Volunteer Immunization Record Submission

In compliance with the requirements set out in the *Public Hospital Act* Regulation 965 by-law 4(1)d. Please provide your completed document to Occupational Health, Safety & Wellness: ohs@wchospital.ca or fax to 416-323-6164.

Women's College Hospital's Occupational Health, Safety and Wellness (OHSW) Department **does not** hold or maintain immunization records for volunteers. **It is the responsibility of the volunteer to retain this form or any supporting documents for their own records**.

First Name:			**Date of Birth:**
Last Name:			
***TUBERCULOSIS SCREENING**	**2-STEP TUBERCULIN SKIN TEST (TST)**		
	Date planted:	Date read:	Induration (mm):
	Date planted:	Date read:	Induration (mm):
	Chest X-Ray (if skin test positive) Date: □ Normal □ Abnormal Comments:		
***MEASLES**	Lab evidence of immunity (serum measles IgG)	Date of test:	□ Immune □ Not immune
	OR documentation of 2 doses of live measles vaccine (e.g. MMR) on or after 1st birthday	Date of 1st MMR:	Date of 2nd MMR
***RUBELLA**	**OR** Lab evidence of immunity (serum rubella IgG)	Date of test:	□ Immune □ Not immune
	OR documentation of immunization with live rubella vaccine (e.g MMR) on or after 1st birthday	Date of MMR:	
***MUMPS**	Lab evidence of immunity (serum mumps IgG)	Date of test:	□ Immune □ Not immune
	OR documentation of 2 doses of mumps vaccine (or trivalent measles-mumps-rubella (MMR) vaccine) on or after 1st birthday	Date of 1st MMR:	Date of 2nd MMR
***VARICELLA (CHICKENPOX)**	Lab evidence of immunity (serum VZV IgG) (previous diagnosis or history is **not** accepted)	Date of test:	□ Immune □ Not immune
	OR Varicella vaccine (2 doses required)	Date of 1st dose:	Date of 2nd dose:
***COVID-19**	Documentation of 2 doses of COVID-19 vaccine	Date of 1st dose: Vaccine:	Date of 2nd dose: Vaccine:

***Mandatory Immunizations**

Completed by:
Physician_______________________________**Signature**________________________________**Date**_____________

I consent to release the above information to the Occupational Health, Safety and Wellness Department, Women's College Hospital. I understand that no personal health information will be released by OHSW without my express consent. *Only my status regarding compliance or non-compliance* with communicable disease protocols will be provided to the Department of Medical Affairs/Management/Human Resources.

Volunteer's Signature ____ Date: ___________________________

Occupational Health, Safety & Wellness Department
Phone: 416-323-6400 ext. 6023
Confidential Fax: 416-323-6164
Email: ohs@wchospital.ca