WEST PARRY SOUND HEALTH CENTRE

Immunization Form

6 Albert St. Parry Sound, ON P2A 3A4
705-746-4540 ext. 2320 Fax 705-773-4036

The Public Hospitals Act, Regulation 965, Section 4.1.e, requires that health surveillance and communicable disease surveillance be conducted on "all persons carrying on activities in the hospital". To meet this requirement, you are asked to complete this information form and return it to Occupational Health Services prior to your start date. You will need to contact your family physician or the Health Unit to obtain the information needed. You will be notified if further immunization is required.

PERSONAL INFORMATION		
Name:	Date of Birth: DD MM YYYY	
e-mail address		
Date of Hire:	Dept.:	Position:
Address:		
City:	Province:	Postal Code:
Home Phone #:	Cell Phone #:	
EMERGENCY CONTACT INFORMATION		
Name: Phone Number(s)	Relationship:	
Family Physician:	Phone #:	
ALLERGIES:		
N95 Respirator Fit Testing: Date:	**Mask Type, attach proof:**	

IMMUNIZATION /COMMUNICABLE DISEASE HISTORY

Disease (MMR requires proof of 2 MMRs or proof of positive titres)	Date of vaccination (Varicella requires ***proof of 2 vaccines or laboratory evidence of immunity or disease**)			Results of Titres/Dates with lab copies	
				Positive	Negative
Mumps					
Measles (Red)					
Rubella (German Measles)					
Varicella (Chicken Pox)					
Tetanus (Td or Tdap)				n/a	n/a
Adacel™ (Tetanus, diphtheria, acellular pertussis) all adults require 1 time booster dose				n/a	n/a
Hepatitis B Immunization	1.	2.	3.		
Hepatitis B Booster Doses					

IMMUNIZATION:	**DATE:**	**PROVIDER:**
Last Influenza vaccine		

- **PROOF of vaccinations, copies of yellow immunization card, or forms with immunization type and date and that are signed off <u>by the profession who provided the vaccine</u>. In addition provide all copies of bloodwork that indicates the results of your antibody titres.**

TUBERCULOSIS SCREENING TEST (TST)

REQUIREMENTS: The tests should be done pre-placement.

Health care workers whose TST status is unknown, and previously identified as tuberculin negative, **require a baseline 2-step TST UNLESS** they have;

- Documented results of a prior 2-step test, OR
- Documentation of a negative TST within the last 12 months, in which case **a single-step test may be given.**

2-Step MantouxTest	Date Given	Date Read (Within 48-72 hrs)	Induration	Interpretation	Health Care Provider
Step 1					
Step 2					

Single Step MantouxTest	Date Given	Date Read (Within 48-72 hrs)	Induration	Interpretation	Health Care Provider(HCP)

Positive TB Test Annual Screening				
CXR Date:	CXR Result:	Symptom Review	Recommendations	HCP

I declare that I have had an opportunity to discuss any need for a workplace accommodation; including my need for assistance, and my ability to assist others, during an emergency i.e. fire, emergency evacuation. I agree to contact Occupational Health Services, in the event that there are any changes in my need for assistance or my ability to assist others during an emergency.

List any accommodation requirements ____

____

____

Signature ____ Date:_______________

I declare that to the best of my knowledge I am capable of performing all duties of this position:

Date: ________________ Signature: ____________________________________