London Health Sciences Centre

STAFF /AFFILIATE HEALTH REVIEW FORM

☐ Paid Staff ☐ Volunteer* ☐ Co-op Student* ☐ Student ☐ Sponsored Student ☐ Private Hire

☐ University Hospital ☐ Victoria Hospital ☐ Westmount Kidney Care Center ☐ FEMAP ☐ Other off site location_____

In order to fulfill the terms and conditions of your employment/volunteer offer, and to start work at LHSC, the following information must be provided to Occupational Health and Safety Services.

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: HealthReviews@lhsc.on.ca or fax to 519-685-8374.** Any costs associated with the completion of this form are your responsibility. Retain a copy for your records.

Start Date (YYYY/MM/DD)	Date of Birth:	Employee ID Number:
LAST NAME	FIRST NAME	MIDDLE INITIAL
JOB TITLE	Sex: ☐ Male ☐ Female	
Department Name:	COORDINATOR/ MANAGER:	
Status: Full Time__ Part Time ___ Casual ____	Preferred Email contact:	
ADDRESS		
HOME PHONE CELL PHONE (optional)	EMAIL (OPTIONAL)	
FAMILY PHYSICIAN	EMERGENCY CONTACT PERSON	EMERGENCY CONTACT #

TUBERCULOSIS

All LHSC Staff and affiliates require a 2 step TB Skin test (TST). The 2 step TB skin test is given 1- 52 weeks of 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.*

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

Required Immunizations/ Proof of Immunity

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 1st dose:	Date of 2nd 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

RECOMMENDED IMMUNIZATIONS

Hepatitis B:	Confirmatory titer test result if available	Received vaccine? ☐ Yes ☐ No	Date of titer test: Result of titer test: ☐ Immune ☐ Not tested ☐ Not Immune
	Vaccination with subsequent proof of immunity is **highly recommended** for Staff who may have exposure to human blood and body fluids. **Hep B is not mandatory for volunteers.**	Date of 1st dose Date of 2nd dose Date of 3rd dose	
Tetanus/ Diphtheria/ Pertussis:	A onetime adult dose of Tdap **is recommended** for all adults Tetanus and Diphtheria is recommended every 10 years	☐ Tdap Date: _____ If never received Tdap ☐ Td Year of most recent booster: _____	
Influenza:	Highly recommended each year	Date of most recent vaccine:	

Have you been fit-tested within the last 2 years to wear an N95 respirator? ☐ Yes ☐ No
Do you have limitations /restrictions to N95 Fit Testing? If Yes, attach proof.

Do you have any food/drug allergies or sensitivities (e.g. Latex, rubber, food, medications, environmental)? ☐ Yes ☐ No
_____

Describe the type of reaction you have experience and any medical follow up/treatment:
_____

Do you have any medical conditions (e.g., asthma, epilepsy, diabetes, heart condition) Occupational Health should be aware of? ☐ Yes ☐ No
_____

Do you have limitations /restrictions or a disability that requires an accommodation? ☐ Yes ☐ No
(If yes, provide details) _____

Do you require any adaptations or ergonomic changes to your work environment? ☐ Yes ☐ No
(If yes, provide details) _____

Is there a possibility of routine/regular exposure to excessive noise in your work unit? ☐ Yes ☐ No
Hearing Assisted: ☐ Yes ☐ No Last hearing test: (yyyy/mm/dd) _____

Glasses worn: ☐ Yes ☐ No Contacts worn: ☐ Yes ☐ No

Physician contact Information and signature required <u>if form was completed by the Physician.</u>

Physician: _____ Signature: _____ Date: _____
PRINT NAME

Address: _____

Phone#: _____

For Staff/ Physician/ Volunteer/ Student

I, _____, agree to release the above information to the Occupational Health and Safety at London Health Sciences Centre

Name: _____

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.

Occupational Health Nurse reviewed, documented in Parklane and communicated fitness to work on (yyyy/mm/dd) _____

Nurses Name (Print) _____ Nurses Signature: _____