

## 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](mailto: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.

## FORM A: Health History

**To be completed by Employee:**

**Name:** \_\_\_\_\_  
(Last name, First name)

**Date of Birth:** \_\_\_\_\_  
(DD/MM/YYYY)

Have you ever received medical treatment for the following:

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Back/neck injury or pain	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/HIV
<input type="checkbox"/>	<input type="checkbox"/>	Upper limb (shoulder, elbow, wrist, hand) injury or pain	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory problems
<input type="checkbox"/>	<input type="checkbox"/>	Lower limb (hip, knee, lower leg, ankle, foot) injury or pain	<input type="checkbox"/>	<input type="checkbox"/>	Immunosuppression
<input type="checkbox"/>	<input type="checkbox"/>	Visual problems	<input type="checkbox"/>	<input type="checkbox"/>	MRSA/VRE
<input type="checkbox"/>	<input type="checkbox"/>	Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>	Skin conditions of the hand
<input type="checkbox"/>	<input type="checkbox"/>	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** \_\_\_\_\_

