HEALTH REVIEW FORM

☐ **Paid Staff** ☐ **Private Hire**

☐ St. Joseph's ☐ Mt. Hope ☐ Parkwood Institute Main Building ☐ Parkwood Institute Mental Health Care ☐ Southwest Centre

To fulfill the terms and conditions of your employment offer, the following information must be provided to Occupational Health and Safety Services no later than 7 business days prior to your start date. INCOMPLETE FORMS AND LATE SUBMISSIONS WILL DELAY YOUR START DATE.

Proof of immunization is required and includes any of the following: Vaccination records from yellow immunization cards, immigration records, notes from a physician's office, copies of laboratory reports (titre levels), health unit records and/or other hospital electronic immunization records.

Fill in the immunization dates below, as noted on your yellow immunization cards. Send a copy of the yellow immunization card along with this form. If you don't have your own records, take this form to your physician or Public Health Unit to complete in full and sign. Relatives are not permitted to complete and sign this record.

Once completed and signed, scan form and email to: OHSS@sjhc.london.on.ca or fax to 519-646-6235.

Any costs associated with the completion of this form are your responsibility. Retain a copy for your records.

LAST NAME:	**FIRST NAME:**	**MIDDLE INITIAL:**
ADDRESS:		
PRIMARY PHONE # (home or cell.):	**EMAIL** (optional):	
COUNTRY OF BIRTH:	**DATE OF BIRTH** (mm/dd/yyyy)**:**	
FAMILY PHYSICIAN:	**EMERGENCY CONTACT PERSON:**	**EMERGENCY CONTACT #**
JOB TITLE:	**DEPARTMENT:**	**COORDINATOR/ DIRECTOR:**

TUBERCULOSIS

All St. Joseph's Staff and affiliates require a 2-Step TB Skin test (TST). The 2-Step TB skin test is given 1- 52 weeks apart from the first single TST. *A TB skin test may be given on the same day as a live vaccine, but otherwise may not be administered until at least 4 weeks have elapsed.*

Step 1:	Date Administered:	Date read:	Result (+ or -)	Induration (mm)
Step 2:	Date Administered:	Date read:	Result (+ or -)	Induration (mm)
If 2-Step TB test was completed more than 12 months ago, a 1-Step TB test must be completed.				
Step 1:	Date Administered:	Date read:	Result (+ or -)	Induration (mm)
If first or second test is POSITIVE (i.e., greater than 10mm induration):**Chest x-ray is required to be completed, post-positive test.**				
X-ray:	Date:	Result**:**		
Did you receive treatment for TB?	☐ Yes ☐ No	Date of Treatment:		
Endemic Travel History	☐ Yes ☐ No Please explain:			

REQUIRED IMMUNIZATIONS

Measles:	Laboratory evidence of immunity (titres), **OR**	Date of test:	Result: ☐ Immune ☐ Not Immune
	2 doses of measles-containing vaccine on or after the first birthday, with doses given at least four weeks apart,	Date of 1st MMR:	Date of 2nd MMR:
Mumps:	Laboratory evidence of immunity (titres), **OR**	Date of test:	Result: ☐ Immune ☐ Not Immune
	2 doses of mumps-containing vaccine given at least four weeks apart on or after the first birthday	Date of 1st MMR:	Date of 2nd MMR:

Rubella:	Laboratory evidence of immunity (titres), **OR**	Date of test:	Result: ☐ Immune ☐ Not Immune
	Evidence of immunization with live rubella containing vaccine (one dose) on or after their first birthday	Date of MMR:	
Varicella:	Varicella vaccine (2 doses required), **OR**	Date of first dose:	Date of second dose:
	Laboratory evidence of immunity (titres), **OR**	Date of test:	Result: ☐ Immune ☐ Not Immune
	Laboratory evidence of chickenpox or shingles (from lesion swab or scraping)	Date of test:	Result: ☐ Varicella-zoster virus detected
Hepatitis B:	Confirmatory titre test result if available	Received vaccine? ☐ Yes ☐ No	Date of titre test: Result of titre test: ☐ Immune ☐ Not Immune ☐ Not tested
	Vaccination is **highly recommended** for Staff who may have exposure to human blood and body fluids. **Hep B is not mandatory for volunteers.**	Date of first dose Date of second dose Date of third dose	
Tetanus/ Diphtheria/ Pertussis:	Tdap **is recommended** for all adults Tetanus and Diphtheria is recommended every 10 years Pertussis- once in adulthood	☐ Tdap Date: _____ If never received Tdap: ☐ Td Year of most recent booster: _____	
Influenza:	Highly recommended each year	Date of most recent vaccine:	

COVID-19	**Vaccine proof required.**	Type:	Date of first dose:	Date of second dose:
		Mt. Hope Staff Required.	Date of third dose:	

Have you been fit-tested within the last 2 years to wear an N95 respirator? ☐ No ☐ Yes. If yes, attach proof.

Do you have any food/drug allergies or any emergent medical conditions (e.g., asthma, epilepsy, diabetes, heart condition) that you feel Occupational Health should be aware of? ☐ No ☐ Yes. If yes, provide details: _____

_____

Do you have a disability that requires an accommodation? ☐ No ☐ Yes. If yes, provide details: _____

_____

Physician contact information and signature required **if form was completed by the physician.**

Physician signature: _____ Date: _____

Physician name (print): _____

Address: _____

Phone #: _____

For Staff/Private Hire

I, _____, agree to:
(print name)

☐ Release the above information to Occupational Health and Safety at St Joseph's Health Care London.

☐ Provide proof of COVID-19 vaccine.

☐ Follow any future Public Health recommendations and St. Joseph's Health Care London policies and processes related to COVID management in the workplace.

Signature: _____ **Date:** _____

Information obtained is strictly confidential, and shall not be released to any source internally or externally without written consent of the employee named herein.