

Occupational Health & Safety Clearance

Instructions:

Observers and Authorized Guests 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 applicants must submit this completed form to observerships@uhn.ca along with all other required documents.

PLEASE NOTE The hospital will not be held liable for illnesses contracted while here as an Observer or Authorized Guest.

Please ensure that this form is to be dated, signed and stamped by your healthcare provider.

Applicant

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

Date #1: Date #2: Laboratory evidence of positive titre levels: Result: 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 Date: Signature: Signature: Signature: Date: Date: Signature: Date: Date: Printed Name: Stamp: Tuberculosis Screening Test Skin Testing History TB Testing Results Health Care Provider Mantoux Skin test Pys No Last 2-stepTB skin test (s TUPPD 0.1 cc ID) Dates: Results: Negative	Evidence of Immunity			Health Care Provider		
Date #1: Date #2: Laboratory evidence of positive titre levels: Result: 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 Date: Signature: Signature: Date: Date: Signature: Date: Signature: Date: Printed Name: Stamp: Tuberculosis Screening Test Skin Testing History TB Testing Results Health Care Provider Mantoux Skin test Pys No Last 2-stepTB skin test (5 TUPPD 0.1 cc ID) Dates: Results: Negative Negativ	Hepatitis	В		Printed Name:	Stamp:	
Laboratory evidence of positive titre levels: Result: Date: Date:	2 completed immunizations: Date #1:			Signature:		
Laboratory evidence of positive litre levels: Result: Date: Printed Name: Stamp:	Date #2:			Data		
Total date of immunization: Total date of immunization: Tetanus vaccine is required to be updated every 10 years Tuberculosis Screening Test Skin Testing History TB Testing Results Health Care Provider Mantoux BCG Struppd 0.1 cc ID Step 1 (if last 2-step TB test done within 5 years) Date: Date: Step 2 (if no recent baseline or if initial test is less than 10 mm of induration) Date: Result: Chest X- Required if skin test positive Unless medically contra-indicated. Reason: Chest X- Readired (optional): Yes (Date) Date: Results: Date: Chast Fit Testing: Please discuss with your Sponsor to determine whether or not a Respirator will be required during your stay.	Laboratory evidence of positive titre levels: Result: Date:			Date:		
Signature: Date:	Tetanus & Diptheria or Tetanus Diphtheria & Pertussis			Printed Name:	Stamp:	
Test Skin Testing History TB Testing Results Health Care Provider Mantoux Skin test Skin Testing History Step 1 (if last 2-step TB test done within 5 years) Dates: Results: Results: Step 2 (if no recent baseline or if initial test is less than 10 mm of induration) Date: Result: Stamp: Chest X- Required if skin test positive Unless medically contra-indicated. Reason: Date: Stamp: Stamp: Mask Fit Testing: Positive Contra-indicated whether or not a Respirator will be required during your stay.	Td date of immunization:			Signature:		
Test Skin Testing History TB Testing Results Health Care Provider	Tetanus vaccine is required to be updated every 10 years		ears	Date:		
Test Skin Testing History TB Testing Results Health Care Provider						
BCG Skin test STUPPD 0.1 cc ID Step 1 (if last 2-step TB test done within 5 years) Date: Result: Date: Date:	Fuberculos	sis Screening				
Step 1 (if last 2-step TB test done within 5 years) Date: Result: Dates: Results: Negative Positive (chest x-ray required) Chest X- ray Reason: Reason: Result: Step 2 (if no recent baseline or if initial test is less than 10 mm of induration) Date: Result: CXR result: CXR results: Date: Stamp: Date: Stamp: Date: Stamp: Date: Stamp: Date: Date: Stamp: Date: Stamp: Date: Stamp: Date: Stamp: Date: Stamp: Date: Date: Da	Test	Skin Testing History	TB Testing Results		Health Care Provider	
Results: Negative Date: Negative Neg	Mantoux skin test	Last 2-stepTB skin test (5 TUPPD 0.1 cc ID)		last 2-step TB test done ears)		
Date: Result: Chest X- ray Required if skin test positive Unless medically contra-indicated. Reason: Date: CXR results: Date: Date: No Mask Fit Testing: Please discuss with your Sponsor to determine whether or not a Respirator will be required during your stay.		Results:	initial test is less than 10 mm of		Date:	
Unless medically contra-indicated. Reason: Date: Pasonal 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.		Positive (chest x-ray required)	Date:	Result:	Stamp:	
Please discuss with your Sponsor to determine whether or not a Respirator will be required during your stay.	Chest X- ray	Unless medically contra-indicated.	CXR results:			
Mask Fit Testing: Please discuss with your Sponsor to determine whether or not a Respirator will be required during your stay.	reason.		Date:			
Please discuss with your Sponsor to determine whether or not a Respirator will be required during your stay.	easonal Inf	iluenza Vaccine (optional):	(Date)	N	0	
Required: ☐ Yes ☐ No Model #: Date:		_	er or not a R	tespirator will be required du	ıring your stay.	
	Required:	☐ Yes ☐ No Model #:	<u>. </u>	Date:		