Instructions: Use a separate Department Specific Work Sheet for each animal species or infectious organism if necessary. Also include in this section any Departmental Infection Control SOP’s.

**Department-Specific Information Sheet: Engineering Controls**

<table>
<thead>
<tr>
<th>Department Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Departmental Coordinator:</td>
<td></td>
</tr>
<tr>
<td>Animal Species and/ or Infectious Organisms:</td>
<td></td>
</tr>
</tbody>
</table>

Place a checkmark by those engineering controls that your department uses to protect employees. In the blanks that follow, write a brief description and the location where employees can find the control device.

- **Handwashing (water or alternate) facilities**
  - Description:  
  - Location:  

- **Needle Safety Devices**
  - Description:  
  - Location:  

- **Sharps Containers**
  - Description:  
  - Location:  

- **Splash guards**
  - Description:  
  - Location:  

- **Resuscitation masks**
  - Description:  
  - Location:  

- **Biosafety cabinets**
  - Description:  
  - Location:  
# Department-Specific Information Sheet: Work Practice Controls

| Department Name:  _________________________________________________________________ |
| Departmental Coordinator:  __________________________________________________________ |
| Animal Species and/ or Infectious Organisms: _________________________________________ |

Place a checkmark by those work practice controls that your department uses to protect employees. In the blanks that follow, write any special instructions your employees might need to follow.

- O Hand and skin washing

- O Sharps Handling

- O Avoiding aerosol generation

- O Dealing with Contaminated Equipment

- O Other
**Department-Specific Information Sheet: Training and Medical Surveillance**

| Department Name: _________________________________________________________________ |
| Departmental Coordinator: __________________________________________________________ |
| Animal Species and/ or Infectious Organisms: ________________________________ |
| _______________________________________________________________________________ |

List the employees and the training and medical surveillance services each should receive. Each employee should sign the appropriate line indicating that they have received training and medical surveillance listed.

Employee name (please print):_____________________________________________________

VT ID #: _______________________________________________________________________

Training [attached roster(s) with employee names listed will fulfill this requirement]:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Medical Surveillance (please check all that apply):

- O Questionnaire filled out
- O Infectious agent vaccination (if available)
- O Infectious agent titer
- O Pulmonary function test
- O Respirator fit test
- O Other blood work
- O Hearing test
- O Examination by Occupational Health Physician
- O Other medical surveillance service (please specify): _____________________________

Signature of employee: ____________________________________________________________