street Apartment No.

City State Zip Code

Local Phone Number E-mail Address

Emergency Contact Information: _____
Full Name Relationship

Phone E-mail Address

Have you ever had a felony or equivalent criminal conviction? Yes (attach details of conviction, including dates) No

Have you ever been and/or are you currently at UTHealth? Yes No

If yes: In what capacity? (Student, Observer, Trainee, Employee, Postdoctoral Fellow, Volunteer, etc.) _____
Please list all previous appointments; add additional pages if needed.

Dates: _____ - _____ Name of Faculty Sponsor: _____
month/day/year - month/day/year

School/Department: _____

Statement of Intent

Please state the objectives of your association, as well as the benefits you expect to receive from this experience.
Please provide detailed information on how you have selected UTHealth for your visit:

For foreign nationals who are not U.S. citizens or U.S. permanent residents:

Passport #: _____ Exp. Date: _____ Issued by (country): _____
month/year

Country of Birth: _____ Country of Last Legal Permanent Resident: _____

Country of Citizenship: _____

Do you currently have a valid U.S. visa status? Yes No If yes, what type? _____ Exp. Date: _____
month/day/year

Are you currently in the U.S.? Yes No If yes, I-94# (11-digits): _____ Exp. Date: _____
month/day/year

Do you have a U.S. Social Security Number? Yes No *If yes, you will be contacted at a later time to provide it directly to a third party who process the background check (please do not write your U.S. Social Security number here).*

Please note:

- Non-Immigrant Visa Holders may **not** begin their association with UTHealth until their application is approved by the EVPCAO and their visas are reviewed and written clearance is granted by the Office of International Affairs (OIA) to begin appointment.
- **Non-Immigrant Visa Holders must have a valid U.S. immigration visa status sufficient for the full period of the proposed appointment.**
- Applicants holding temporary visas are bound by the restrictions placed on UTHealth by the U.S. Department of Homeland Security and the U.S. Department of State.
Applicants needing assistance from UTHealth in obtaining a U.S. J-1 Exchange Visitor visa must first be accepted to the program. If accepted, the inviting department must submit the complete J-1 sponsorship packet to OIA: <http://www.uth.edu/international-affairs/exchange-visitors-j-1/new.htm>.
- Please direct visa-related inquiries to the Office of International Affairs at utoiahouston@uth.tmc.edu or (713) 500-3176.

Acknowledgements - Read the following statements carefully before signing.

UTHealth takes your privacy seriously and will only use your personal information to administer your application.

UTHealth collects personal information listed in the application. UTHealth needs to know your personal information to process your application. UTHealth will not collect any personal data from you UTHealth does not need to process your application. All of the personal data UTHealth collects is processed by UTHealth personnel. No third parties have access to your personal data. UTHealth maintains secure information technology to keep your information safe while UTHealth has it. UTHealth is required to keep your information for five years after you have left the institution.

In consideration of UTHealth allowing me to participate in this association and for other good and valuable consideration, I agree and attest as follows:

- I certify that I have requested and am entering into this association without any promise or expectation of financial compensation or offer of employment or other appointment by UTHealth.
- I understand that all application material submitted to UTHealth becomes the property of UTHealth and is not returnable. I also understand that UTHealth is not obligated to furnish me with duplicate copies.
- I understand that the information submitted herein will be relied upon by UTHealth to determine my status for eligibility for this association. I authorize UTHealth to verify the information I have provided. I understand that any omission of requested data may jeopardize my consideration for this association with UTHealth. I agree to notify the proper UTHealth officials of any changes in the information provided.
- I release from liability and from any restrictions as to confidentiality or privacy all hospitals, schools, physicians, employers, individuals, agencies, or organizations that provide information about me at the request of UTHealth or its agents.
- I affirm and agree that at all times during my association with UTHealth and at any time while on the premises of UTHealth, I will comply with all applicable federal, state and local laws and regulations and all policies and procedures of UTHealth, including but not limited to all policies contained in the [Handbook of Operating Procedures](#) (HOOP) and the [Rules and Regulations of The University of Texas System Board of Regents](#).
- I agree to complete at UTHealth any and all required training relevant to my association with UTHealth, including but not limited to training on [safety](#), [human subjects](#), and [animal handling](#).
- I have reviewed and understand the “[HIPAA Overview and Information Safeguards](#)” document at <https://uth.edu/evpara/otvs/>.
- I agree to comply with the privacy and security rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and UTHealth’s policies regarding the privacy of individually identifiable health information, including but not limited to those contained

in [HOOP Policy 206 Privacy of Individually Identifiable Health Information](#) and the [Policy and Procedure Manual for the Confidentiality of Health Care Information](#).

- I. I understand that I may become aware of or acquire information that is the intellectual property of UTHealth and which may be confidential and/or proprietary in nature (“UTHealth IP”). This intellectual property may consist of unpublished results, know-how, non-patentable information, patentable or other written or orally transmitted information. I agree to hold all such UTHealth IP in confidence and further agree that no UTHealth IP that I have become aware of or that has been acquired by me will be transmitted by me in any form to a third party.
- J. To the extent an invention or other intellectual property arises from my association with UTHealth, the invention and intellectual property will be automatically owned by UTHealth. I hereby assign any and all inventions and creations, whether or not patentable, that are created by me during the term of this association (the “Intellectual Property”) to the Board of Regents of the University of Texas System (“Board”), on behalf of UTHealth. I agree to sign any and all documentation that is required to perfect or evidence this assignment and all documents reasonably necessary for the Board and UTHealth to protect Intellectual Property. Unless otherwise agreed by the parties in writing, neither I nor my Home Organization will be entitled to receive from UTHealth or the Board any compensation for the assignment of any Intellectual Property or any portion of royalties or proceeds generated from any Intellectual Property.
- K. I understand that (i) certain data, technologies, and products are subject to U.S. laws and regulations controlling the export of technical data, computer software, laboratory prototypes, and other items (including but not limited to the [Arms Export Control Act](#), as amended, the [Export Administration Regulations](#), and [U.S. economic sanctions](#)) and (ii) my observation of UTHealth activities is contingent on my agreement to comply with such laws and regulations. I hereby agree to comply with all such laws and regulations.
- L. I agree that I am not authorized to engage in (i) the diagnoses of disease or other conditions in humans; or (ii) the cure, mitigation, therapy, treatment, treatment planning, or prevention of disease in humans or to affect the structure or function thereof, irrespective of whether or not I am certified or qualified for any of the foregoing.
- M. I represent and certify that (a) I am not a person who has been designated as a specifically designated national or blocked person under applicable U.S. law or regulation, and (b) neither I nor any entity with which I am employed or otherwise affiliated is (i) a person or entity with whom U.S. persons or entities are restricted from doing business under U.S. law, executive power, or regulation promulgated thereunder by any regulatory body, or (ii) in violation of any U.S. money laundering law.
- N. I understand that I will be subject to a background check in accordance with UTHealth’s policy on [Criminal Background Checks](#).
- O. I understand that my association with UTHealth may be revoked at any time by UTHealth without cause and without advance notice to me.
- P. I agree to indemnify, release, and hold UTHealth and The University of Texas System, their Regents, officers, agents, and employees, harmless from and against any loss, claim, damage, injury, or liability of any kind arising out of or in connection with my association with or presence at UTHealth.
- Q. I certify that the information in the application is complete and correct to the best of my knowledge and belief. I acknowledge the submission of any false information is grounds for rejection of my application or termination of my association with UTHealth.

Signature of Applicant _____ **Date** _____
(handwritten signature required)

Note - **For Applicants under the age of 18:** parent or legal guardian must also sign the application.

Signature of Parent or Legal Guardian Printed Name Date

For FOREIGN Observers and Professional Trainees

The non-refundable application processing fee is required with the application. Do not send personal check or cash

Method of payment: \$750 USD Money order drawn on a U.S. bank and made payable to: UTHSC-H; or

\$775 USD Wire transfer sent on _____ (date), reference # _____

Please contact the administrative coordinator for your Faculty Sponsor in order to receive the instructions for wire transfer.

For office-EVPCAO use only

Payment received on: _____ **by** _____

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Please attach all other required documentation (see checklist) to this application before submitting to the sponsoring department for review.

NOTE: *If this application is approved by the EVPCAO, the Applicant may come to UTHealth for the purposes stated herein, contingent upon an appropriate visa being obtained (if applicable) and any additional agreements being successfully executed (if applicable). Once all the paperwork is in order, the Applicant must also complete the following intake process **before starting the visit:***

- 1) Visa clearance by Office of International Affairs (for foreign nationals only)
- 2) Check-in with Human Resources to obtain their ID badge.

Request for Observer / Trainee (OTVS): Department Section

Department Section

Must be typed and completed by the UTHealth sponsoring department.

Faculty Sponsor:

Printed Name: _____ Phone Number: _____

Title: _____

Department/School: _____ E-mail Address: _____

Administrative Support Contact:

Printed Name: _____ Phone Number: _____

Title: _____

E-mail address: _____ Building Code/Room Number: _____

Planned Activities:

Select all area(s) where the applicant will be: *(please select all applicable)*

Clinical setting

Office

Research lab

Other, specify: _____

Number of Days per Week: _____ Number of Hours per Day: _____

Please provide information if the Applicant's visit is related to an existing agreement/collaboration:

Faculty's Statement of Intent

Please describe briefly, but specifically, what activities the applicant will do at UTHealth. Attach additional pages as needed.

For Pre-Baccalaureate and Professional Trainees, please attach the UTHealth Trainee Plan.

Compliance and Safety Considerations:

For all applicants (Observers and Trainees):

- Will Applicant be in a clinical setting and/or have access to patient records/information? Yes No
- Will Applicant be exposed to human blood, body fluids or other material potentially infected with bloodborne pathogens? Yes No
- Will Applicant be present in a lab/clinic setting where potentially hazardous materials may be used? Yes No
- If yes, will the Applicant be exposed to or handle:
 - Chemicals? Yes No
 - Potentially infectious materials or specimens? Yes No
 - Sources of radiation? Yes No

For Trainees only (Observers may not engage in human subjects, animal or clinical research):

- Will the Applicant handle animals? Yes No
- Will the Applicant participate in human subjects research? Yes No

NOTE: If yes to any of the above, it is the Faculty Sponsor’s responsibility to ensure that the Visitor receives all proper safety and compliance training. Please contact Safety, Health, Environment & Risk Management (SHERM) at 713-500-8100, the Office of Research Support Committees (ORSC) at 713-500-7943, and Privacy Officer at (713) 500-3305 to determine training needs.

Security Considerations: All Visitors must obtain a UTHealth badge issued by HR and display it at all times. The sponsoring department is responsible to collect the badge upon the completion of applicant’s appointment.

Which building access is needed? _____ Expected access hours needed: _____

Does the Faculty Sponsor have any export controlled technology, data, information and/or equipment in the area where the Visitor will be located? If yes, please call Legal Affairs at 713-500-3268. Yes No

Approval – Faculty Sponsor

I certify that I have reviewed the Applicant’s background and references and believe the Applicant to be qualified and fit for this association with UTHealth. I agree to be responsible for the Applicant during his or her association with UTHealth and to ensure that he/she receives all required compliance and safety training (e.g., training on human subjects, animal handling, patient privacy) at the onset of the association. I will ensure that the Applicant’s activities will be strictly limited to those outlined and approved in this application. I certify that I have not implied and will not imply that a job offer or other appointment at UTHealth might result from this association. I certify that I will maintain proper oversight of these activities to ensure compliance with UTHealth rules and regulations. I agree to ensure that the Applicant’s UTHealth badge is collected and returned to Human Resources upon the completion of the association.

Signature of Faculty Sponsor	Printed Name	Date
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Approval – Department / School

I approve this application and confirm that this association is consistent with the university’s educational mission, and the activities are appropriate to the category selected.

Signature of Department Chair	Printed Name	Date
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NOTE: The sponsoring department *submits the completed application and Health Form(s) to UT Health Clinical Services (EHCS) by fax to 713-486-0983. EHCS will send a “Health Clearance email” once the applicant receives health clearance. This completed, signed application must be submitted with the required documentation, including the Health Clearance email and payment (if applicable), by email or hard copy, to the Office of the EVPCAO. The application will be routed to Human Resources for background check. The Office of the EVPCAO will notify the department when the process is complete.*

The Office of the EVPCAO requires at least eight (8) weeks to process applications; incomplete applications will not be processed until all required documents are received.

I. Health Clearance – UT Health Clinical Services (EHCS)

Health Screening by UT Health Clinical Services

Date: _____

II. Background Check

The following has been completed:

Background Check by Human Resources

Signature / Human Resources

Printed Name

Date

Visual Compliance screening (for foreign nationals only)

Signature

Printed Name

Date

III. Approval – Office of the Executive Vice President & Chief Academic Officer

I certify that this application is consistent with UTHealth’s policies and procedures.

Eric J. Solberg, MS

Vice President for Academic & Research Affairs

Date

This association is authorized, contingent upon:

- 1) no change in the Applicant’s health status which may adversely affect individuals in the UTHealth community;
- 2) an appropriate visa being obtained by the Applicant (for foreign nationals); and
- 3) the signing by all needed parties of an additional Affiliation Agreement or Visiting Agreement (if applicable).

Michael R. Blackburn, PhD

Executive Vice President & Chief Academic Officer

Date

Copy:

- Faculty Sponsor
- Human Resources
- Office of International Affairs (for foreign nationals only)

Copies distributed by:

Name: _____

Date: _____

UTHealth Trainee Plan (for Pre-Baccalaureate Trainee & Professional Trainee)

For Pre-Baccalaureate/Professional Trainee:

_____ Name

Training Plan:

Include activities and training outcomes that are appropriate to the Trainee's level of education.

I certify the following:

1. This training is similar to training which would be given in an educational environment;
2. This training experience is for the benefit of the trainee;
3. The trainee does not displace regular employees, but trains under close supervision of existing staff;
4. UTHealth derives no immediate advantage from the activities of the trainee; and on occasion its operations may actually be impeded;
5. The trainee is not entitled to a job at the conclusion of the training; and
6. UTHealth and the trainee understand that the trainee is not entitled to wages for the time spent in the training.

Faculty Sponsor

Date

University of Texas Employee Health Clinical Services
FOR THE FACULTY/DEPARTMENT SPONSOR:

All applicants must obtain health clearance from UT Employee Health Clinical Services (EHCS).

Please use the below matrix to inform the applicant which form(s) and immunization(s) are required.

The applicant must complete and submit the appropriate form(s) to the sponsored department. Then, the sponsored department will forward the application with the appropriate health form(s) to EHCS for clearance.

EHCS will contact the department if information is missing. Once the applicant is cleared, EHCS will send a "Health Clearance email" to the department; copy of that email must be included in the application.

For questions, please contact EHCS: phone 713-500-3254, fax 713-486-0983.

Risk-based Matrix of Required Health Forms, Immunizations, Tests for "Visitors" at UTHealth

Environment to be encountered	Observer	Professional or Pre-Baccalaureate Trainee	Visiting Scientist or Visiting Student Trainee
CATEGORY 1 Office or classroom setting	<u>VH-1 Form "Health History"</u>	<u>VH-1 Form "Health History"</u>	<u>VH-1 Form "Health History"</u>
CATEGORY 2 Research lab, <u>no</u> animals, <u>no</u> potential bloodborne pathogen exposures	<u>VH-1 Form "Health History"</u> • TB skin test	<u>VH-1 Form "Health History"</u> • TB skin test	<u>VH-1 Form "Health History"</u> • TB skin test
CATEGORY 3 Research lab, <u>no</u> animals, but <u>with</u> potential bloodborne pathogen exposures	<u>VH-1 Form "Health History"</u> • TB skin test	<u>VH-1 Form "Health History"</u> • TB skin test • Hep B series	<u>VH-1 Form "Health History"</u> • TB skin test • MMR • Tetanus/Tdap • Hep B series
CATEGORY 4 Research lab, <u>with</u> animals, but <u>no</u> potential bloodborne pathogen exposures	<u>VH-2 Form "Animal Exposure"</u> • TB skin test • MMR • Tetanus/Tdap	<u>VH-2 Form "Animal Exposure"</u> • TB skin test • MMR • Tetanus/Tdap	<u>VH-1 Form "Health History"</u> <u>VH-3 Form "Occupational Health Enrollment"</u> ** • TB skin test • MMR • Tetanus/Tdap
CATEGORY 5 Research lab, <u>with</u> animals, <u>with</u> potential bloodborne pathogen exposures	<u>VH-2 Form "Animal Exposure"</u> • TB skin test • MMR • Tetanus/Tdap	<u>VH-2 Form "Animal Exposure"</u> • TB skin test • MMR • Tetanus/Tdap • Hep B series	<u>VH-1 Form "Health History"</u> <u>VH-3 Form "Occupational Health Enrollment"</u> ** • TB skin test • MMR • Tetanus/Tdap • Hep B series
CATEGORY 6 Child Development Center (CDC), Data Collectors or Research Associates around K-12 schools	<u>VH-1 Form "Health History"</u> • TB skin test • MMR • Tetanus/Tdap • Seasonal Influenza (11/1-3/31)	<u>VH-1 Form "Health History"</u> • TB skin test • MMR • Tetanus/Tdap • Seasonal Influenza (11/1-3/31)	<u>VH-1 Form "Health History"</u> • TB skin test • MMR • Tetanus/Tdap • Seasonal Influenza (11/1-3/31)
CATEGORY 7 Direct patient contact	<u>VH-1 Form "Health History"</u> • TB skin test • MMR • Tetanus/Tdap • Seasonal Influenza (11/1-3/31)	<u>VH-1 Form "Health History"</u> • TB skin test • MMR • Tetanus/Tdap • Hep B series • Varicella • Seasonal Influenza (11/1-3/31)	<u>VH-1 Form "Health History"</u> • TB skin test • MMR • Tetanus/Tdap • Hep B series • Varicella • Seasonal Influenza (11/1-3/31)

Notes: *Occupational Health Program Enrollment applies when visitor is added to Animal Welfare Committee (AWC) research protocol.

CATEGORY 4 – Specifically includes Visitors to Center for Laboratory Animal Medicine and Care (CLAMC)

ALL SUPPORTING DOCUMENTS AND LAB REPORT MUST BE IN ENGLISH.

"Bloodborne pathogens" means pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV) and human immunodeficiency virus (HIV) (29 CFR 1910. 1030(b))

• TB skin test and/or chest xray required within the last 6 months, even if you received BCG vaccine as a child. **OR NEGATIVE QuantiFERON- TB Gold In-Tube test (QFT-GIT) or NEGATIVE T-SPOT**

- MMR Measles (rubeola) vaccine: (2 are required if born after January 1, 1957) or Positive rubeola titer (attach lab report)
- Mumps vaccine or Positive mumps titer (attach lab report)
- Rubella vaccine or Positive rubella titer (attach lab report)

• Tetanus/diphtheria or Tdap (Within last 10 years)

• Hepatitis B vaccine series (3 injections) or positive Hepatitis B surface antibody titer (attach lab report) or **Positive** Hepatitis B surface antibody titer (attach lab report)

• Varicella vaccine series (2 doses given at least 28 days apart) or Chicken pox disease (documented by health care provider) or positive Varicella titer (attach lab report)

VH-1 Form “Health History”



University of Texas Employee Health Clinical Services (EHCS)

Health History Questionnaire Form

TYPE OR PRINT CLEARLY

Name:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address:	City/State/ZIP/Country:	
Your Contact Number(s):	Your email:	
Your UTHealth Faculty Sponsor & Department/School:	Visitor Category:	

CONFIDENTIALITY STATEMENT: This form requires 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 EHCS. 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. All applicants must submit the completed form to their sponsored department, who will forward it to EHCS. Health Clearance will be sent, by email, to the sponsored department.

Please indicate your classification:

- Pre-baccalaureate trainee Visiting Student trainee Estimated length of stay _____ Months _____ Days
 Professional trainee Visiting Scientist Estimated length of stay _____ Months _____ Days
 Observer

Are you are visiting a laboratory, K-12 school, or be in a clinical setting? Yes No Don't Know Yet

(If “Yes”, proceed to 1.TB test below. If No, go to Page 2)

Your application will not be considered unless supporting documentation in English is included:

1. **Tuberculin (TB) skin test (PPD) required within the last 6 months, even if you received BCG vaccine.**
 - 1.1. Date of last TB skin test: _____ **(ATTACH DOCUMENTATION OR LABORATORY REPORT)**
 - 1.1.1. Result (mm) _____ Negative _____ Positive (measurement _____ mm if available)
 - 1.2. Have you ever had a positive tuberculosis (TB) skin test? Yes No If yes, when? _____
 - 1.2.1. Chest x-ray findings if PPD is positive (attach x-ray report) Date of chest x-ray: _____
2. **Hepatitis B Series. Three-dose series or laboratory report of positive hepatitis surface antibody titer (ATTACH DOCUMENTATION OR LABORATORY REPORT)**
 - 2.1. #1 _____ #2 _____ #3 _____
3. Tetanus/Diphtheria or TDAP. One dose within the past 10 years. Date of last vaccination: _____
4. MMR/Measles booster. Two (2) doses of measles vaccine if born after January 1, 1957, administered on or after your first birthday and at least 30 days apart. Or laboratory report of positive rubeola, mumps, and rubella titers. #1 _____ #2 _____
5. Varicella vaccine series (2 doses given at least 28 days apart) or Chicken pox disease (documented by health care provider) or positive varicella titer (attach lab report)
6. Seasonal influenza vaccination. Date _____ Attach evidence of vaccination.

Bloodborne Pathogen Exposure Questions:

1. While at The UTHealth, will you be exposed to human blood and bodily fluids? Yes No Don't Know Yet
 - 1.1. If you are a **visitor** and have a risk of being exposed to bloodborne pathogens while at the University; do you want UTHealth to provide the vaccine series at your expense, or perhaps refer you to another source for the vaccination series?
 Yes No Don't Know Yet



VH-2 Form “Animal Exposure”

University of Texas Employee Health Clinical Services (EHCS)

Animal Minimum Exposure Acknowledgement Form

TYPE OR PRINT CLEARLY

Name:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address:	City/State/ZIP/Country:	
Your Contact Number(s):	Your email:	
	What is the estimated length of stay at UTHealth? Days _____ Months _____	
UTHealth Faculty Sponsor:	UTHealth Department/School:	
Visitor Category:		
<p>The University of Texas Health Science Center at Houston (UTHealth) has provided me with the opportunity to review the handout, <i>Occupational Health for Individuals Exposed to Animals in their Studies or Work</i> (http://www.uthouston.edu/animal-research/osha.htm). The University of Texas Health Science Center at Houston (UTHealth) has provided me with the opportunity to review the on line <i>Basic Safety Orientation</i> (http://www.uthouston.edu/safety/training/hazard-communication.htm) video. I understand there may be risks associated with laboratory environments and animal exposures that could possibly result in illness or injury. Such risks include: physical, biological, chemical, and radiologic hazards. If I experience an illness or injury while I am visiting UTHealth, or I feel unsafe in any situation, I understand that I should notify my host or sponsoring agency immediately.</p>		
Your Signature:	Date:	

Please indicate your classification:

Observer

Pre-baccalaureate trainee

Professional trainee

Your application will not be considered unless supporting documentation (MUST BE IN ENGLISH) is included:

1. Minimum exposure visitors participating in activities involving Animal exposure are required to have and present proof of the following:
 - 1.1. **Tuberculin (TB) skin test (PPD) required within the last 6 months, even if you received BCG vaccine as a child.**
 - 1.2. Date of last TB skin test: _____ **(ATTACH DOCUMENTATION OR LABORATORY REPORT)**
 - 1.2.1. Result: _____ Negative _____ Positive (measurement _____ mm if available)
 - 1.3. Have you ever had a positive tuberculosis (TB) skin test? Yes No If yes, when? _____
 - 1.3.1. Chest x-ray findings if PPD is positive (attach x-ray report) Date of chest x-ray: _____
 - 1.4. MMR/Measles booster. Two (2) doses of measles vaccine if born after January 1, 1957, administered on or after your first birthday and at least 30 days apart. Or **laboratory report** of positive rubeola, mumps, and rubella titers.
 - 1.4.1. Dates of MMR booster (attach report) #1 _____ #2 _____
 - 1.5. Tetanus /Diphtheria or Tdap. One dose within the past 10 years Date of last Tetanus/Tdap: _____ **(Attach Report)**

All applicants must submit this completed form to their sponsored department, who will forward it to EHCS. Health Clearance will be sent, by email, to the sponsored department. You **MUST BE APPROVED by EHCS** prior to any animal exposure.



VH-3 Form "Occupational Health Enrollment"

University of Texas Employee Health Clinical Services (EHCS) Occupational Health Program Enrollment Form

Confidential Medical Information

TYPE OR PRINT CLEARLY

Name:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address:	City/State/ZIP/Country:	
Your Contact Number(s):	Your email:	
Your UTHealth Faculty Sponsor:	For visitors, what is the estimated duration of your stay at UTHealth? Visiting Student Trainee <input type="checkbox"/> _____ Months _____ Days Visiting Scientist <input type="checkbox"/> _____ Months _____ Days	
Visitor Category:	UTHealth Department/School:	

CONFIDENTIALITY STATEMENT: This form requests 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 Employee Health Services. 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 are not required to disclose this information and may decline enrollment at the end of this form.

Animal / Biological Agent Contact

Please indicate the animals you may be in contact with (check the box if you have contact with the specified animal).

Amphibians		Gerbils		Rats		Other list:
Birds		Goats		Rabbits		
Cats		Guinea Pigs		Reptiles		
Cattle		Hamsters		Sheep		
Dogs		Mice		Swine		
Ferrets		Non-Human Primate		Wild Rodents		
Fish		Poultry				

Please indicate tissue, blood, or biological agents that you may have contact with (check the appropriate box):

Do you have contact with primate tissues? Yes No

Do you have contact in an area where primates or primate tissues are housed or handled? Yes No

Do you have contact with human blood products? Yes No

Do you have contact with animal blood products? Yes No

Do you have contact with human tissue? Yes No

Do you have contact with animal tissue? Yes No

Do you have contact with recombinant DNA technology? Yes No

If yes, does the research involve techniques in which viable, recombinant DNA-containing micro-organisms are used to infect animals that require Bio-safety level 3 containment? Yes No

VH-3 Form "Occupational Health Enrollment"

Medical History

Have you had any changes in your health condition in the past year? Yes No

Do you have any breathing problems? Yes No

Do you have any heart problems? Yes No

Have you gained or lost 20 or more pounds in the past year? Yes No

Have you been told by a physician that you have an immune compromising medical condition or are you taking medications that impair your immune system (steroids, immunosuppressive drugs, or chemotherapy)? Yes No

For Women: Are you pregnant, or planning to be pregnant in the next year? Yes No

Animal Allergies

Have you had any recent problems with the following symptoms? Yes No

Please indicate which symptoms you have experienced:

Condition	Yes	No	Condition	Yes	No
Watery or itching eyes			Shortness of breath		
Runny nose			Chest tightness		
Sneezing			Rash or hives		
Wheezing			Chronic allergies (dust, pollen, food, mold)		
Chronic cough			Asthma		

Are these more frequent while at work? Yes No

Are these symptoms associated with:

Dogs	<input type="checkbox"/>	Cats	<input type="checkbox"/>	Cattle	<input type="checkbox"/>	Horses	<input type="checkbox"/>	Bird (Feathers)	<input type="checkbox"/>
Pigs	<input type="checkbox"/>	Primates	<input type="checkbox"/>	Rabbits	<input type="checkbox"/>	Goats	<input type="checkbox"/>	Sheep (Wool)	<input type="checkbox"/>
Rats or Mice	<input type="checkbox"/>	Guinea Pigs	<input type="checkbox"/>	Alfalfa	<input type="checkbox"/>	Weeds	<input type="checkbox"/>	Trees	<input type="checkbox"/>
Chemicals	<input type="checkbox"/>	Latex	<input type="checkbox"/>	Wood	<input type="checkbox"/>	Grasses	<input type="checkbox"/>	Mold	<input type="checkbox"/>
Other	<input type="checkbox"/>	List:	_____						

Have these symptoms required any treatment with over-the-counter medications (Claritin, Benadryl, decongestants, eye drops, etc.)? 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 while visiting? Yes No

Have you been treated by your own physician for allergies that began while visiting? Yes No

If you suspect you may have related allergies while visiting or have any other questions about your health status or this form, please contact UT Employee Health at 713-500-3248.

ACCEPTANCE: I agree to be enrolled in the Occupational Health Program at this time. I understand that I may change my status at any time in the future by calling Employee Health at 713-500-3248.

Signature for enrollment: _____ **Date** _____

DECLINATION: I decline to be enrolled in the Occupational Health Program at this time. I understand that I may enroll at any time in the future by calling Employee Health at 713-500-3248.

Signature for declination: _____ **Date** _____

**Please submit this completed form to your sponsored department, who will forward it to EHCS. Health Clearance will be sent, by email, to the sponsored department.