North Wellington Health Care & Groves Memorial Community Hospital
Staff/Contract Worker
Pre-Employment Health Assessment

Welcome to North Wellington Health Care and/or Groves Memorial Community Hospital. The mandatory immunization information **must be completed by your own Health Care Provider or your current employer's Occupational Health Nurse** prior to starting work in the hospital.

Questions may be directed to the Occupational Health Nurse at:
Groves Memorial Hospital – Fergus: 519 843 5331 ext. 3217
Louise Marshall Hospital - Mt Forest: 519 323 2210 ext. 2270
Palmerston & District Hospital – Palmerston: 519 343 2033 ext. 4270

Please have your health care provider return completed form(s) and attachments to the Occupational Health Department by fax to:
Fergus 519 787 4401 Mt Forest 519 509 6654 Palmerston 519 417 8784

Employee/ Contract Worker must complete this section:

Name______________________________ **Date of Birth** ______________________

Telephone (during normal business hours) : ________________________

Position: __________________________**Department:** ___________________________

I, ______________________________ agree to release the information provided below to Occupational Health Services of North Wellington Health Care/ Groves Memorial Community Hospital. I understand that Human Resources will be allowed to know the status of my compliance (no actual result will be provided-only compliance or non -compliance). I also declare that the information I have provided to be accurate to the best of my knowledge.

Date: _____________________ Signed ______________________________

1. Do you have any restrictions as a result of a medical condition which you have or have had in the past which may affect your ability to perform the essential duties of your position? **Yes** □ **No** □
If yes, please explain:

2. Are there any accommodations required to enable you to perform the essential duties and responsibilities of your position? **Yes** □ **No** □
If yes, please explain:

Name____ **Date of Birth** ____________________________

3. Do you have any concerns about your ability to wear personal protective equipment such as gloves, gowns, respirators, masks, goggles etc? **Yes** □ **No** □
If yes please explain:

4. **Respirator fit testing (**required every two years) **Enclose copy of fit testing certificate**

Date of fit test ________________ **Make/Model** ___________________________

5.

Allergies and Medications	
Allergies: **Yes** □ **No** □ Latex □ Medications (list) □ Other (list) □	Are you currently taking any medications which may affect your ability to safely perform the essential duties of the job? **Yes** □ **No** □ If yes, please explain:

Remaining sections to be completed by your own Health Care Provider or your current employer's Occupational Health Nurse
Please attach copies of immunization records and/or laboratory results.

The requirements below apply to all health care workers in compliance with the OHA/OMA Communicable Disease Surveillance Protocols.

Vaccine or Test	Requirements
Tetanus/Diphtheria (Td) Tetanus/Diphtheria/Pertussis (Tdap)	Vaccine is not mandatory but desirable A single dose of Tdap should be given to all health care workers who have not previously received an adult dose. Td booster doses are given every 10 years.
Measles	Documentation of 2 doses of Measles vaccine given at least 4 weeks apart on or after the first birthday **OR** laboratory evidence of immunity (have blood drawn and tested and provide copy of results)
Mumps	Documentation of 2 doses of Mumps vaccine given at least 4 weeks apart on or after the first birthday **OR** laboratory evidence of immunity (have blood drawn and tested and provide copy of results)
Rubella	Documentation of Rubella vaccine on or after the first birthday **OR** laboratory evidence of immunity (have blood drawn and tested and provide copy of results)
Varicella	Documentation of 2 Varicella vaccinations **OR** Laboratory evidence of immunity (have blood drawn and tested and provide copy of results **OR** Laboratory confirmation of disease (provide copy of results)
Hepatitis B	Susceptible health care workers who have the potential for exposure to the blood and/or body fluids of patients must be protected by Hepatitis B vaccine. A Hepatitis B titer (have blood drawn and tested) must be provided. Immunity to Hepatitis B is not mandatory.
Influenza	Vaccine is not mandatory, however, it is expected that all health care workers will have an annual influenza vaccine in accordance with the Hospital's influenza vaccination policy. Persons not immunized will be excluded from any influenza outbreak area unless they take appropriate anti-viral medication.
Tb Skin Test (TST)	Health care workers whose TST status is unknown, and those previously identified as tuberculin negative, require a baseline two-step TST unless they have: • documented results of a prior two-step test, **OR** • documentation of a negative TST within the last 12 months in which case a single-step test may be given.

North Wellington Health Care – Quality care close to home

GROVES – A Vision for Health, Caring for People – Groves Memorial Community Hospital

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Immunization Requirements

Tetanus/Diphtheria/Pertussis (required every 10 years)
Most recent booster date:_____________ ☐Tetanus/Diphtheria/Pertussis ☐ Tetanus/Diphtheria
Has an adult dose of acellular pertussis been given Yes ☐ No ☐ Date: _________________

Measles
2 documented doses of Measles vaccine : Date of 1st _______________Date of 2nd ____________________
OR Lab evidence of immunity ☐ Date ___________________ (provide copy)

Mumps
2 documented doses of Mumps vaccine : Date of 1st ______________Date of 2nd ___________________
OR Laboratory evidence of immunity ☐ Date ___________________ (provide copy)

Rubella
1 documented dose of Rubella vaccine: Date of dose_______________
OR Laboratory evidence of immunity ☐ Date ___________________ (provide copy)

Chicken Pox (Varicella)
Laboratory evidence of immunity ☐ Date ___________________ (provide copy)
OR Two documented doses of vaccine: Date of 1st _______________Date of 2nd ___________________
OR Laboratory confirmed varicella ☐ Date ___________________ (provide copy)

Hepatitis B
Immunization Dates**:** Hep B #1:________________Hep B#2 ______________ Hep B #3______________

Date of titer _______________ Result: ☐ Positive ☐ Negative

Level (if known)________________(provide copy)

☐ Date of Booster(s) (if required):______________________ ___________________________

☐ Date of repeat titer (if required): ________________ Result: ☐ Positive ☐ Negative

Level (if known)__________________ (provide copy)

Seasonal Influenza Vaccine
Vaccination Date: __________________

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TB Skin Testing			
	2-step TB Skin test		**1 step TB skin test within past 12 months** (Required if 2-step is outside past 12 months)
	Step 1	Step 2	
Date of Test (yy/mm/dd)			
Result (Pos / Neg)			
Induration			
X-ray (for positive result)	Date of X-ray: ____________________ Result/follow up:		

Note:
If your immunizations are not up to date and the vaccine is not available through your health care provider, our Occupational Health Nurse will be able to provide the vaccination and/or complete any respirator fit testing. Please contact them to make an appointment at the phone number provided on page 1.

Name of Health Care Provider completing form: _________________________________

Contact Information:____

Signature: ___________________________________ **Date:**__________________________

Please attach copies of immunization records and/or laboratory results and return by fax at the fax number provided on page 1.

Date reviewed by Occupational Health Nurse ___________________________

Reviewed by (signature) ____

Follow up required **Yes** □ **No** □

Comments: