UTHealth Houston *Visiting Scholars Program*

Instructions on Application for Visiting Student (VSt)

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.

Purpose:

- 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.
- 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 are not considered employees, and are not entitled to wages or benefits.

Eligibility:

- **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.
- Proficiency in English is required for all Visiting Student. Visiting Students are expected to speak, read and understand English in an academic environment.

Duration:

- 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.

Process:

- 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 18 years old on the start date.**
- Visiting Students 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" at: 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.
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 *Please submit the following documents to your sponsoring department.*	√
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.	

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 *Please submit the following documents to the Office of the EVP/CAO.*	√
The Applicant's completed section (pages 1-4) with the required supporting documents.	
Faculty section (pages 5-6-7), typed and signed by faculty sponsor, Department Chair, and if applicable, Dean or designee	
Health Clearance Email from UT Health Services *The sponsoring department* ***submits the Health Form (and supporting documentation as requested on the form) to UT Health Services (UTHS)*** *by fax to 713-486-0983 or email to Occupational.Health@uth.tmc.edu. UTHS will send a "Health Clearance email" once the applicant receives health clearance.*	

For Office Use Only *Application #: ________________*
Additional Agreement Required: Yes No
Export Control _______ OIA _______ Privacy Officer/MHH _______
Health Insurance _____
Animal Care _______ Human Subjects ________

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* 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:

A. 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.
B. 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.
C. 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.
D. 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.
E. 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 will 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.
F. I understand that all members of UTHealth's community, including me while participating in this program, are required to comply with the COVID-19 policies and procedures as posted on UTHealth's website, which include vaccination, masking, and physical distancing requirements.
G. I understand that each affiliated hospital maintains its own immunization policies. Individuals who are assigned to observe and/or train at an office location or clinic setting that is within an affiliated hospital, medical office building, or agency are required to abide by UTHealth's rules and regulations, as well as the affiliate's rules and regulations, including COVID-19 vaccination requirements.

H. I understand that the information that I submit in connection with UTHealth's COVID-19 policies will be securely stored. I further understand that my vaccination status or my exemption status may be shared with the appropriate administrators, student affairs offices, GME office, supervisors, instructors, managers, and other UTHealth personnel to administer and comply with federal regulations regarding COVID-19 vaccination.
I. I understand that I can receive the COVID-19 vaccine from any health provider or the option of scheduling an appointment for the COVID-19 vaccine at no cost through UT Physicians by visiting https://www.utphysicians.com/schedule-a-covid-19-vaccine-appointment/.
J. 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.
K. I have reviewed and understand the "HIPAA Overview and Information Safeguards" document at https://uth.edu/evpara/otvs/.
L. 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.
M. 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.
N. 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.
O. 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.
P. 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.
Q. 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.
R. I understand that I will be subject to a background check in accordance with UTHealth's policy on Criminal Background Checks.
S. I understand that my association with UTHealth may be revoked at any time by UTHealth without cause and without advance notice to me.
T. 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.
U. 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)

*-- **STOP HERE** --*

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 EVP/CAO, 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.

UTHealth Houston

Request for Visiting Student (VSt): <u>Department Section</u>

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:

How will the training take place: ☐ In-person ☐ Remote / virtual ☐ Both

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.

Anticipated locations where the Visiting Student will be (buildings, other facilities, etc.)? ______________________________

Expected access hours needed: __________________________

<u>If the Applicant is a Foreign National</u> (i.e. non-U.S. citizen, non-U.S. Permanent Resident, etc.) (see citizenship status on Page 1, Applicant Section): 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

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 Visiting Student 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 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 Services (UTHS)*** *by fax to 713-486-0983 or email to Occupational.Health@uth.tmc.edu. UTHS 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 Services (UTHS)

☐ 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 Date
Senior Vice President for Academic & Research Affairs

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 Date
Executive Vice President & Chief Academic Officer

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 Health Services (UTHS).

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

For questions, please contact UTHS: phone 713-500-3254, fax 713-486-0983, Occupational.Health@uth.tmc.edu.

Risk-based Matrix of Required Health Forms, Immunizations, Tests for Visiting Students at UTHealth

Environment to be encountered	Visiting Student
Office or classroom setting	VH-1 Form "Health History" • COVID-19 vaccine
Research lab, no animals, no potential bloodborne pathogen exposures	VH-1 Form "Health History" • COVID-19 vaccine • TB skin test
Research lab, no animals, but with potential bloodborne pathogen exposures	VH-1 Form "Health History" • COVID-19 vaccine • TB skin test • Hep B series • MMR • Tetanus/Tdap
Research lab, with animals, but no potential bloodborne pathogen exposures	VH-1 Form "Health History" VH-3 Form "Occupational Health Enrollment"* • COVID-19 vaccine • TB skin test • MMR • Tetanus/Tdap
Research lab, with animals, with potential bloodborne pathogen exposures	VH-1 Form "Health History" VH-3 Form "Occupational Health Enrollment"* • COVID-19 vaccine • TB skin test • MMR • Tetanus/Tdap • Hep B series
Direct patient contact	VH-1 Form "Health History" • COVID-19 vaccine • MMR • Tetanus/Tdap • TB skin test • Hep B series • Varicella • Flu vaccine (Sept-March)

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)

UTHealth
The University of Texas
Health Science Center at Houston

VH-1 Form "Health History"

UT Health Services Health History Questionnaire Form

Please type or print clearly and return completed form to Occupational.Health@uth.tmc.edu
Your application will not be considered unless supporting documentation in English is included.

SECTION I: TO BE COMPLETED BY ALL

Name:	Date of Birth: Gender: ☐ Male ☐ Female
Street Address:	City/State/ZIP/Country:
Your Contact Number(s):	Your email:
Your UTHealth Faculty Sponsor & Department/School:	
Please indicate your classification of Visiting Scholar: ( ) Observer ( ) Visiting Student Estimated length of stay ______Months ______ Days ( ) Professional trainee ( ) Visiting Scientist Estimated length of stay ______Months ______ Days	

SECTION II: TO BE COMPLETED BY ALL

1. **Are you fully vaccinated against COVID-19? Yes _______ No ________**
   - People are considered "fully vaccinated" two weeks after an individual receives an FDA or WHO approved COVID-19 vaccine: Single-dose (e.g., J&J/Janssen) or two dose series (e.g., Pfizer and Moderna); or completing a full vaccination series (e.g. Astra Zeneca, Covidshield, Sinopharm
   - HCPC employees, residents, fellows, contractors, students, new hires, and volunteers are considered fully vaccinated after they have received their final dose without the need for a two-week post-vaccination period.
   - If you do not meet these requirements, you are NOT fully vaccinated.

2. **If you answered "yes" to question 1, please provide the dates of your vaccinations**:
   Dose 1: ________________
   Dose 2: ________________

3. **If you answered "yes" to question 1, do you have your vaccination record?** Yes _____ No ______ If yes, please attach vaccination records.
   Acceptable forms of proof include the following: (1) immunization record from provider or pharmacy; (2) COVID-19 Vaccination Record Card (CDC Form MLS-319813_r); (3) medical records documenting the vaccination; (4) immunization records from a public health or State immunization information system; or (5) any other official documentation verifying vaccination information, including the manufacturer of the vaccine, date(s) of vaccine administration, name of health care professional or clinic site administering vaccine. Digital copies of such records, including a digital photograph or PDF, are permitted as proof. Attestations or verbal declarations of prior completed COVID-19 vaccination series, or laboratory proof of antibodies are not acceptable forms of compliance. At this time, boosters are not required to be considered fully vaccinated and proof of booster shots are not required to be disclosed at this time. All documentation must be submitted in English or accompanied by a certified translation.

4. **If you answered "no" to question 1, do you intend to be fully vaccinated before the start of your approved start date?** Yes ______ No ______
   If answered yes, by what date (month/day/year)? Date________________

5. **If you answered "no" to question 1, do you wish to receive a COVID-19 Vaccination?**
   Yes ______ No _____

COVID-19 vaccines and boosters are available free of charge. You may make an appointment at UT Physicians by clicking this link here.

6. **If you answered "no" to question 1, are you declining to receive a COVID-19 vaccination for medical or religious reasons?**
   Yes ______ No _____

Individuals seeking an exemption must provide a completed COVID-19 Immunization Exemption & Safety Protocol Exemption Form to CALL@uth.tmc.edu.

SECTION III: TO BE COMPLETED BY INDIVIDUALS VISITING A LABORATORY, K-12 SCHOOL, OR BE IN A CLINICAL SETTING. IF THIS DOES NOT DESCRIBE YOU, PLEASE GO TO SECTION IV.

7. **Are you in a laboratory, K-12 school, or in a clinical setting?**

   Yes ______ No _____ Don't know yet_______

8. **Tuberculin (TB) skin test (PPD) required within the last 6 months, even if you received BCG vaccine.**

   8.1 Date of last TB skin test: __________ (ATTACH DOCUMENTATION OR LABORATORY REPORT)
   8.1.1 Result (mm) _____ Negative _____ Positive ____ (measurement _____ mm if available)
   8.2 Have you ever had a positive tuberculosis (TB) skin test? _____ Yes _____ No If yes, when __________
   8.2.1 Chest x-ray findings if PPD is positive (attach x-ray report) Date of chest x-ray: __________

9. **Hepatitis B Series Three-dose series or laboratory report of positive hepatitis surface antibody titer (ATTACH DOCUMENTATION OR LABORATORY REPORT)**
   9.1 #1 __________ #2 __________ #3 __________

10. **Tetanus/Diphtheria or TDAP. One dose within the past 10 years (ATTACH DOCUMENTATION OR LABORATORY REPORT)** Date of last vaccination: ____________

11. **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 __________ **(ATTACH DOCUMENTATION OR LABORATORY REPORT)**

12. **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 DOCUMENTATION OR LABORATORY REPORT)**

13. **Seasonal influenza vaccination**. Date______________Attach evidence of vaccination.

14. **Bloodborne Pathogen Exposure**
    14.1 While at UTHealth, will you be exposed to human blood and bodily fluids? ❑ Yes ❑ No ❑ Don't know yet
    14.2 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 **If you answered "Don't Know Yet" to either question above (14.1 or 14.2), you need to ask your supervisor upon arrival at your assigned location. If the answer then becomes "Yes" to either question you must inform UTHealth Services at 713-500-3248.**

    14.3 **If you are an employee and will be exposed to human blood and bodily fluid and choose NOT to accept the vaccine, please read and sign the Hepatitis B Declination Statement below:**

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of

acquiring Hepatitis B (HBV) infection. I have been given the opportunity to be vaccinated (at my own expense) with Hepatitis B vaccine at this time. I understand that be declining this vaccine, I continue to be at risk of acquiring Hepatitis B infection, 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 Hepatitis B vaccine, I can receive the vaccine series at my own expense.

____________________________	____________________________	________________
Printed Name	**Signature**	**Date**

SECTION IV: TO BE COMPLETED BY ALL

Past History and Review of Systems:

Please check if you have ever had any of the following:

☐ Skin Problems	☐ Diabetes/Sugar disorders
☐ Communicable Diseases	☐ Neck/back/knee problems
☐ Persistent or unusual cough	☐ Difficulty with hearing
☐ Color blindness/vision problems	☐ Hepatitis
☐ Loss of consciousness/seizures/ convulsions	☐ Alcohol/drug abuse
☐ Unsteadiness in balance/dizzy spells	☐ Psychiatric/emotional problems/depression/anxiety

For any items checked above, are you or were you under the care of a physician? ❑ Yes ❑ No

Comments:

SECTION V: TO BE COMPLETED BY ALL

By signing below, I agree to and acknowledge the following:

- I understand that I am required to provide accurate information to UTHealth in connection with my vaccination information and attest that the information provided is complete and accurate.
- I understand that it is my responsibility to maintain current vaccination status information and agree to update it when necessary.
- I understand that if I misrepresent information contained in this document that I may be subject to discipline, up to and including termination of employment or dismissal from my program.
- I understand that the information concerning my vaccination status will be kept securely, but may be disclosed for internal use, including but not limited to student health and counseling, school student affairs offices and GME offices, limited to determination of safety protocols necessary to maintain a safe working environment, administration of our leave and accommodation policies and procedures, managing clinician or staffing placement, accommodating patient requests, or ensuring compliance with affiliate agreements.
- I understand that some information concerning my vaccination status may be shared with my supervisor and appropriate administrative personnel. I understand that some information concerning my vaccination status may be shared with third parties, including but not limited to partner healthcare facilities, health departments, and other local, state, or federal agencies.

- If I have not provided proof of my vaccination, I give UTHealth permission to verify my vaccination status via ImmTrac2, the state immunization registry.
- I also understand that the information provided concerning my vaccination status may be disclosed for reporting to local, state and federal public health agencies, including but not limited to the Food and Drug Administration (FDA), Centers for Disease Control (CDC), Texas Health and Human Services Commission (HHSC), and the state immunization registry.
- The information that I have disclosed will be stored separately from my personnel file. Nothing in this vaccine disclosure process creates a medical record, and shall instead be stored securely, outside of my medical record.

____________________________	______________________________	________________
Printed Name	**Signature**	**Date**

Office Use Only

Seasonal Influenza: _____________ MMR Booster: _____________ Td/TDap Booster ________________

Hepatitis B Vaccine: #1_________________ #2_______________#3_____________________

TB Skin test given: Date ___________TB skin test result _____mm Date of reading___________

Sent for CXR: Date____________________ Result: ________________________

☐ Occupational Health Enrollment Form (Working with Animals)

☐ Respiratory Clearance form for EHS ☐ Schedule Spirogram ☐ Fax Respiratory Clearance form to 713.500.5841

☐ Not cleared

VH-3 Form "Occupational Health Enrollment"

UT Health Services (UTHS)

Occupational Health Program Enrollment Form

Confidential Medical Information

TYPE OR PRINT CLEARLY

Name:	Date of Birth: Gender: ☐ Male ☐ Female
Street Address:	City/State/ZIP/Country:
Your Contact Number(s):	Your email:
Your Supervisor or Sponsoring Agency:	What is the estimated duration of your stay at UTHealth? Visiting Student ☐ ________Months ______ Days Visiting Scientist ☐ ________Months ______ Days
Please indicate your classification of Visiting Scholar:	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.

<u>Hepatitis B Vaccination or Declination</u>

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 ☐	Cats ☐	Cattle ☐	Horses ☐	Bird (Feathers) ☐
Pigs ☐	Primates ☐	Rabbits ☐	Goats ☐	Sheep (Wool) ☐
Rats or Mice ☐	Guinea Pigs ☐	Alfalfa ☐	Weeds ☐	Trees ☐
Chemicals ☐	Latex ☐	Wood ☐	Grasses ☐	Mold ☐
Other ☐	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.