

Immunization Record Submission

In compliance with the requirements set out in the *Public Hospital Act* Regulation 965 by-law 4(1)d. This form must be completed by a licensed medical practitioner, or you may provide documentation of these records that include all the required elements below.

First Name:	Last Name:	Date of Birth:	
*Mantoux TB Skin Test Status		Mantoux TB Skin Test Results	
2-Step TB Skin Test (TST) To be completed if there is no <u>documented</u> history of a 2-Step TB Skin Test on record.		1. Date Given:	Date read: Result (mm):
1-Step TB Skin Test (TST) To be completed if 2-Step TB Skin Test is more than 12 months old <u>and</u> must provide dates of last 2-Step TB Skin Test.		2. Date Given:	Date read: Result (mm):
Positive TB Skin Test Documentation of a Chest X-ray required.		Date of positive TB test:	CXR Date: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
*MMR		MMR Results	
Measles laboratory evidence of immunity		Date of test:	<input type="checkbox"/> Immune <input type="checkbox"/> Not Immune
Mumps laboratory evidence of immunity		Date of test:	<input type="checkbox"/> Immune <input type="checkbox"/> Not Immune
Rubella laboratory evidence of immunity		Date of test:	<input type="checkbox"/> Immune <input type="checkbox"/> Not Immune
OR documentation of 2 doses of Measles, Mumps, and Rubella (MMR) vaccine		Date of 1 st MMR:	Date of 2 nd MMR:
*Varicella (Chicken pox)		Varicella Results	
Varicella laboratory evidence of immunity		Date of test:	<input type="checkbox"/> Immune <input type="checkbox"/> Not Immune
OR documentation of 2 doses of Varicella vaccine		Date of 1 st dose:	Date of 2 nd dose:
*COVID-19 Documentation of 2 doses of COVID-19 vaccine		Date of 1 st dose: Vaccine:	Date of 2 nd dose: Vaccine:
Hepatitis B		Hepatitis B Results	
Hepatitis B laboratory evidence of immunity		Date of test:	<input type="checkbox"/> Immune <input type="checkbox"/> Not Immune
OR documentation of 3 doses of Hepatitis B vaccine (Highly recommended for staff who may have exposure to blood & body fluids)		Date of 1 st dose:	Date of 2 nd dose: Date of 3 rd dose:
Tetanus, Diphtheria. Pertussis Not mandatory but Adacel vaccine (one time in adulthood) is recommended to protect against pertussis		<input type="checkbox"/> Td <input type="checkbox"/> d-Tap (Adacel)	Td Date: d-Tap Date:
Influenza Not mandatory but highly recommended		Date of last Influenza vaccine:	
*N95 Respirator Fit Test Valid N95 Respirator Fit Test Certificate within the last 2 years Please email maskfit@wchospital.ca to book N95 Mask Fit Test.		Certificate Expiry: Model: Size:	
Completed by Licensed Medical Practitioner			
Name (Please Print):		Address:	
Date:	Telephone:	Signature:	

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 Human Resources/Management.*

Staff's Signature _____ **Date:** _____