Health Services Mandatory Requirements

UHN requires all TeamUHN provide Health Services 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:

- **Onboarding Immunization Record:** 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 this form.** This must be submitted as an attachment to the completed record**.**
- **Health History:** Must be fully completed by the onboarding TeamUHN member.

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.

If you do not have a health care provider please use the following link to find one: https://www.ontario.ca/page/find-family-doctor-or-nurse-practitioner.

Submit the below information and supporting documentation using the online forms located at **kics.uhn.ca/kics/formlist.php** **no later than 5 business days prior to your start date**. Please have all of your documentation ready to submit together.

You will receive a follow up e-mail once submitted. The medical information collected will be maintained in confidence and will remain part of your Health Services Clinic medical record. If you have concerns regarding submitting your documents online, please contact Health Services at 416-979-4441.

N95 RESPIRATOR FIT TESTING

Upon hire at UHN, all healthcare workers will be provided with the opportunity to be fit tested on an N95 respirator. Please complete the N95 Respirator Fit Testing online form, located at **kics.uhn.ca/kics/formlist.php** to provide us with a copy of your valid fit test record (completed within the last two years) and/or to be provided with instructions on how to complete an N95 respirator fit test when you start at UHN.

Onboarding Immunization Record for TeamUHN

Can be filled out by a licensed medical practitioner OR you may provide documentation of these records that include **all the required elements (1-6) found on this 2-page form.** This form once completed may be submitted with your records using the online form located at **kics.uhn.ca/kics/formlist.php**.

UHN EMPLOYEE NAME: **UHN EMPLOYEE ID:**

1) Mantoux (TB) Skin test status • A **2-step TB skin test (TST) is mandatory**. • If the previous two-step TST was performed greater than 5 years ago, a one-step TST within the past 12 months is also required. • **If any historical skin test is positive, a CHEST X-RAY is required** (unless contraindicated for medical reasons), and **must be valid within 2 years**. • Persons who have had previous BCG vaccine should be assessed as above.	**Mantoux (TB) Skin test results** 1. Date Given: _____ Location: (L) (R) Given By:_____ Date Read: _____ Read By: _____ Skin Read Result: _____ (_____ mm. induration) 2. Date Given: _____ Location: (L) (R) Given By:_____ Date Read: _____ Read By: _____ Skin Read Result: _____ (_____ mm. induration) **If previous two-step TST greater than 5 years ago:** 3. Date Given: _____ Location: (L) (R) Given By:_____ Date Read: _____ Read By: _____ Skin Read Result: _____ (_____ mm. induration) **If any historical skin test Positive:** **CXR**: Date: _____ Result(circle one): Positive / Negative
2) Evidence of immunity to Measles, Mumps and Rubella (MMR) • Documentation of **2 doses of Measles, Mumps and Rubella (MMR) vaccine or blood titers** showing immunity.	**Record of MMR Immunization** 1. First Dose Date: _____Given By: _____ 2. Second Dose Date: _____Given By: _____ **OR** **Laboratory evidence of immunity** **Measles** Date Immunity Test Completed:_____ Result (circle one): Reactive / Non-Reactive / Indeterminate **Mumps** Date Immunity Test Completed:_____ Result (circle one): Reactive / Non-Reactive / Indeterminate **Rubella** Date Immunity Test Completed:_____ Result (circle one): Reactive / Non-Reactive / Indeterminate
3) Evidence of Varicella (chickenpox) or Shingles Immunity • Verbal history or verification of diagnosis of varicella is no longer acceptable proof. • Documentation of **2 doses of varicella vaccine or blood titers** showing immunity.	**Record of Varicella Immunization** 1. First Dose Date: _____ 2. Second Dose Date: _____ **OR** **Laboratory evidence of Varicella immunity** Date Immunity Test Completed:_____ Result (circle one): Reactive / Non-Reactive / Indeterminate

4) Immunization against Tetanus and Diphtheria (Tdap/Td)	**Record of Vaccination for Tetanus and Diphtheria (Td/Tdap)** Method Received (circle one): Tdap / Td Date Completed:_____
5) Documentation of evidence of 2 doses of the COVID-19 vaccine • Documentation of evidence of minimum **2 doses of the COVID-19 Vaccine.**	**Record of COVID-19 Vaccine** 1. First Dose Vaccine Manufacturer: _____ First Dose Date:_____ 2. Second Dose Vaccine Manufacturer: _____ Second Dose Date:_____
6) Documentation of Hepatitis B status *Applies ONLY for staff who will work with patients and/or may be exposed to blood, bodily fluids or infectious waste.* • Proof of **Hepatitis B immunity (bloodwork) required.** • If **immunity negative**: ➢ Documentation of evidence of minimum **2 doses of the hepatitis B vaccine required <u>OR</u>** ➢ Proof of **non-responder status** to Hepatitis B required.	**Record of Hepatitis B Immunity** Date Immunity Test Completed:_____ Result (circle one): Positive / Negative / Indeterminate **<u>If Negative:</u>** **Record of Hepatitis B Immunization** 1. First Dose Date: _____ 2. Second Dose Date: _____ 3. Third Dose Date (if necessary): _____ 3. Booster Dose Date (if necessary): _____ **<u>If Non-Responder:</u>** HbSAg Date:_____ Result (circle one): Positive / Negative / Indeterminate

_____ _____
Health Practitioner's Signature **Date**

_____ _____
Employee's Signature **Date**

(PRACTITIONER STAMP HERE)

Health History

This form to be completed by the TeamUHN member online using the "Health History" form located at **kics.uhn.ca/kics/formlist.php**.

Name:_____ **Date of Birth:**_____
(last name, first name) (DD/MM/YYYY)

The following questions are important to identify any health conditions that could be affected by potential exposure to workplace hazards.

List any Allergies or sensitivities (eg. Latex, rubber, food, medications, environmental) and describe the type of reaction you have experienced and any medical follow-up/treatment to noted allergies:

Allergy	Type of Reaction

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 describe: _____

_____

Are any of the above noted restrictions or limitations permanent in nature? Yes ☐ No ☐

If yes, please describe: _____

_____

Do you have any current medical restrictions or limitations? Yes ☐ No ☐

How long are they in place for? _____

Are any of these permanent? Yes ☐ No ☐

Do you require an accommodation to complete the duties of the job? Yes ☐ No ☐

If yes, 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? Yes ☐ No ☐

If yes, please describe: _____

_____

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

If yes, please describe: _____

_____

Information collected on this form will be maintained in confidence. Only information related to ability to perform work and accommodation requirements will be shared with your Hiring Manager/Principle Investigator (PI)/Supervisor.

Employee Signature: _____ **Date:** _____