Collingwood General and Marine Hospital
Employee Occupational Health Record

To comply with the Communicable Disease Surveillance Protocols for Ontario Hospitals and the CGMH Screening and Immunization of Employees Policy, this **form must be completed** prior **to commencing employment.** If for medical reasons, you are unable to receive the required immunization(s), your health care provider must include a detailed explanation for this exclusion. This form with required attachments can be submitted on the first day of your Orientation (preferable) but **MUST be completed no later than 30 days after commencing employment**. All new employees will meet with the Occupational Health Practitioner on the day of general orientation to review immunizations and/or complete any outstanding requirements. Please bring your Ontario health care with you to this appointment. **Failure to comply may result in a delay in your start date and/or an unpaid leave of absence until such time the form is completed.**

Instructions: Complete this form and attach all supporting documentation with. Once complete, please return to the Occupational Health Practitioner and **retain a copy for your records.**

If you have any questions, reach out to Occupational Health: (705) 445-2550 Ext: 8149

LAST NAME:	FIRST NAME:	DATE OF BIRTH:
DEPARTMENT:	POSITION:	DATE OF HIRE:

Tuberculosis Screening:

A 2-step TB Skin Test (TST) is required. A historical 2-Step TST is accepted but if completed more than 30 days from start date, an updated 1-Step TST will be required (see below). 1st step to be completed day one and read 48-72 hours later. If the 1st step is negative, 2nd step must be administered 7-21 days after the 1st step in the opposite arm. Please also attach supporting documentation.

1st step	Date planted:	Date read:	Result (+ or -)	Induration (mm)
2nd step	Date planted:	Date read:	Result (+ or -)	Induration (mm)

If a 2-step test was NOT completed within 30 days of start date, the results of a 1-step TST completed within 30 days of start date must be documented below. Please also attach supporting documentation.

1st step	Date planted:	Date read:	Result (+ or -)	Induration (mm)

If the 1st or 2nd test is POSITIVE (i.e. greater than 10mm induration): Chest x-ray is required. X-ray must have been completed within the last year. Please also attach supporting documentation.

X-ray	Date:	Result:

OPTIONAL: In lieu of a TST, results of Interferon-Gamma Release Assay (IGRA) can be provided. The IGRA must be completed within 30 days of start date.

IGRA	Date:	Result:

Vaccine Preventable Diseases: (Please attach laboratory evidence and/or proof of immunization)

Measles	Laboratory evidence of immunity OR	Date of test:	☐ Immune ☐ Not immune
	2 MMR vaccinations	Date of 1st MMR:	Date of 2nd MMR:
Mumps	Laboratory evidence of immunity OR	Date of test:	☐ Immune ☐ Not immune
	2 MMR vaccinations	Date of 1st MMR:	Date of 2nd MMR:
Rubella	Laboratory Evidence of immunity OR	Date of test:	☐ Immune ☐ Not immune
	2 MMR Vaccinations	Date of 1st MMR:	Date of 2nd MMR:
Varicella	Laboratory evidence of immunity OR	Date of test:	☐ Immune ☐ Not Immune
	Varicella Vaccine	Date of 1st Dose:	Date of 2nd Dose:
Tetanus/Diphtheria/ Pertussis	Tdap is recommended for all adults once in adulthood Td recommended every 10 years	☐ Tdap ☐ Td	Date: Date:
Hepatitis B ***Recommended for high-risk staff**	Laboratory evidence of immunity OR	Date of test:	☐ Immune ☐ Not immune
	Series of 3 vaccinations (some HCWs would have received 2 1.0mL doses of HB as an adolescent, this is considered a complete series)	Received vaccine: ☐ Yes ☐ No	Date of vaccine: #1 _____ #2 _____ #3 _____
Meningococcal Disease ***Recommended for Lab staff who are routinely exposed to preparations or cultures of Neisseria Meningitidis**	A, C, Y W-135 Conjugate AND/OR	Date of vaccine:	
	Meningococcal B Vaccine	Date of vaccine:	
Influenza	Highly recommended each year for all staff	Year of most recent vaccine:	
Covid-19 Vaccination	**Highly recommended for all staff**	Date of 1st Vaccine: Date of 2nd Vaccine:	

*High risk staff include: those who handle blood and blood related products, those who handle biological fluids, biological wastes and dirty surgical instruments, those who start IVs or collect blood specimens routinely, those who may be at an increased risk of bites from patients. High risk are all staff that work in the following areas: Nurses working on Medical, OBS/Surgical, ED, ICU, OR and in AmbCare, and staff working in the Laboratory, Housekeeping, Diagnostic Imaging, Security, Mental Health, Cardio-Respiratory, and Medical Device Reprocessing Departments**.**

Employee Declaration/Consent:

Please return this completed and signed form with the required supporting documentation to the Occupational Health Practitioner. Keep a copy of this form and any supporting documentation for your own records. If you have any questions, please contact the Occupational Health Practitioner at extension 8149.

I have read the recommended immunization schedule and to the best of my knowledge my immunization history is complete. I understand that this information is confidential and will be kept on file by Occupational Health. I understand also, that should an exposure or an outbreak situation occur, this information may also be shared with the Simcoe Muskoka District Health Unit.

I,_____, agree to release the above information to Collingwood General and Marine Hospital. I understand that my manager will be informed of my compliance status.

Employee Signature:_____Date: _____

To be completed by the Occupational Health Practitioner:

Immunization Status for the above employee is:

□ **Complete**

Employee has all required immunizations

□ Yes
□ No

Written documentation: Medical certificate/immunization record/lab results on file

□ Yes
□ No

Received by:_____ Date: _____

□ **Incomplete**

If incomplete or unknown immunization status (check all that apply)

□ Documentation to support immunization information provided is missing and must be provided

Comments: _____

_____

□ Employee signature is missing (please sign and resubmit)

***Please resubmit no later than_____with the requested information.**

Failure to comply may result in a delay in your start date and/or an unpaid leave of absence until such time the form is completed.

Received by:_____ Date: _____

□ **Follow up**

□ Employee has obtained required immunizations or boosters and provided verifications

□ Employee has obtained blood work and provided verifications of immunity

□ Facility's policy regarding accommodating employees who are not immunized or incompletely immunized or not immune was reviewed with this employee

Received by:_____ Date: _____