UHN Toronto General Toronto Western Princess Margaret Toronto Rehab Michener Institute
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Occupational Health Mandatory Requirements

UHN requires all new staff to provide Occupational Health & Safety with current immunization records that meet our organizational policy and the minimum standards for all Ontario hospitals (OHA/OMA Guidelines). The purpose of these requirements are to limit the risk of exposure and transmission of communicable diseases for staff and patients and support a healthy and safe work environment.

As it may take 4-6 weeks to complete these requirements, **the requirements should be started well in advance of your start date**. Staff are not permitted to verify their own record and are advised to retain a copy of this form for their own records:

- Form A must be fully completed by employee.
- Form B: Can be filled out by a licensed medical practitioner OR you may provide documentation of these records that include **all the required elements found on Form B.** This must be in PDF format, in a **single attachment.**

To access your past records:

- Contact your current or past employer, or organization where you performed volunteer work, and request a copy of your record from the Occupational Health Department.
- Contact your health care training school program and request a copy of your immunization record from Student Health Services.
- Contact the Public Health Department in the school district that you attended to ask for a copy of your vaccination record. If you attended school in Toronto you can access your record online: https://tph.icon.ehealthontario.ca/#!/welcome
- Obtain your childhood record (often a yellow card or form) from your family doctor or parents. Other health care professionals you have received care from may also have pertinent documentation of immunity such as obstetricians, midwives or family physicians.
- Blood tests are required if you are unable to confirm vaccination dates and test results may take 2-4 weeks. You may want to discuss revaccination as an option with your doctor.

Submit these forms to the secure e-mail address ***OHSNEO@uhn.ca*** **no later than 5 business days prior to your start date**. **Include the site where you will be working in the subject line of your email**. If you have concerns regarding transmitting your documents over e-mail, please contact occupational health.

This form will be reviewed by an occupational health nurse, and you will receive a follow up e-mail once reviewed. The medical information collected will be maintained in confidence and will remain part of your Occupational Health Clinic medical record.

N95 MASK FIT TESTING

It is a legislated requirement for healthcare workers who have patient contact to be fitted for a N95 mask. Please ensure you attend a mask fit testing session, schedule is available on the Occupational Health intranet site and posted in the Occupational Health Clinic. No appointment is necessary.

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FORM A: Health History

To be completed by Employee:

Name:_____ **Date of Birth:**_____
(Last name, First name) (DD/MM/YYYY)

Have you ever received medical treatment for the following:

Yes	No		Yes	No	
☐	☐	Back/neck injury or pain	☐	☐	Hepatitis/HIV
☐	☐	Upper limb (shoulder, elbow, wrist, hand) injury or pain	☐	☐	Respiratory problems
☐	☐	Lower limb (hip, knee, lower leg, ankle, foot) injury or pain	☐	☐	Immunosuppression
☐	☐	Visual problems	☐	☐	MRSA/VRE
☐	☐	Hearing problems	☐	☐	Skin conditions of the hand
☐	☐	Seizures/Loss of consciousness			

If checked yes, please explain:

_____

List any Allergies or sensitivities (eg. Latex, rubber, food, medications, environmental):

_____

Describe the type of reaction you have experienced and any medical follow-up/treatment to noted allergies:

_____

Have you ever had any limitations placed on your physical or work activities because of illness, injury, or WSIB/work related injury? Yes ☐ No ☐ if yes, please elaborate:

_____

Do you have any permanent restrictions or limitations? If so, please describe:

_____

Do you require an accommodation to complete the duties of the job? If so, please describe. Did you disclose this prior to being hired for the job? Yes ☐ No ☐

_____

Do you have any disability for which you require accommodation under the Human Rights code? If so, please describe.

_____

Do you have restrictions that require accommodation related to your personal safety in the event of an emergency? Yes ☐ No ☐

_____

_____

I hereby declare that this information as well as the information I provided prior to being hired is true and complete. I understand that all medical information provided by me will be kept confidential as per the UHN Confidentiality Policy. Should I have any need for accommodation due to an existing disability, the UHN accommodation policy and disability management procedures will be followed and an accommodation will be provided if possible.

Employee's signature _____ **Date** _____

FORM B: IMMUNIZATION STATUS RECORD

To be completed by:

- **a medical practitioner OR**
- **you may attach documentation of your immunization records that include *all the required elements* below**

NAME:	**DATE OF BIRTH:**
1. Mantoux (TB) skin test status A 2-step TB skin test (TST) is mandatory unless previously tested positive (5 TUPPD 0.1cc ID) or have documentation of a previous two-step TST, in which case a one-step TST within the past 12 months is required. CHEST X-RAY required if skin test is positive (unless contraindicated for medical reasons) valid within 2 years Persons who have had previous BCG vaccine should be assessed as above.	**Tuberculin Skin Test** 1. Date Given: _____ (L) (R) Given By:_____ Date Read: _____ Read By: _____ Result: _____ (_____ mm. induration) 2. Date Given: _____(L) (R) Given By: _____ Date Read: _____ Read By: _____ Result: _____ (_____ mm. induration) **Annual TB test: Date** _____ **(L) (R)** Given By:_____ **Date Read**_____ **Result:**_____ **Read By :**_____ **CXR** : Date: _____ Result: _____
2. Evidence of immunity to Measles, Mumps and Rubella (MMR) 2 doses of MMR vaccination OR laboratory evidence of immunity are required. **Tdap/ Td** *(circle one)* ***Optional*** Date: _____	**Record of MMR Immunization** 1. Date: _____ 2. Date: _____ **Laboratory evidence of immunity** Measles: Date:_____ Result:_____ Mumps: Date:_____ Result:_____ Rubella: Date:_____ Result:_____
3. Varicella (chickenpox) Evidence of Immunity 2 doses of Varicella vaccination OR laboratory evidence of immunity are required.	**Record of Varicella Immunization** 1 Date: _____ 2 Date**:** _____ **Laboratory evidence of immunity** Date: _____ Result:_____
PLEASE NOTE: THE FOLLOWING SECTION IS ONLY REQUIRED FOR STAFF WHO WILL WORK WITH PATIENTS AND/OR MAY BE EXPOSED TO BLOOD, BODILY FLUIDS OR INFECTIOUS WASTE.	
4. Hepatitis B Evidence of Immunity **Laboratory evidence of immunity** Date:_____ Result: _____	**Record of Immunization** 1 Date: _____ 2 Date:_____ 3 Date: _____Booster: _____ Non-Responder to immunization HbSAg Date:_____ Result:_____

Information collected on this form will be maintained in confidence. Only information that confirms that you have met these requirements will be shared with your manger.

_____ _____

Health Practitioner's Signature **Date**

_____ _____

Employee's Signature **Date**

(STAMP HERE)

Revised: 10-May-2019