**Appendix B: Template Example for Predeparture Assessment Form for US Healthcare Personnel—Non VHF Treatment Unit (non-VTU) Facilities**

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** (To be completed within one day before departure. Questions apply to the previous number of days within one incubation period of the virus.)

For workers in non-VTU healthcare or laboratory settings:

Provided care to patients with VHF or other acute febrile illness? **☐ YES ☐ NO**

Exposed to body of person who died of VHF or compatible illness\*? **☐ YES ☐ NO**

Performed environmental cleaning in patient care areas? **☐ YES ☐ NO**

Performed clinical lab work? **☐ YES ☐ NO**

Worker should complete the section below if answers YES to any question in this section.

Exposure Incidents (Complete this section if answered YES to any question above.)

PPE worn during incident (check all that apply):

☐ none ☐ gloves ☐ facemask ☐ face shield/eye protection ☐gown

Date of incident (mm/dd/yyyy): \_\_ /\_\_ /\_\_\_

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

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**