

California Department of Public Health
 Center for Infectious Diseases
 Division of Communicable Disease Control
 Infectious Diseases Branch
 Surveillance and Statistics Section
 MS 7306, P.O. Box 997377
 Sacramento, CA 95899-7377

BABESIOSIS CASE REPORT

Please complete this form only for laboratory confirmed cases of babesiosis that meet at least one of the case definition clinical conditions. For case definition, see pages 5 and 6. **Completion of this form is not required** but encouraged to improve surveillance and understanding of this disease. Jurisdictions not participating in CalREDIE should **securely** email the completed form to IDB-SSS@cdph.ca.gov; otherwise, mail the completed form to IDB-SSS at the address above. Jurisdictions participating in CalREDIE should create a CalREDIE incident and enter the information directly into the CalREDIE system.

PATIENT INFORMATION					
Last Name	First Name	Middle Name	Suffix	Primary Language	
Social Security Number (9 digits)		DOB (mm/dd/yyyy)	Age	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	
Address Number & Street – Residence			Apartment / Unit Number		
City / Town		State	Zip Code		
Census Tract	County of Residence		Country of Residence		
Country of Birth		If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)			
Home Telephone		Cellular Phone / Pager		Work / School Telephone	
E-mail Address		Other Electronic Contact Information			
Work / School Location		Work / School Contact			
Gender <input type="checkbox"/> Female <input type="checkbox"/> Trans female / transwoman <input type="checkbox"/> Genderqueer or non-binary <input type="checkbox"/> Unknown <input type="checkbox"/> Male <input type="checkbox"/> Trans male / transman <input type="checkbox"/> Identity not listed <input type="checkbox"/> Declined to answer					
Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		If Yes, Est. Delivery Date (mm/dd/yyyy)			
Medical Record Number		Patient's Parent/Guardian Name			
Occupation Setting (see list on page 8)		Other Describe/Specify			
Occupation (see list on page 8)		Other Describe/Specify			
Race(s) (check all that apply, race descriptions on page 7) The response to this item should be based on the patient's self-identity or self-reporting. Therefore, patients should be offered the option of selecting more than one racial designation.					
<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian (check all that apply, see list on page 7) <input type="checkbox"/> Asian Indian <input type="checkbox"/> Korean <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Laotian <input type="checkbox"/> Cambodian <input type="checkbox"/> Malaysian <input type="checkbox"/> Chinese <input type="checkbox"/> Pakistani <input type="checkbox"/> Filipino <input type="checkbox"/> Sri Lankan <input type="checkbox"/> Hmong <input type="checkbox"/> Taiwanese <input type="checkbox"/> Indonesian <input type="checkbox"/> Thai <input type="checkbox"/> Japanese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other: _____					
<input type="checkbox"/> Black or African-American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander (check all that apply, see list on page 7) <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Fijian <input type="checkbox"/> Tongan <input type="checkbox"/> Guamanian <input type="checkbox"/> Other: _____					
<input type="checkbox"/> White <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown					
ADDITIONAL PATIENT DEMOGRAPHICS					
Sex Assigned at Birth		Sexual Orientation			
<input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Male <input type="checkbox"/> Declined to answer		<input type="checkbox"/> Heterosexual or straight <input type="checkbox"/> Questioning, unsure, or patient doesn't know <input type="checkbox"/> Declined to answer <input type="checkbox"/> Gay, lesbian, or same-gender loving <input type="checkbox"/> Orientation not listed <input type="checkbox"/> Unknown <input type="checkbox"/> Bisexual			

First three letters of
patient's last name:

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CLINICAL INFORMATION													
Physician Name - Last Name					First Name			Telephone Number					
SIGNS AND SYMPTOMS													
Symptomatic? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Onset Date (mm/dd/yyyy)			Is the patient asplenic? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			If patient had splenectomy, date of surgery (mm/dd/yyyy)					
Signs / Symptoms				Yes	No	Unk	Signs / Symptoms				Yes	No	Unk
Fever							Sweats						
Anemia							Myalgia						
Thrombocytopenia							Arthralgia						
Headache							Other sign/symptom (specify)						
Chills							Other sign/symptom (specify)						
Specify any complications in the clinical course of infection (check all that apply)													
<input type="checkbox"/> Acute respiratory distress			<input type="checkbox"/> Congestive heart failure			<input type="checkbox"/> Renal failure			<input type="checkbox"/> None				
<input type="checkbox"/> Disseminated intravascular coagulation (DIC)			<input type="checkbox"/> Myocardial infarction			<input type="checkbox"/> Other: _____							
HOSPITALIZATION													
Did patient visit the emergency room for illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown													
Was patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				If Yes, how many total hospital nights? <input type="checkbox"/> Still hospitalized as of _____ (mm/dd/yyyy)									
During any part of the hospitalization, did the patient stay in an intensive care unit (ICU) or a critical care unit (CCU)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown													
If there were any ER visits or hospital stays related to this illness, specify details in the Hospitalization – Details section on next page.													
HOSPITALIZATION – DETAILS													
Hospital Name 1		Street Address				Admit Date (mm/dd/yyyy)							
		City				Discharge / Transfer Date (mm/dd/yyyy)							
		State	Zip Code	Telephone Number		Medical Record Number		Discharge Diagnosis					
Hospital Name 2		Street Address				Admit Date (mm/dd/yyyy)							
		City				Discharge / Transfer Date (mm/dd/yyyy)							
		State	Zip Code	Telephone Number		Medical Record Number		Discharge Diagnosis					
TREATMENT / MANAGEMENT													
Received antimicrobial treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			If Yes, which drugs? (check all that apply) <input type="checkbox"/> Clindamycin <input type="checkbox"/> Quinine <input type="checkbox"/> Atovaquone <input type="checkbox"/> Azithromycin <input type="checkbox"/> Other: _____										
OUTCOME													
Outcome? <input type="checkbox"/> Survived <input type="checkbox"/> Died <input type="checkbox"/> Unknown			If Survived, Survived as of _____ (mm/dd/yyyy)										
				If Died, Date of Death (mm/dd/yyyy)			Was the death related to the infection? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown						

First three letters of patient's last name:

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LABORATORY INFORMATION				
LABORATORY RESULTS SUMMARY - SEROLOGY				
IFA - total antibody (Ig) <input type="checkbox"/> Done <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	Result <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Unknown <input type="checkbox"/> Pending	If Positive, specify Babesia Species	Titer	
Collection Date (mm/dd/yyyy)		Laboratory Name		Telephone Number
IFA - IgG <input type="checkbox"/> Done <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	Result <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Unknown <input type="checkbox"/> Pending	If Positive, specify Babesia Species	Titer	
Collection Date (mm/dd/yyyy)		Laboratory Name		Telephone Number
IFA - IgM <input type="checkbox"/> Done <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	Result <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Unknown <input type="checkbox"/> Pending	If Positive, specify Babesia Species	Titer	
Collection Date (mm/dd/yyyy)		Laboratory Name		Telephone Number
Immunoblot <input type="checkbox"/> Done <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	Result <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Unknown <input type="checkbox"/> Pending	If Positive, specify Babesia Species		
Collection Date (mm/dd/yyyy)		Laboratory Name		Telephone Number
Blood smear <input type="checkbox"/> Done <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	Result <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Unknown <input type="checkbox"/> Pending	Description		
Collection Date (mm/dd/yyyy)		Laboratory Name		Telephone Number
PCR <input type="checkbox"/> Done <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	Result <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Unknown <input type="checkbox"/> Pending	If Positive, specify Babesia Species		
Collection Date (mm/dd/yyyy)		Specimen Type	Laboratory Name	Telephone Number
Other test (specify): _____	Result <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Unknown <input type="checkbox"/> Pending	If Positive, specify Babesia Species		
Collection Date (mm/dd/yyyy)		Specimen Type	Laboratory Name	Telephone Number
Other test (specify): _____	Result <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Unknown <input type="checkbox"/> Pending	If Positive, specify Babesia Species		
Collection Date (mm/dd/yyyy)		Specimen Type	Laboratory Name	Telephone Number
EPIDEMIOLOGIC INFORMATION				
INCUBATION PERIOD: 8 WEEKS PRIOR TO ILLNESS ONSET OR DIAGNOSIS (USE EARLIER DATE)				
EXPOSURES / RISK FACTORS - TRANSFUSION				
Was patient's infection transfusion associated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			If Yes, describe	
Was patient a blood donor identified during a transfusion investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			If Yes, describe	
EXPOSURES / RISK FACTORS - OUTDOOR EXPOSURES				
IN THE 8 WEEKS BEFORE SYMPTOM ONSET OR DIAGNOSIS (USE EARLIER DATE), DID THE PATIENT:				
Exposure	Yes	No	Unk	If Yes, Specify as Noted
Engage in outdoor activities				Type of Activity (check all that apply) <input type="checkbox"/> Camping <input type="checkbox"/> Hiking <input type="checkbox"/> Hunting <input type="checkbox"/> Yard work <input type="checkbox"/> Other: _____
Spend time outdoors in or near wooded or brushy areas				Describe
Notice any tick bites				Date Noticed (mm/dd/yyyy)
				Approximate Duration of Attachment
				Where Obtained (geographic location)

First three letters of patient's last name:

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EPIDEMIOLOGIC INFORMATION (continued)

TRAVEL HISTORY

Did patient travel outside of county of residence during the incubation period? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Did the patient travel outside the U.S. during the incubation period? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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If Yes for either of these questions, specify all locations and dates below.

TRAVEL HISTORY - DETAILS

Location (city, county, state, country)	Date Travel Started (mm/dd/yyyy)	Date Travel Ended (mm/dd/yyyy)

NOTES / REMARKS

REPORTING AGENCY

Investigator Name	Local Health Jurisdiction	Telephone Number	Date (mm/dd/yyyy)
First Reported By <input type="checkbox"/> Clinician <input type="checkbox"/> Laboratory <input type="checkbox"/> Other (specify): _____			

DISEASE CASE CLASSIFICATION

Case Classification (see case definition on next page)
 Confirmed Probable Suspected

OUTBREAK

Part of known outbreak?	If Yes, extent of outbreak:
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> One CA jurisdiction <input type="checkbox"/> Multiple CA jurisdictions <input type="checkbox"/> Multistate <input type="checkbox"/> International <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify): _____

STATE USE ONLY

Case Classification
 Confirmed Probable Suspected Not a case Need additional information

First three letters of
patient's last name:

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CASE DEFINITION**BABESIOSIS (2011)****CLINICAL DESCRIPTION**

Babesiosis is a parasitic disease caused by intraerythrocytic protozoa of the *Babesia* genus (*Babesia microti* and other species). *Babesia* are transmitted in nature through the bites of infected ticks but can also be acquired through contaminated blood components from asymptomatic parasitemic donors or, more rarely, transplacentally. *Babesia* infection can range from subclinical to life-threatening. Clinical manifestations, if any, can include hemolytic anemia and nonspecific influenza-like signs and symptoms (e.g., fever, chills, sweats, headache, myalgia, arthralgia, malaise, fatigue, generalized weakness). Splenomegaly, hepatomegaly, or jaundice may be evident. In addition to signs of hemolytic anemia, laboratory findings may include thrombocytopenia, proteinuria, hemoglobinuria, and elevated levels of liver enzymes, blood urea nitrogen, and creatinine. Risk factors for severe babesiosis include asplenia, advanced age, and other causes of impaired immune function (e.g., HIV, malignancy, corticosteroid therapy). Some immunosuppressive therapies or conditions may mask or modulate the clinical manifestations (e.g., the patient may be afebrile). Severe cases can be associated with marked thrombocytopenia, disseminated intravascular coagulation, hemodynamic instability, acute respiratory distress, myocardial infarction, renal failure, hepatic compromise, altered mental status, and death.

CLINICAL CRITERIA

For the purposes of surveillance:

- Objective: one or more of the following: fever, anemia, or thrombocytopenia.
- Subjective: one or more of the following: chills, sweats, headache, myalgia, or arthralgia.

LABORATORY CRITERIA FOR DIAGNOSIS

For the purposes of surveillance:

Laboratory confirmatory:

- Identification of intraerythrocytic *Babesia* organisms by light microscopy in a Giemsa, Wright, or Wright-Giemsa–stained blood smear; **OR**
- Detection of *Babesia microti* DNA in a whole blood specimen by polymerase chain reaction (PCR); **OR**
- Detection of *Babesia* spp. genomic sequences in a whole blood specimen by nucleic acid amplification; **OR**
- Isolation of *Babesia* organisms from a whole blood specimen by animal inoculation.

Laboratory supportive:

- Demonstration of a *Babesia microti* Indirect Fluorescent Antibody (IFA) total immunoglobulin (Ig) or IgG antibody titer of greater than or equal to (\geq) 1:256 (or \geq 1:64 in epidemiologically linked blood donors or recipients); **OR**
- Demonstration of a *Babesia microti* Immunoblot IgG positive result; **OR**
- Demonstration of a *Babesia divergens* IFA total Ig or IgG antibody titer of greater than or equal to (\geq) 1:256; **OR**
- Demonstration of a *Babesia duncani* IFA total Ig or IgG antibody titer of greater than or equal to (\geq) 1:512.

EPIDEMIOLOGIC LINKAGE

Epidemiologic evidence for transfusion transmission.

For the purposes of surveillance, epidemiologic linkage between a transfusion recipient and a blood donor is demonstrated if all of the following criteria are met:

- In the transfusion recipient:
 - Received one or more red blood cell (RBC) or platelet transfusions within one year before the collection date of a specimen with laboratory evidence of *Babesia* infection; **AND**
 - At least one of these transfused blood components was donated by the donor described below; **AND**
 - Transfusion-associated infection is considered at least as plausible as tickborne transmission; **AND**
- In the blood donor:
 - Donated at least one of the RBC or platelet components that was transfused into the above recipient; **AND**
 - The plausibility that this blood component was the source of infection in the recipient is considered equal to or greater than that of blood from other involved donors. (More than one plausible donor may be linked to the same recipient.)

(continued on page 6)

First three letters of
patient's last name:

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CASE DEFINITION (continued)**CASE CLASSIFICATION****Confirmed:**

A case that has confirmatory laboratory results and meets at least one of the objective or subjective clinical evidence criteria, regardless of the mode of transmission (can include clinically manifest cases in transfusion recipients or blood donors).

Probable:

- A case that has supportive laboratory results and meets at least one of the objective clinical evidence criteria (subjective criteria alone are not sufficient); OR
- A case that is in a blood donor or recipient epidemiologically linked to a confirmed or probable babesiosis case (as defined above) **AND**:
 - has confirmatory laboratory evidence but does not meet any objective or subjective clinical evidence criteria; **OR**
 - has supportive laboratory evidence and may or may not meet any subjective clinical evidence criteria but does not meet any objective clinical evidence criteria.

Suspected:

A case that has confirmatory or supportive laboratory results, but insufficient clinical or epidemiologic information is available for case classification (e.g., only a laboratory report was provided).

COMMENTS

The validity of the diagnosis of babesiosis is highly dependent on the laboratory that performs the testing. For example, differentiation between *Plasmodium* and *Babesia* organisms on peripheral blood smears can be difficult. Confirmation of the diagnosis of babesiosis by a reference laboratory is strongly encouraged, especially for patients without residence in or travel to areas known to be endemic for babesiosis.

A positive *Babesia* IFA result for immunoglobulin M (IgM) is insufficient for diagnosis and case classification of babesiosis in the absence of a positive IFA result for IgG (or total Ig). If the IgM result is positive but the IgG result is negative, a follow-up blood specimen drawn at least one week after the first should be tested. If the IgG result remains negative in the second specimen, the IgM result likely was a false positive.

When interpreting IFA IgG or total Ig results, it is helpful to consider factors that may influence the relative magnitude of *Babesia* titers (e.g., timing of specimen collection relative to exposure or illness onset, the patient's immune status, the presence of clinically manifest versus asymptomatic infection). In immunocompetent persons, active or recent *Babesia* infections that are symptomatic are generally associated with relatively high titers (although antibody levels may be below the detection threshold early in the course of infection); titers can then persist at lower levels for more than a year. In persons who are immunosuppressed or who have asymptomatic *Babesia* infections, active infections can be associated with lower titers.

Babesia microti is the most frequently identified agent of human babesiosis in the United States; most reported tick-borne cases have been acquired in parts of northeastern and north-central regions. Sporadic U.S. cases caused by other *Babesia* agents include *B. duncani* (formerly the WA1 parasite) and related organisms (CA1-type parasites) in several western states as well as parasites characterized as "*B. divergens* like" (MO1 and others) in various states. Serologic and molecular tests available for *B. microti* infection do not typically detect these other *Babesia* agents.

Blood-borne transmission of *Babesia* is not restricted by geographic region or season. The epidemiologic linkage criteria for transfusion transmission that are described here provide a low threshold for asymptomatic donor or recipient cases to be considered probable cases for surveillance purposes and are not intended to be regulatory criteria. Transfusion investigations entail laboratory testing for evidence of *Babesia* infection in recipients and donors as well as epidemiologic assessments of the plausibilities of blood- and tick-borne transmission.

First three letters of
patient's last name:

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RACE DESCRIPTIONS	
Race	Description
American Indian or Alaska Native	Patient has origins in any of the original peoples of North and South America (including Central America).
Asian	Patient has origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g., including Bangladesh, Cambodia, China, India, Indonesia, Japan, Korea, Malaysia, Nepal, Pakistan, the Philippine Islands, Thailand, and Vietnam).
Black or African American	Patient has origins in any of the black racial groups of Africa.
Native Hawaiian or Other Pacific Islander	Patient has origins in any of the original peoples of Hawaii, Guam, American Samoa, or other Pacific Islands.
White	Patient has origins in any of the original peoples of Europe, the Middle East, or North Africa.
ASIAN GROUPS	
<ul style="list-style-type: none"> <li style="width: 20%; margin-right: 20%;">• Bangladeshi <li style="width: 20%; margin-right: 20%;">• Filipino <li style="width: 20%; margin-right: 20%;">• Japanese <li style="width: 20%; margin-right: 20%;">• Maldivian <li style="width: 20%; margin-right: 20%;">• Sri Lankan <li style="width: 20%; margin-right: 20%;">• Bhutanese <li style="width: 20%; margin-right: 20%;">• Hmong <li style="width: 20%; margin-right: 20%;">• Korean <li style="width: 20%; margin-right: 20%;">• Nepalese <li style="width: 20%; margin-right: 20%;">• Taiwanese <li style="width: 20%; margin-right: 20%;">• Burmese <li style="width: 20%; margin-right: 20%;">• Indian <li style="width: 20%; margin-right: 20%;">• Laotian <li style="width: 20%; margin-right: 20%;">• Okinawan <li style="width: 20%; margin-right: 20%;">• Thai <li style="width: 20%; margin-right: 20%;">• Cambodian <li style="width: 20%; margin-right: 20%;">• Indonesian <li style="width: 20%; margin-right: 20%;">• Madagascar <li style="width: 20%; margin-right: 20%;">• Pakistani <li style="width: 20%; margin-right: 20%;">• Vietnamese <li style="width: 20%; margin-right: 20%;">• Chinese <li style="width: 20%; margin-right: 20%;">• Iwo Jiman <li style="width: 20%; margin-right: 20%;">• Malaysian <li style="width: 20%; margin-right: 20%;">• Singaporean 	
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER GROUPS	
<ul style="list-style-type: none"> <li style="width: 20%; margin-right: 20%;">• Carolinian <li style="width: 20%; margin-right: 20%;">• Kiribati <li style="width: 20%; margin-right: 20%;">• Micronesian <li style="width: 20%; margin-right: 20%;">• Pohnpeian <li style="width: 20%; margin-right: 20%;">• Tahitian <li style="width: 20%; margin-right: 20%;">• Chamorro <li style="width: 20%; margin-right: 20%;">• Kosraean <li style="width: 20%; margin-right: 20%;">• Native Hawaiian <li style="width: 20%; margin-right: 20%;">• Polynesian <li style="width: 20%; margin-right: 20%;">• Tokelauan <li style="width: 20%; margin-right: 20%;">• Chuukese <li style="width: 20%; margin-right: 20%;">• Mariana Islander <li style="width: 20%; margin-right: 20%;">• New Hebrides <li style="width: 20%; margin-right: 20%;">• Saipanese <li style="width: 20%; margin-right: 20%;">• Tongan <li style="width: 20%; margin-right: 20%;">• Fijian <li style="width: 20%; margin-right: 20%;">• Marshallese <li style="width: 20%; margin-right: 20%;">• Palauan <li style="width: 20%; margin-right: 20%;">• Samoan <li style="width: 20%; margin-right: 20%;">• Yapese <li style="width: 20%; margin-right: 20%;">• Guamanian <li style="width: 20%; margin-right: 20%;">• Melanesian <li style="width: 20%; margin-right: 20%;">• Papua New Guinean <li style="width: 20%; margin-right: 20%;">• Solomon Islander 	

First three letters of patient's last name:

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OCCUPATION SETTING

- | | |
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| <ul style="list-style-type: none"> • Childcare/Preschool • Correctional Facility • Drug Treatment Center • Food Service • Health Care - Acute Care Facility • Health Care - Long Term Care Facility • Health Care - Other | <ul style="list-style-type: none"> • Homeless Shelter • Laboratory • Military Facility • Other Residential Facility • Place of Worship • School • Other |
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OCCUPATION

- | | |
|--|--|
| <ul style="list-style-type: none"> • Agriculture - farmworker or laborer (crop, nursery, or greenhouse) • Agriculture - field worker • Agriculture - migratory/seasonal worker • Agriculture - other/unknown • Animal - animal control worker • Animal - farm worker or laborer (farm or ranch animals) • Animal - veterinarian or other animal health practitioner • Animal - other/unknown • Clerical, office, or sales worker • Correctional facility - employee • Correctional facility - inmate • Craftsman, foreman, or operative • Daycare or child care attendee • Daycare or child care worker • Dentist or other dental health worker • Drug dealer • Fire fighting or prevention worker • Flight attendant • Food service - cook or food preparation worker • Food service - host or hostess • Food service - waiter or waitress • Food service - other/unknown • Homemaker • Laboratory technologist or technician • Laborer - private household or unskilled worker • Manager, official, or proprietor • Manicurist or pedicurist • Medical - emergency medical technician or paramedic • Medical - health care worker | <ul style="list-style-type: none"> • Medical - medical assistant • Medical - pharmacist • Medical - physician assistant or nurse practitioner • Medical - physician or surgeon • Medical - registered nurse • Medical - other/unknown • Military - officer • Military - recruit or trainee • Protective service - police officer • Protective service - other • Professional, technical, or related profession • Retired • Sex worker • Student - preschool or kindergarten • Student - elementary or middle school • Student - high (secondary) school • Student - college or university • Student - other/unknown • Teacher/employee - preschool or kindergarten • Teacher/employee - elementary or middle school • Teacher/employee - high (secondary) school • Teacher/instructor/employee - college or university • Teacher/instructor/employee - other/unknown • Unemployed - seeking employment • Unemployed - not seeking employment • Unemployed - other/unknown • Other • Refused • Unknown |
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