Vendors Health & Safety Clearance

Instructions:

Vendors must comply with the requirements set out in the Public Hospital Act Regulation 965 by-law 4(1)d. Clearance promotes the well-being of our patients and staff by preventing the transmission of infectious and communicable diseases.

All Vendors that have an agreement with University Health Network (UHN) must submit this completed form to vendors@uhn.ca along with all other required documents.

******PLEASE NOTE****** UHN will not be held liable for illnesses contracted during a vendors contract.

Please ensure that this form is to be dated, signed and stamped by your healthcare provider. If you do not have a healthcare provider, you may choose to call ahead to make an appointment at Bay College Medical & Lockwood Diagnostic Centre, 790 Bay Street, Suite 108, 416-929-1900.

Applicant

First Name:	
Last Name:	

Evidence of Immunity	**Health Care Provider**
Measles, Mumps & Rubella ☐ Live MMR on /or after first birthday and as required. A second MMR vaccine is strongly recommended. Date #1: Date #2: **OR** Laboratory evidence of positive titre levels: ☐ Measles Result: Date: ☐ Mumps Result: Date: ☐ Rubella Result: Date:	Printed Name: Stamp: Signature: Date:
Varicella (Chickenpox) Screening ☐ Proof of receipt of 2 doses of Varicella vaccination **OR** ☐ Laboratory report indicating immunity to Varicella **OR** ☐ Diagnosis or verification of a history of typical Varicella by a health care provider **OR** ☐ Diagnosis or verification of Shingles by a health care provider	Printed Name: Stamp: Signature: Date:

Evidence of Immunity	Health Care Provider
Hepatitis B 2 completed immunizations: Date #1: Date #2: Laboratory Evidence of positive titre levels: Result: Date:	Printed Name: Stamp: Signature: Date:
Tetanus & Diptheria or Tetanus Diphtheria & Pertussis Td date of immunization: Tdap date of immunization: Tetanus vaccine is required to be updated every 10 years	Printed Name: Stamp: Signature: Date:

Tuberculosis Screening

Test	Skin Testing History	TB Testing Results	Health Care Provider
Mantoux skin test	BCG ☐Yes ☐No Last 2-stepTB skin test **(5 TUPPD 0.1 cc ID)** Dates: Results: ☐Negative ☐Positive (chest x-ray required)	5TUPPD 0.1 cc ID **Step 1** (if last 2-step TB test done within 5 years) Date: Result: **Step 2** (if no recent baseline or if initial test is less than 10 mm of induration) Date: Result:	Printed Name: Signature: Date: Stamp:
Chest X-ray	**Required if skin test positive** Unless medically contra-indicated. Reason:	CXR results: Date:	

Seasonal Influenza Vaccine (optional): ☐ Yes (Date)_____ ☐ No

Mask Fit Testing:

Please discuss with your Sponsor to determine whether or not a Respirator will be required during your stay.

Required: ☐ Yes ☐ No Model #:_____ Date:_____