

FORM 4
MEDICAL SURVEILLANCE REPORT

Name of the organization: _____

IBSC code: _____

Name of the personnel: _____ Designation _____

Department _____ Phone _____ Email: _____

Date _____ DOB _____

I. CONTACT WITH PRODUCTS OF rDNA TECHNOLOGY

1. Please indicate rDNA products, tissue, blood, or biological agents that you work with (tick yes or no).

i. Do you work with recombinant DNA technology? Yes No

If yes, please specify _____

ii. What is the biosafety containment level requirement of organisms handled by you?

BL-1 BL-II BL-III BL-IV

iii. Do you work with human blood products or human tissue? Yes No

If yes, please specify _____

iv. Do you work with animal blood products or animal tissue? Yes No

If yes, please specify _____

II. MEDICAL HISTORY

i. Have you had any change in your health status in the previous year? Yes No

If yes, please describe _____

ii. Have you developed any chronic illness in the past year? Yes No

If yes, please describe _____

iii. Have you developed any new allergies in the past year? Yes No

If yes, please describe _____

- iv. 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

III. If yes to any of the above, please attach a medical surveillance report certified and signed by the registered medical practitioner in the following format:

- i. Date of health surveillance
- ii. Test or examinations performed and results