Pre-Travel Survey for Vanderbilt Business Travel

Section 1: To be completed by supervisor — return this to traveler when complete. Traveler completes section 2 and then submits forms to OHC to book a pre-travel consultation.

Traveler’s Name__________________________________________ Department_________________

1. Destination (city and country) Arrival Date Departure Date Purpose of trip
□ Conference, meeting, interview or lecture
□ Research
□ Providing medical care
□ Other:

☐ Conference, meeting, interview or lecture
☐ Research
☐ Providing medical care
☐ Other:

☐ Conference, meeting, interview or lecture
☐ Research
☐ Providing medical care
☐ Other:

2. What is the traveler’s work status while abroad?
☐ On Vacation
☐ On Leave
☐ On Personal Time (Unpaid)
☐ Working for Vanderbilt

3. Will traveler be providing medical care at a rural, remote, primitive or inaccessible location, without immediate access to evaluation and medication in the event of a needlestick?
☐ No
☐ Yes. OHC will provide a prescription for post exposure prophylactic HIV medication for the traveler. Please provide an 1180 form which the traveler will take to the pharmacy with the OHC prescription to cover the cost of the medication. Each 3 day kit costs approximately $100. For an exposure requiring extended post exposure treatment, evacuation may be necessary.

4. Advise the employee that international business travelers must register their itineraries with International SOS at www.vanderbilt.edu/vio.

5. Some destinations are excluded from Vanderbilt’s usual workers compensation coverage. For destinations with a state department travel warning, contact Risk Management to arrange additional coverage if needed. Current travel warnings are posted at http://travel.state.gov
☐ No travel warning for this destination
☐ Travel warning is in effect – I have called Risk Management or will do so prior to trip

Supervisor’s Name and Title: ________________________________
Supervisor’s Signature: ________________________________ Date: __________
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Section 2: To be completed by traveler – do not give this information to your supervisor

Name: ___________________________  SS# or VU ID # __________________
Date of Birth: ______________________  Country of Birth______________
E-mail address______________________  Phone____________________

Trip Itinerary
Departure date: _______________ Return date or length of stay: _______________
List all countries that you will visit in the order of travel:
1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
Have you previously traveled to this destination?  Yes___  No___
Have you registered this trip with International SOS at www.vanderbilt.edu/vio? Yes___ No___

Vaccination History (list dates of vaccine)
Tetanus:  Td__________ or Tdap__________ (date of latest tetanus vaccine only)
MMR:      #1__________  #2__________  #3__________
Hepatitis B #1__________  #2__________  #3__________
Hepatitis A #1__________  #2__________
Polio Booster __________________
Typhoid:   Oral(live)________ or Injectable (inactivated)__________
Rabies     #1__________  #2__________  #3__________  #4__________  #5__________
Meningitis __________________
Varicella  #1__________  #2__________
Japanese Encephalitis___________
Yellow Fever___________________
Influenza_____________________
Pneumonia____________________
Other vaccines__________________

Previous Malaria prophylaxis Yes___ No____
Malaria medication reactions Yes___ No____
Health Assessment
Check any of the following that apply to you:

- Immunity or immune suppression
- Spleen removal
- Transplant recipient
- Cancer/chemotherapy
- HIV
- Steroid medication use
- Depression/Panic attack/Anxiety
- Psoriasis
- Seizures
- Thymus disease/thymus surgery
- Cardiac conduction defect (irregular heart beat)
- Heart disease
- Lung disease
- Kidney disease or frequent Urinary Tract Infections
- Liver disease
- Musculoskeletal problems
- Gastrointestinal problems
  (Crohn’s, ulcerative colitis, irritable bowel)
- Diabetes
- Blood transfusion within the last year
- Altitude problem-mountain sickness
- Have been ill or had a fever in the past 3 days

Describe all “checked” responses:

List all current medications:

List all allergies (egg, bees, medications, foods)

Women – LMP _____ Risk of pregnancy? Yes____ No____ Pregnant____ weeks
Breast Feeding? Yes_____No____

Trip Risk Assessment
Solo traveler? Yes____ No_____ If no, name of group leader/organizer: ____________________
Will you be visiting friends or relatives? Yes______ No ______
Lodging:
  Urban - Hotel Class 5____ Hotel Class #_____ Local apartment____
  Live with locals / private home____
  Rural - Remote location______ Tents/travel camper________
Occupational exposures:
  Healthcare work_____ Animal research_____ Other___________________________
Recreational activities:
  Cruise _____ Safari _____ Trekking _____ Surfing _____ Diving _____
  Rafting _____ Spelunking ______ Biking _____ Camping _____ Other______
  Contact with animals (dogs or farm animals) ________

Insurance Coverage
Vanderbilt Blue Cross___ Vanderbilt Aetna___ Other____ Extra travel medical insurance ____

Traveler’s Signature:____________________________________ Date:_________________________