**Appendix A: Template Example for Predeparture Assessment Form for US Healthcare Personnel in VHF Treatment Units (VTUs)**

Updated XX/XX/2024

Worker’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB (mm/dd/yyyy): \_\_\_ /\_\_\_ /\_\_\_\_\_

Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State of residence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Facility name, location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates worked (mm/dd/yyyy): \_\_ /\_\_ /\_\_\_\_\_ to \_\_ /\_\_ /\_\_\_\_\_

Staff role: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Duties: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EXPOSURE ASSESSMENT** (This section and the two sections below are to be completed, ideally by Safety Officer, after worker’s last VTU shift)

Name of person performing the assessment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date assessment completed: (mm/dd/yyyy): \_\_ /\_\_ /\_\_\_\_\_ Time: \_\_\_\_\_\_\_

**Potential Exposures** (Complete for all workers. Questions apply to the previous number of days within one incubation period of the virus.)

For healthcare workers, environmental cleaners, or others who entered patient care area of VTU:

* Used recommended personal protective equipment (PPE) every time? **☐YES ☐ NO**
* Donning and doffing of PPE supervised and documented by Safety Officer? **☐ YES ☐ NO**

For laboratory workers:

* Followed all required lab safety protocols every time? **☐ YES ☐ NO**

For workers engaged in the movement or burial of dead bodies:

* Used recommended personal protective equipment (PPE) every time exposed to dead body or contaminated items associated with burial? **☐ YES ☐ NO**

If NO to any of above, describe in the “Infection Control Breaches” section below.

For all personnel:

* Had direct contact with an acutely ill patient later diagnosed with VHF? **☐ YES ☐ NO**
* Had direct contact with a patient who died of VHF-compatible illness\* (unconfirmed)? **☐ YES ☐ NO**
* Exposed to body of person who died of VHF-compatible illness\* or unknown cause? **☐ YES ☐ NO**
* If YES to any of above, describe incident(s) under Infection Control Breaches below.

Infection Control Breaches (Complete for all workers. Questions apply to the past 21 days.)

☐ No known infection control breach occurred

☐ Infection control breach occurred

If an infection control breach occurred, specify:

☐ Needlestick or other sharps injury ☐ Splash to mucous membrane (eye/nose/mouth)

☐ Direct exposure to skin ☐ Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe the incident:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of incident (mm/dd/yyyy): \_\_ /\_\_ /\_\_\_\_\_ Reported to Safety Officer? **☐ YES ☐ NO**

Action taken: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Non-occupational exposures:

Visited a health care facility or traditional healer? **☐ YES ☐ NO**

Did this occur in designated outbreak area? **☐ YES ☐ NO**

Describe circumstances: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Attended a funeral or burial ? **☐ YES ☐ NO**

Did this occur in designated outbreak area? **☐ YES ☐ NO**

Describe circumstances including any potential exposures to dead body or contaminated items:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Had exposure to a person with acute febrile illness? **☐ YES ☐ NO**

Did this occur in designated outbreak area? **☐ YES ☐ NO**

Was the ill person a household member? **☐ YES ☐ NO**

Describe circumstances including any direct contact with ill person or body fluids: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Compatible illness includes body temperature ≥100.4o F or 38o C or subjective fever, or signs/symptoms including severe headache, fatigue, muscle pain, vomiting, diarrhea, abdominal pain, or unexplained hemorrhage.

**END OF EXPOSURE ASSESSMENT**

**HEALTH ASSESSMENT** (To be completed by Medical Supervisor within one day of worker’s departure to the US)

Worker name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB (mm/dd/yyyy): \_\_ /\_\_ /\_\_\_\_\_

Date assessment completed (mm/dd/yyyy): \_\_ /\_\_ /\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of person performing the assessment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ebola vaccination status: Ebola vaccine received: **☐ YES ☐ NO**

If vaccinated against Ebola virus, specify: ☐ Pre-exposure ☐ Post-exposure

Date of vaccination (mm/dd/yyyy): \_\_ /\_\_ /\_\_\_\_\_ Name of Vaccine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of vaccination (mm/dd/yyyy): \_\_ /\_\_ /\_\_\_\_\_ Name of Vaccine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinical Assessment

Appears well? **☐ YES ☐ NO**, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Temperature measurement: \_\_\_\_\_\_\_\_\_\_\_\_ Method: \_\_\_\_\_\_\_\_\_\_\_\_

Signs/symptoms in the **past 48 hours?**

☐ None reported

☐ Fever – if YES, T-max: \_\_\_\_\_ Method: \_\_\_\_\_\_\_ Date (mm/dd/yyyy): \_\_ /\_\_ /\_\_\_\_\_ Time:\_\_\_\_\_\_\_

☐ Fatigue

☐ Weakness

☐ Muscle pain

☐ Vomiting

☐ Diarrhea

☐ Abdominal pain

☐ Headache

☐ Joint pain

☐ Sore throat

☐ Difficulty breathing

☐ Chest pain

☐ Unexplained bruising/bleeding

☐ Red eyes

☐ Skin rash

☐ Hiccups

Earliest symptom onset date (mm/dd/yyyy): \_\_ /\_\_ /\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_

Use of antipyretic medication(s) in past 12 hours: **☐ YES ☐ NO**

Name of antipyretic : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_ Time: \_\_\_\_\_\_ Purpose: \_\_\_\_\_\_\_\_\_\_\_\_ Name of antipyretic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_ Time: \_\_\_\_\_\_ Purpose: \_\_\_\_\_\_\_\_\_\_\_\_\_

Was malaria prophylaxis taken as prescribed? **☐ YES ☐ NO.** Name of antimalarial: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**END OF HEALTH ASSESSMENT**