Office of Safety
3851 Campus Road, Stop 9031
Grand Forks, ND 58202

MEDICAL PROVIDER HEALTH ASSESSMENT REPORT TO UND (Appendix D)

Participant: Department:

Supervisor Name:

I certify that I have evaluated the above participant's health assessment and have concluded the following:

- ☐ No medical exam/vaccine is recommended based on the submitted information.
- ☐ Recommend vaccine only:
  - ☐ Tetanus ☐ Hepatitis B ☐ Hepatitis A ☐ Rabies ☐ Other
- ☐ Recommend medical exam/vaccine based on the submitted information. Participant must contact Altru Occupational Health or their personal physician and reference this assessment.
- ☐ I believe the participant can work with research animals with the following restrictions:
- ☐ I recommend the participant not be involved in work with research animals.

Additional Comments:

Medical Provider: Health Care facility (DMP):

Provider Signature: Date:

To be completed by UND participant named above.

Complete either option 1 or 2 below, sign and date on page 2, and return to the Office of Safety.

1. I, _____ (*Name of Participant*), on _____ (*Date*), **CONSENT** to the medical provider recommendation(s) as stated above. An authorization must be sent to Altru Occupational Health prior to treatment. Contact the Office of Safety.

2. I, _____ (*Name of Participant*), on _____ (*Date*), **DECLINE** the medical provider recommendation(s) as stated above. I, the undersigned participant, affirm that I am at least 18 years of age and am freely signing this agreement. I have read the details below and fully understand that by signing this form I am giving up legal rights and/or remedies which may otherwise be available to me regarding any losses I may sustain as a result of my participation. I agree that if any portion is held invalid, the remainder will continue in full legal force and effect.

I have received and reviewed the Medical Provider Health Assessment Report. I have been given the opportunity to be vaccinated/undergo medical exam as per the recommendation of the medical provider. However, I decline the medical exam/vaccination at this time. I understand

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that by declining the recommended medical exam/vaccine, I continue to be at risk of acquiring certain disease/infection.

In consideration for being allowed to participate in the above-referenced activity, on behalf of myself, my personal representatives, heirs, next of kin, successors and assigns, I forever:

a) waive, release, and discharge the State of North Dakota, its agencies, officers, and employees from any and all negligence and liability for my death, disability, personal injury, property damages, property theft or claims of any nature which may hereafter accrue to me, and my estate as a direct or indirect result of my participation in the above referenced activity or event; and

b) defend, indemnify, and hold harmless the State of North Dakota, its agencies, officers and employees, from any and all claims of any nature, including all costs, expenses, and attorney's fees, which may in any manner result from or arise out of this agreement, except for claims resulting from or arising out of the State's sole negligence.

I acknowledge that I have read and understand the Medical Provider's recommendations as indicated above.

Participant Signature: Date:

Provide the response to the UND Office of Safety - email: UND.safety@UND.edu or mail: Office of Safety, 3851 Campus Rd Stop 9031, Grand Forks, ND 58202-9031.