State of California—Health and Human Services Agency

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

Local ID Number: _____

HEPATITIS E CASE REPORT

Please complete this form for confirmed and probable cases of Hepatitis E virus infections (HEV). For case definitions, see page 8. ***Completion of this form is not required but encouraged to improve surveillance of this disease****. Jurisdictions not participating in CalREDIE should 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*

Social Security Number (9 digits)	*DOB (mm/dd/yyyy)*	*Age*	☐ Years ☐ Months ☐ Days

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
☐ Female ☐ Trans female / transwoman ☐ Genderqueer or non-binary ☐ Unknown
☐ Male ☐ Trans male / transman ☐ Identity not listed ☐ Declined to answer

Pregnant? ☐ Yes ☐ No ☐ Unknown	*If Yes, Est. Delivery Date (mm/dd/yyyy)*

Medical Record Number	*Patient's Parent/Guardian Name*

Occupation Setting (see list on page 10)	*Other Describe/Specify*

Occupation (see list on page 10)	*Other Describe/Specify*

Primary Language
☐ English
☐ Spanish
☐ Other: _____

Ethnicity (check one)
☐ Hispanic/Latino
☐ Non-Hispanic/Non-Latino
☐ Unknown

Race(s)
(check all that apply, race descriptions on page 9)

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.

☐ American Indian or Alaska Native

☐ Asian *(check all that apply, see list on page 9)*
- ☐ Asian Indian
- ☐ Bangladeshi
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Hmong
- ☐ Indonesian
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Malaysian
- ☐ Pakistani
- ☐ Sri Lankan
- ☐ Taiwanese
- ☐ Thai
- ☐ Vietnamese
- ☐ Other: _____

☐ Black or African-American

☐ Native Hawaiian or Other Pacific Islander *(check all that apply, see list on page 9)*
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Fijian
- ☐ Tongan
- ☐ Guamanian
- ☐ Other: _____

☐ White

☐ Other: _____

☐ Unknown

ADDITIONAL PATIENT DEMOGRAPHICS

Sex Assigned at Birth
☐ Female ☐ Unknown
☐ Male ☐ Declined to answer

Sexual Orientation
☐ Heterosexual or straight ☐ Questioning, unsure, or patient doesn't know ☐ Declined to answer
☐ Gay, lesbian, or same-gender loving ☐ Orientation not listed ☐ Unknown
☐ Bisexual

First three letters of patient's last name: | | | |

CLINICAL INFORMATION

Physician Name - Last Name	*First Name*	*Telephone Number*

SIGNS AND SYMPTOMS

Symptomatic? ☐ Yes ☐ No ☐ Unknown	*First Symptom*	*Onset Date of Symptom (mm/dd/yyyy)*	*Duration of Acute Symptoms (days)*

Pregnant? ☐ Yes ☐ No ☐ Unknown	*Weeks of Gestation at Onset*	*Pregnancy Outcome* ☐ Live birth, healthy infant ☐ Live birth, complications (describe): _____ ☐ Fetal loss ☐ Still birth

Signs and Symptoms	Yes	No	Unk	If Yes, Specify as Noted
Anorexia (loss of appetite)				
Abdominal pain				
Clay stools (white or gray)				
Dark urine (orange or brown)				
Diarrhea				
Fatigue				
Fever				
Jaundice (yellow skin and eyes)				*Onset date of jaundice (mm/dd/yyyy)*

Other signs and symptoms (specify)

PAST MEDICAL HISTORY

Does the patient have a history of liver disease? ☐ Yes ☐ No ☐ Unknown	*If Yes, specify condition(s)*
Does the patient have any other medical conditions? (e.g., renal disease, diabetes, immuno-compromising conditions) ☐ Yes ☐ No ☐ Unknown	*If Yes, specify medical conditions(s)*
Is the patient on immunosuppressive therapy? ☐ Yes ☐ No ☐ Unknown	*If Yes, specify medication(s)*
Does the patient drink alcohol? ☐ Yes ☐ No ☐ Unknown	*If Yes, how many servings of alcohol in a typical week?*
Does the patient use illicit drugs? ☐ Yes ☐ No ☐ Unknown	*If Yes, specify type, route, frequency*

HOSPITALIZATION

Did patient visit the emergency room for illness? ☐ Yes ☐ No ☐ Unknown

Was patient hospitalized? ☐ Yes ☐ No ☐ Unknown	*If Yes, how many total hospital nights?* ☐ 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)? ☐ Yes ☐ No ☐ 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*

(continued on page 3)

First three letters of patient's last name: | | | |

HOSPITALIZATION – DETAILS (continued)

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

OUTCOME

Outcome? ☐ Survived ☐ Died ☐ Unknown	If Survived, Survived as of _____ (mm/dd/yyyy)	If Died, Date of Death (mm/dd/yyyy)	Died of Hepatitis E infection? ☐ Yes ☐ No ☐ Unknown

Complications? ☐ Yes ☐ No ☐ Unknown	If Yes, what type of complications? ☐ Liver failure ☐ Pregnancy loss ☐ Other (specify): _____

Notes, Clinical Course

LABORATORY INFORMATION

Reasons for Testing (check all that apply)

☐ Symptoms of acute hepatitis ☐ Evaluation of elevated liver enzymes ☐ Other (specify): _____
☐ Exposure to HEV case ☐ Unknown

HEPATITIS E DIAGNOSTIC TESTS

Diagnostic Test	Yes	No	Unk	If Yes, Specify as. Noted		
Hepatitis E Virus (HEV) RNA				Specimen source ☐ Blood ☐ Other: _____ ☐ Feces	Collection date (mm/dd/yyyy)	Result ☐ Positive ☐ Unknown ☐ Negative ☐ Not done
Anti-HEV IgM				Collection date (mm/dd/yyyy)	Result ☐ Positive ☐ Negative ☐ Unknown ☐ Not done	
Anti-HEV IgG acute serum				Collection date (mm/dd/yyyy)	Result ☐ Positive ☐ Unknown ☐ Negative ☐ Not done	If Positive, titer
Anti-HEV IgG convalescent serum				Collection date (mm/dd/yyyy)	Result ☐ Positive ☐ Unknown ☐ Negative ☐ Not done	If Positive, titer
Other diagnostic tests for HEV				Specimen source ☐ Blood ☐ Other: _____ ☐ Feces	Collection date (mm/dd/yyyy)	Result ☐ Positive ☐ Unknown ☐ Negative ☐ Not done
				Describe tests		

Was specimen sent to CDC for genotyping? ☐ Yes ☐ No ☐ Unknown	Type of Test	Result	Genotype ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other: _____

LIVER ENZYME LEVELS AT DIAGNOSIS

Diagnostic Test	Yes	No	Unk	If Yes, Specify as Noted		
Alanine aminotransferase (ALT)				Collection date (mm/dd/yyyy)	Result (U/L)	Comments
Aspartate aminotransferase (AST)				Collection date (mm/dd/yyyy)	Result (U/L)	Comments
Bilirubin				Collection date (mm/dd/yyyy)	Result (U/L)	Comments
Other relevant tests				Collection date (mm/dd/yyyy)	Result (U/L)	Specify test(s)

First three letters of patient's last name: | | | |

OTHER VIRAL HEPATITIS DIAGNOSTIC TESTS

Diagnostic Test	Yes	No	Unk	If Yes, Specify as Noted	
Hepatitis A Virus (HAV) antibody (anti HAV IgM)				*Collection date (mm/dd/yyyy)*	*Result* ☐ Positive ☐ Negative ☐ Unknown ☐ Not done
				Comments	
Hepatitis B Virus (HBV) core antibody (anti-HBc IgM)				*Collection date (mm/dd/yyyy)*	*Result* ☐ Positive ☐ Negative ☐ Unknown ☐ Not done
				Comments	
HBV surface antigen (HBsAg)				*Collection date (mm/dd/yyyy)*	*Result* ☐ Positive ☐ Negative ☐ Unknown ☐ Not done
				Comments	
Anti-Hepatitis C Virus (HCV)				*Collection date (mm/dd/yyyy)*	*Result* ☐ Positive ☐ Negative ☐ Unknown ☐ Not done
				Comments	
Other viral hepatitis diagnostic tests				*Collection date (mm/dd/yyyy)*	*Result* ☐ Positive ☐ Negative ☐ Unknown ☐ Not done
				Specify test(s)	

Notes, Diagnostic Tests

EPIDEMIOLOGIC INFORMATION

INCUBATION PERIOD: 60 DAYS PRIOR TO ILLNESS ONSET

Infection Timeline

Incubation period: 15-60 days (mean, 40 days)
Infectious period: Transmission most likely to occur 7 days before onset of illness until 14 days after jaundice onset

Enter date of onset in onset box*
Count backward and forward to determine probable exposure and communicable periods

Days from onset:	-60 days	*-7 days*	***Onset***	*+14 days*
Calendar dates:	_____	_____	_____	_____
	(mm/dd/yyyy)	*(mm/dd/yyyy)*	*(mm/dd/yyyy)*	*(mm/dd/yyy)*

TRAVEL HISTORY

*Did patient travel or live **outside the United States** during the 60 days prior to illness onset?* ☐ Yes ☐ No ☐ Unknown	*If No, is patient a close personal contact of a person who traveled internationally?* ☐ Yes ☐ No ☐ Unknown	*Describe (relationship to patient, location of travel)*

*Did the patient travel overnight or longer **outside county of residence** (but within the U.S.) during the 60 days prior to illness onset?*
☐ Yes ☐ No ☐ Unknown

If Yes to either travel question, specify all locations and dates on next page.

First three letters of patient's last name: | | | |

TRAVEL HISTORY – DETAILS

Travel Type	State	Country	Other location details (city, resort, etc.)	Date Travel Started *(mm/dd/yyyy)*	Date Travel Ended *(mm/dd/yyyy)*
☐ Domestic ☐ Unknown ☐ International					
☐ Domestic ☐ Unknown ☐ International					
☐ Domestic ☐ Unknown ☐ International					

FOOD HISTORY

DID THE PATIENT EAT OR DRINK ANY OF THE FOLLOWING ITEMS DURING THE INCUBATION PERIOD?

Food Item	Yes	No	Unk	If Yes, Specify as Noted		
Seafood or meat item imported from outside the U.S.				*Type(s)*	*Eaten undercooked or raw?* ☐ Yes ☐ No ☐ Unknown	*Where originated*
				Details (dates of exposure, any other details of food item, etc.)		
Organ meats (e.g., liver)				*Type(s)*	*Eaten undercooked or raw?* ☐ Yes ☐ No ☐ Unknown	*Where purchased*
				Details (dates of exposure, any other details of food item, etc.)		
Wild game (e.g., swine, deer, venison)				*Type(s)*	*Eaten undercooked or raw?* ☐ Yes ☐ No ☐ Unknown	*Where purchased*
				Details (dates of exposure, any other details of food item, etc.)		
Shellfish				*Type(s)*	*Eaten undercooked or raw?* ☐ Yes ☐ No ☐ Unknown	*Where purchased*
				Details (dates of exposure, any other details of food item, etc.)		
Other food exposures of interest				*Type(s)*	*Eaten undercooked or raw?* ☐ Yes ☐ No ☐ Unknown	*Where purchased*
				Details (dates of exposure, any other details of food item, etc.)		

ANIMAL EXPOSURES

DID THE PATIENT HAVE ANY OF THE FOLLOWING ANIMAL EXPOSURES DURING THE INCUBATION PERIOD?
This includes direct or indirect contact with the animal or environment.

Animal Exposures	Yes	No	Unk	If Yes, Specify as Noted		
Pig or boar				*Type(s) of animal(s)*	*Animal ill?* ☐ Yes ☐ No ☐ Unknown	*Setting / Location*
				Details (dates of exposure, type of contact, etc.)		
Rodents, including rats				*Type(s) of animal(s)*	*Animal ill?* ☐ Yes ☐ No ☐ Unknown	*Setting / Location*
				Details (dates of exposure, type of contact, etc.)		
Other livestock (e.g., cows, sheep, goats)				*Type(s) of animal(s)*	*Animal ill?* ☐ Yes ☐ No ☐ Unknown	*Setting / Location*
				Details (dates of exposure, type of contact, etc.)		
Other animal exposures of interest				*Type(s) of animal(s)*	*Animal ill?* ☐ Yes ☐ No ☐ Unknown	*Setting / Location*
				Details (dates of exposure, type of contact, etc.)		

First three letters of patient's last name: | | | |

WATER EXPOSURES

DID THE PATIENT HAVE ANY OF THE FOLLOWING WATER EXPOSURES DURING THE INCUBATION PERIOD?

Water Source	Yes	No	Unk	If Yes, Specify as Noted	
Natural recreational water (rivers, lakes, oceans, etc.)				*Activity*	*Location*
				Details (dates of exposure, type of water exposure, etc.)	
Artificial recreational water (swimming pools, water parks, fountains, etc.)				*Activity*	*Location*
				Details (dates of exposure, type of water exposure, etc.)	
Drank untreated water/other water exposures of interest				*Activity*	*Location*
				Details (dates of exposure, type of water exposure, etc.)	

Source of household drinking water (check all that apply)

☐ Municipal tap water ☐ Filtered tap water ☐ Bottled water (specify): _____

☐ Private well water ☐ Untreated water

BLOOD / ORGAN DONATION

*Did patient **receive a blood transfusion** during the incubation period?* ☐ Yes ☐ No ☐ Unknown	*If Yes, details of blood transfusion, including date*
*Did patient **donate blood** during the infectious period?* ☐ Yes ☐ No ☐ Unknown	*If Yes, details of blood donation, including date*
*Did patient **receive an organ transplan**t during the incubation period?* ☐ Yes ☐ No ☐ Unknown	*If Yes, details of organ transplant, including date*
*Did patient **donate an organ** during the infectious period?* ☐ Yes ☐ No ☐ Unknown	*If Yes, details of organ donation, including date*

OTHER EXPOSURES OR EPIDEMIOLOGICAL RISKS

DID THE PATIENT HAVE ANY OF THE FOLLOWING EXPOSURES OR EPIDEMIOLOGIC RISK FACTORS DURING THE INCUBATION OR INFECTIOUS PERIOD?

Setting or Exposure	Yes	No	Unk	If Yes, Specify as Noted	
Exposed to a confirmed or probable HEV case				*Provide details in the Ill Contacts section on next page.*	
Attended or worked in daycare				*Location*	
Contact with a diapered child or adult				*Location*	
Lived in congregate setting (e.g., dorm, residential care facility, corrections, etc.)					
Homeless					
Sexual activity				*Sexual partner(s)* ☐ Male ☐ Female ☐ Other: _____ ☐ Refused	*Engaged in oral-anal sex?* ☐ Yes ☐ No ☐ Unknown
Exposure to sewage or human excreta				*Describe*	
Other exposures of interest				*Describe*	

Notes, Epidemiologic History / Risk Factors

First three letters of patient's last name: | | | |

CONTACTS

IF THE PATIENT HAS ANY RELEVANT ILL HOUSEHOLD, SEXUAL, OR OTHER CLOSE CONTACTS, PLEASE PROVIDE DETAILS BELOW AND ENTER INTO NOTES OR MANAGE EXTERNALLY.

Does the patient have any relevant ill household, sexual, or other close contacts? ☐ Yes ☐ No ☐ Unknown	*If Yes, please provide details below and enter into Notes or manage externally.*
How many people besides the case, live in the household?	*Please provide details below. Include any guests who visited from outside the US and stayed at the patient's home, or social or sexual contacts who experienced a similar illness.*

III CONTACTS – DETAILS

Name 1	*Relationship*	*Age*	*Gender*	*Occupation*	*Sensitive occupation / situation?* ☐ Yes ☐ No ☐ Unknown
	Telephone Number	*Similar illness?* ☐ Yes ☐ No ☐ Unknown		*Onset Date (mm/dd/yyyy)*	*Pregnant or immunocompromised?* ☐ Yes ☐ No ☐ Unknown
Name 2	*Relationship*	*Age*	*Gender*	*Occupation*	*Sensitive occupation / situation?* ☐ Yes ☐ No ☐ Unknown
	Telephone Number	*Similar illness?* ☐ Yes ☐ No ☐ Unknown		*Onset Date (mm/dd/yyyy)*	*Pregnant or immunocompromised?* ☐ Yes ☐ No ☐ Unknown
Name 3	*Relationship*	*Age*	*Gender*	*Occupation*	*Sensitive occupation / situation?* ☐ Yes ☐ No ☐ Unknown
	Telephone Number	*Similar illness?* ☐ Yes ☐ No ☐ Unknown		*Onset Date (mm/dd/yyyy)*	*Pregnant or immunocompromised?* ☐ Yes ☐ No ☐ Unknown
Name 4	*Relationship*	*Age*	*Gender*	*Occupation*	*Sensitive occupation / situation?* ☐ Yes ☐ No ☐ Unknown
	Telephone Number	*Similar illness?* ☐ Yes ☐ No ☐ Unknown		*Onset Date (mm/dd/yyyy)*	*Pregnant or immunocompromised?* ☐ Yes ☐ No ☐ Unknown

NOTES / REMARKS

REPORTING AGENCY

Investigator Name	*Local Health Jurisdiction*	*Telephone Number*	*Date Form Completed (mm/dd/yyyy)*
First Reported By ☐ Clinician ☐ Laboratory ☐ Other (specify):_____		*Health education provided?* ☐ Yes ☐ No ☐ Unknown	

EPIDEMIOLOGICAL LINKAGE

Epi-linked to known case? ☐ Yes ☐ No ☐ Unknown	*Contact Name / Case Number*

DISEASE CASE CLASSIFICATION

Case Classification (see case on next page)
☐ Confirmed ☐ Probable

OUTBREAK

Part of known outbreak? ☐ Yes ☐ No ☐ Unknown	*If Yes, extent of outbreak:* ☐ One CA jurisdiction ☐ Multiple CA jurisdictions ☐ Multistate ☐ International ☐ Unknown ☐ Other:_____		
Mode of Transmission ☐ Point source ☐ Person-to-person ☐ Unknown ☐ Other:_____	*Vehicle of Outbreak*	*Pattern 1 ID number*	*Pattern 2 ID number*

STATE USE ONLY

State Case Classification
☐ Confirmed ☐ Probable ☐ Not a case ☐ Need additional information

First three letters of patient's last name: | | | |

CASE DEFINITION

HEPATITIS E VIRUS INFECTION (CDPH Definition, Dec 2019)

CLINICAL CRITERIA

An acute illness with discrete onset of any sign or symptom associated with acute viral hepatitis (e.g., fever, headache, malaise, anorexia, nausea, vomiting, diarrhea, abdominal pain, or dark urine), **AND**

- Jaundice or elevated total bilirubin levels >3.0 mg/dL **and/or** elevated serum alanine aminotransferase (ALT) levels >200 IU/L, **AND**
- The absence of a more likely diagnosis.

LABORATORY CRITERIA

Confirmatory laboratory evidence

- Detection of HEV RNA by nucleic acid amplification testing (NAAT; such as polymerase chain reaction [PCR] or genotyping) in any clinical specimen, **OR**
- Detection (in blood) of
  - Anti-HEV immunoglobulin M (IgM), **and**
  - Anti-HEV immunoglobulin G (IgG), **and**
  - Negative tests for other causes of acute viral hepatitis including negative hepatitis A virus IgM antibody, hepatitis B virus surface antigen, hepatitis C virus RNA, and hepatitis D virus IgM antibody and other causes of liver injury, such as drug-induced liver injury and hepatotropic viruses such as Epstein-Barr Virus (EBV) and cytomegalovirus (CMV), **OR**
- Detection of a four-fold increase in quantitative anti-HEV IgG in acute and convalescent serum specimens.

Probable laboratory evidence

- Detection of anti-HEV IgM **and** negative tests for other causes of acute viral hepatitis including negative hepatitis A virus IgM antibody, hepatitis B virus surface antigen, hepatitis C virus RNA, and hepatitis D virus IgM antibody and other causes of liver injury, such as drug-induced liver injury and hepatotropic viruses such as EBV and CMV.

EPIDEMIOLOGIC LINKAGE

- A clinically compatible illness in a person who is an epidemiologic contact (e.g., household, meal sharer, travel partner, or sexual partner) to a confirmed or probable HEV case, 15-60 days prior to symptom onset.

CASE CLASSIFICATION

Confirmed (acute)

- A person meeting clinical criteria AND confirmatory laboratory criteria.

Probable (Acute)

- A person meeting clinical criteria AND probable laboratory criteria.
- A person meeting clinical criteria who is epidemiologically linked to a confirmed case of HEV.

Chronic

- A person from whom HEV RNA is detected in a clinical specimen for longer than six months.

First three letters of patient's last name: | | | |

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

- Bangladeshi
- Bhutanese
- Burmese
- Cambodian
- Chinese
- Filipino
- Hmong
- Indian
- Indonesian
- Iwo Jiman
- Japanese
- Korean
- Laotian
- Madagascar
- Malaysian
- Maldivian
- Nepalese
- Okinawan
- Pakistani
- Singaporean
- Sri Lankan
- Taiwanese
- Thai
- Vietnamese

NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER GROUPS

- Carolinian
- Chamorro
- Chuukese
- Fijian
- Guamanian
- Kiribati
- Kosraean
- Mariana Islander
- Marshallese
- Melanesian
- Micronesian
- Native Hawaiian
- New Hebrides
- Palauan
- Papua New Guinean
- Pohnpeian
- Polynesian
- Saipanese
- Samoan
- Solomon Islander
- Tahitian
- Tokelauan
- Tongan
- Yapese

First three letters of patient's last name: | | | |

OCCUPATION SETTING

- Childcare/Preschool
- Correctional Facility
- Drug Treatment Center
- Food Service
- Health Care - Acute Care Facility
- Health Care - Long Term Care Facility
- Health Care - Other
- Homeless Shelter
- Laboratory
- Military Facility
- Other Residential Facility
- Place of Worship
- School
- Other

OCCUPATION

- 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
- 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