



# ENROLLMENT FORM/OCCUPATIONAL HEALTH AND SAFETY PROGRAM

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
**PLEASE PRINT** (Last, First, Middle initial)

Are you an OSU employee? \_\_\_\_\_ CWID #: \_\_\_\_\_

If not, please explain: \_\_\_\_\_

Title: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Email: \_\_\_\_\_ Department: \_\_\_\_\_

Work Phone # \_\_\_\_\_ Work Address \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: Male Female

**Please check all of the following that apply to you:**

I work with potentially hazardous chemicals

I work with biohazardous agents: BSL1 BSL2 BSL3

I work with genetically engineered materials

I have Security Risk Assessment clearance for the select agent and toxin program: (**check all that apply**)

I work directly with select agents and/or toxins that are infectious/toxic to humans

I work directly with select agents and/or toxins that are non-infectious/toxic to humans

I enter spaces where work is performed with select agents and/or toxins that are infectious/toxic to humans

I handle select agent and/or toxin packages

I do not enter spaces where select agent and/or toxin work is performed

I work with radioactive materials or X-ray machines

I work with compounds whose safety is unknown

I work with animals: ABSL1 ABSL2 ABSL3 (**check all that apply**)

Amphibians, reptiles, fish

Birds

Cattle, Horses, Pigs

Dogs, Cats, Ferrets

Nonhuman primates

Rodents, Rabbits

Sheep, Goats

Wildlife/Other \_\_\_\_\_

**To be completed by UHS**

- |                                       |                                      |
|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Category I   | <input type="checkbox"/> Category VI |
| <input type="checkbox"/> Category II  | <input type="checkbox"/> A           |
| <input type="checkbox"/> Category III | <input type="checkbox"/> B           |
| <input type="checkbox"/> Category IV  | <input type="checkbox"/> C           |
| <input type="checkbox"/> Category V   | <input type="checkbox"/> D           |

Med Questionnaire on file \_\_\_\_\_ (date)

Serum banked \_\_\_\_\_ (date)

No medical evaluation required

Med. Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

**List** chemical hazards, biohazards or radioisotopes you use

\_\_\_\_\_  
\_\_\_\_\_

Employee

Supervisor Signature