

## Instructions on Application for Visiting Student (VSt)

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

A **Visiting Student** is a student who is enrolled in an undergraduate, graduate or professional degree program at another institution of higher education (their “home institution”), who seeks an educational experience/training from UTHealth faculty and staff, at UTHealth facilities and/or UT Physicians Clinics, but is not registered and not enrolled in a course at UTHealth. The main purpose of the Visiting Student’s educational/training experience at UTHealth must be related to their current degree program and/or fulfill an educational requirement of the student’s home institution. Visiting Students receive specific training at UTHealth in research and/or health education, appropriate to their educational objectives and qualifications. The general purpose of the training is to learn how to conduct research, data collection, and participate in other non-clinical hands-on activities (visiting clinical educational experiences are only permitted as specified in a program agreement with the student’s home institution).

Visiting Students must remain enrolled, in good standing, at the home institution for the duration of their learning experience at UTHealth.

In order to comply with various accreditation requirements, an agreement with the applicant’s home institution will be required (before the training can begin) if the visiting student will receive credit for their educational/training experience at UTHealth and/or if the educational/training experience is related to an educational requirement from their home institution. UTHealth will make this determination during the application review process and will advise if required.

The duration of training is limited to a one year appointment, with enrollment verification required for each semester. Any requests for an extension beyond a one year appointment will be reviewed in the context of the visiting student’s degree requirements at their home institution.

A **Visiting Student**, though **uncompensated by UTHealth**, and not enrolled in UTHealth educational programs, may be given access to UTHealth property, facilities and/or information systems, at the discretion of UTHealth, for a specific period for approved training or educational purposes. Visiting Students are **not considered employees, and are not entitled to wages or benefits**.

To apply as Visiting Student, the Applicant must first identify a Faculty Sponsor at UTHealth. The Applicant and Faculty Sponsor must complete this Application, receive departmental/school approvals, and submit it to the UTHealth administration for review and approval.

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 (EVP/CAO) of UTHealth. An Applicant **may not begin their visit at UTHealth until the application is approved by the Office of the EVP/CAO, and all intake processes are complete.**
- **It is the responsibility of non-U.S. citizens/permanent residents to have a visa appropriate to be a Visiting Student at UTHealth.**
- 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.**
- **Applicants must be at least 16 years old on the start date.** 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>).
- 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 must read and acknowledge the "[HIPAA Overview and Information Safeguards](https://www.uth.edu/evpara/otvs)" at: [www.uth.edu/evpara/otvs](https://www.uth.edu/evpara/otvs).
- UTHealth schools and departments may charge separate fees to participate in the visiting student 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.*

## Required documents for Visiting Student (VSt)

**The Office of the EVP/CAO 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.**

<b>Applicant - Required Documents Checklist</b>	√
<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)	
Proof of current health insurance	
Letter, from the Applicant's home institution, confirming enrollment, and good standing; must be on official letterhead, dated and signed. If Visiting Student will receive credit at her/his home institution for the training at UTHealth: letter must also clearly specify the educational requirement and information on the related course. An updated letter must be submitted each semester.	
<i>For Applicants under the age of 18:</i> Clearance Request for Minors in the Workplace (form available from the sponsoring department)	

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

<b>Department - Required Documents Checklist</b>	√
<i>Please submit the following documents to the Office of the EVP/CAO.</i>	
The Applicant's completed section (pages 1-4) with the required supporting documents.	
Faculty section (pages 5-6-7), typed and signed	
Health Clearance Email from UT Health Services <i>The sponsoring department <b>submits the Health Form (and supporting documentation as requested on the form) 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.</b></i>	



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

## Application for Visiting Student (VSt): 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:** \_\_\_\_\_

- Visiting Student:**  Undergraduate  
 Graduate  
 Other: \_\_\_\_\_

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

Location of educational institution (City, State, Country): \_\_\_\_\_

This institution is: public  or private

Expected Degree: \_\_\_\_\_ Expected Graduation Date: \_\_\_\_\_

- Will you receive credit from your educational institution for your training/learning experience at UTHealth:
- Yes Please specify (course, etc):  
\_\_\_\_\_
- No Please specify how this training is related to your degree program:  
\_\_\_\_\_

**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: \_\_\_\_\_

## **Biographical Information**

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

Preferred Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
month / day year

Gender:  Male  Female  Other: \_\_\_\_\_

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: (add additional page if needed)

## **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 EVP/CAO 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](mailto: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



## Request for Visiting Student (VSt): 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:

**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



## UTHealth Trainee Plan – Faculty’s Statement of Intent

### **Detailed Training Plan:** *(attach additional pages as needed)*

Please describe briefly, but specifically:

- type of training the visiting student will receive
- activities the applicant will do at UTHealth
- expected training outcomes for the Visiting Student
- ability to accommodate the visiting student without impacting the department’s daily activities

## Application for Visiting Student (VSt): Faculty section - Addendum (COVID-19 form)

*Due to the current COVID-19 pandemic, the faculty sponsor must complete these additional questions in order for the Office of the EVP/CAO to conduct a meaningful review of the Visiting Student application. (add additional pages if needed)*

**Anticipated location(s) where the Visiting Student will be**

Lab/training building(s) and room number(s):

\_\_\_\_\_

Lab size in sq. ft: \_\_\_\_\_

Number of persons accessing the lab/training area each day and/or per shift:

\_\_\_\_\_

**What health/safety measures are in place, in the lab and/or area where the visiting student will receive their training or educational experience?**

**Please describe how the department will accommodate the visiting student by providing a safe learning environment:**

**Any additional comments:**

**By executing this document below, the department and Faculty Sponsor will ensure that the visiting student will be trained in the use of PPE (where appropriate) and other safety precautions in the context of the current COVID-19 pandemic.**

\_\_\_\_\_  
Faculty Sponsor – Signature

\_\_\_\_\_  
Date

**Compliance and Safety Considerations:**

- 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
- 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.*

**Approval – Faculty Sponsor**

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 visiting student;
3. The visiting student does not displace regular employees, but trains under close supervision of existing staff;
4. UTHealth derives no immediate advantage from the activities of the visiting student; and on occasion, its operations may actually be impeded;
5. The Visiting Student is not entitled to a job at the conclusion of the training; and
6. UTHealth and the visiting student understand that the visiting student is not entitled to wages for the time spent in the training.

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

**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

***If applicable (per School's guidelines):***

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 Dean (or Designee)

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

**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 EVP/CAO. The application will be routed to Human Resources for background check. The Office of the EVP/CAO will notify the department when the process is complete.

**The Office of the EVP/CAO 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: \_\_\_\_\_

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**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

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**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

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**Copy:**

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

**Copies distributed by:**

Name: \_\_\_\_\_

Date: \_\_\_\_\_



**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 Visiting Students at UTHealth**

Environment to be encountered	Visiting Student
Office or classroom setting	<a href="#">VH-1 Form “Health History”</a>
Research lab, <u>no</u> animals, <u>no</u> potential bloodborne pathogen exposures	<a href="#">VH-1 Form “Health History”</a> • TB skin test
Research lab, <u>no</u> animals, but <u>with</u> potential bloodborne pathogen exposures	<a href="#">VH-1 Form “Health History”</a> • TB skin test • Hep B series • MMR • Tetanus/Tdap
Research lab, <u>with</u> animals, but <u>no</u> potential bloodborne pathogen exposures	<a href="#">VH-1 Form “Health History”</a> <a href="#">VH-3 Form “Occupational Health Enrollment”*</a> • TB skin test • MMR • Tetanus/Tdap
Research lab, <u>with</u> animals, <u>with</u> potential bloodborne pathogen exposures	<a href="#">VH-1 Form “Health History”</a> <a href="#">VH-3 Form “Occupational Health Enrollment”*</a> • TB skin test • MMR • Tetanus/Tdap • Hep B series
Direct patient contact	<a href="#">VH-1 Form “Health History”</a> • MMR • Tetanus/Tdap • TB skin test • Hep B series • Varicella • Seasonal Influenza

**ALL SUPPORTING DOCUMENTS AND LAB REPORT MUST BE IN ENGLISH.**

Notes:

- \*Occupational Health Program Enrollment occurs when visitor is added to Animal Welfare Committee (AWC) research protocol.
- 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))
- 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)
- 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)
- Bacterial Meningitis (Meningococcal) vaccine (within past 5 years)
- TB skin test/+ 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**
- 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)

# 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:

Visiting Student

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-3 Form “Occupational Health Enrollment”

## University of Texas Employee Health Clinical Services 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 Supervisor or Sponsoring Agency:	For visitors, what is the estimated duration of your stay at UTH? Visiting Student Trainee <input type="checkbox"/> _____ Months ____ Days Visiting Scientist <input type="checkbox"/> _____ Months ____ Days	
Job Title:	UTH 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.

### Hepatitis B Vaccination or Declination

**Have you completed the three-shot series of Hepatitis B vaccine in the past?**

- Yes     No  
 I do not remember

If you responded yes or if you do not remember, would you like to complete a titer test with Occupational Health to confirm your immunity?

- Yes     No

**Please select one of the following two options:**

**Option 1: I consent to receive the Hepatitis B Vaccination.**

I understand that I must have three doses of vaccine to confer immunity.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Option 2: I decline to receive the Hepatitis B Vaccination.**

“I understand that due to my occupational exposure to blood or other potentially infectious materials (OPIM), I may be at risk of acquiring Hepatitis B (HBV) infection. Although I have been given the opportunity to be vaccinated with Hepatitis B vaccine at no charge to myself, 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, a serious disease.

If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with the Hepatitis B vaccine or to confirm my immunity, I can receive the vaccination series or titer test at no charge to me.”



# VH-3 Form "Occupational Health Enrollment"

Please check one of the following:

- I am declining the vaccination because I have received the vaccination in the past.
- I am declining the vaccination due to a medical contradiction.
- I am declining the vaccination for personal reasons.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Animal / Biological Agent Contact

**Please indicate tissue, blood, or biological agents that you work or will be working with (check the appropriate box):**

Do you work with primate tissues? Yes  No

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

Do you work with human blood products? Yes  No

Do you work with animal blood products? Yes  No

Do you work with human tissue? Yes  No

Do you work with animal tissue? Yes  No

Do you work 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

If you are not working with animals, you do not need to complete the rest of the form.

**Please indicate the animals you work or will be working with (check the box if you work 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				

## 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

# VH-3 Form "Occupational Health Enrollment"

**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 work? Yes  No

Have you been treated by your own physician for allergies that began at work? Yes  No

**If you suspect you may have work related allergies or have any other questions about your health status or this form, please contact UT Employee Health at 713-500-3254.**

**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 713-500-3254.**

**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 713-500-3254.**

**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.