

☐ Paid Staff      ☐ Private Hire

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

**In order 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](mailto: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 # (May be home or cell)		EMAIL (OPTIONAL)		
COUNTRY OF BIRTH		DATE OF BIRTH		
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.**

<b>1<sup>st</sup> step:</b>	Date administered:	Date read:	Result (+ or -)	Induration (mm)
<b>2<sup>nd</sup> step:</b>	Date administered:	Date read:	Result (+ or -)	Induration (mm)
<b>If 2-Step TB test was completed more than 6 months ago, a 1-Step TB test must be completed.</b>				
<b>1<sup>st</sup> step:</b>	Date administered:	Date read:	Result (+ or -)	Induration (mm)
<b>If 1<sup>st</sup> or 2<sup>nd</sup> test is POSITIVE (i.e. greater than 10mm induration): Chest x-ray is required to be completed, post-positive test.</b>				
<b>X-ray:</b>	Date:	Result:		
	Did you receive treatment for TB <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Treatment:		
	Endemic Travel History <input type="checkbox"/> Yes <input type="checkbox"/> No Please explain:			

**Required Immunizations**

<b>Measles:</b>	Laboratory evidence of immunity (titres), <b>OR</b>	Date of test:	Result: <input type="checkbox"/> Immune <input type="checkbox"/> Not Immune
	2 doses of measles-containing vaccine on or after the first birthday, with doses given at least four weeks apart,	Date of 1 <sup>st</sup> MMR:	Date of 2 <sup>nd</sup> MMR:
<b>Mumps:</b>	Laboratory evidence of immunity (titres), <b>OR</b>	Date of test:	Result: <input type="checkbox"/> Immune <input type="checkbox"/> Not Immune
	2 doses of mumps-containing vaccine given at least four weeks apart on or after the first birthday	Date of 1 <sup>st</sup> MMR:	Date of 2 <sup>nd</sup> MMR:
<b>Rubella:</b>	Laboratory evidence of immunity (titres), <b>OR</b>	Date of test:	Result: <input type="checkbox"/> Immune <input type="checkbox"/> Not Immune
	Evidence of immunization with live rubella containing vaccine (one dose) on or after their first birthday	Date of MMR:	
<b>Varicella:</b>	Varicella vaccine (2 doses required), <b>OR</b>	Date of 1 <sup>st</sup> dose:	Date of 2 <sup>nd</sup> dose:
	Laboratory evidence of immunity (titres), <b>OR</b>	Date of test:	Result: <input type="checkbox"/> Immune <input type="checkbox"/> Not Immune
	Laboratory evidence of chickenpox or shingles (from lesion swab or scraping)	Date of test:	Result: <input type="checkbox"/> Varicella-zoster virus detected

	Confirmatory titre test result if available	Received vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of titre test:
<b>Hepatitis B:</b>	Vaccination is <b>highly recommended</b> for Staff who may have exposure to human blood and body fluids. <b>Hep B is not mandatory for volunteers.</b>	Date of 1 <sup>st</sup> dose Date of 2 <sup>nd</sup> dose Date of 3 <sup>rd</sup> dose	Result of titre test: <input type="checkbox"/> Immune <input type="checkbox"/> Not Immune <input type="checkbox"/> Not tested
<b>Tetanus/ Diphtheria/ Pertussis:</b>	Tdap <b>is recommended</b> for all adults Tetanus and Diphtheria is recommended every 10 years Pertussis- once in adulthood	<input type="checkbox"/> Tdap If never received Tdap <input type="checkbox"/> Td	Date: _____ Year of most recent booster: _____
<b>Influenza:</b>	Highly recommended each year	Date of most recent vaccine: _____	

Have you been fit-tested within the last 2 years to wear an N95 respirator?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, attach proof.
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Do you have any food/drug allergies or any emergent medical conditions (eg, asthma, epilepsy, diabetes, heart condition) that you feel Occupational Health should be aware of? ☐ Yes ☐ No

Do you have a disability that requires an accommodation? ☐ Yes ☐ No  
(If yes, provide details) \_\_\_\_\_

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

Physician: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
PRINT NAME

Address: \_\_\_\_\_

Phone#: \_\_\_\_\_

**For Staff/Private Hire**

I, \_\_\_\_\_, agree to release the above information to Occupational Health and Safety at St Joseph's Health Care London.

Name: \_\_\_\_\_  
PRINT 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.**