Providence Care

GUIDE: Communicable Disease Screening Requirements
Pre-Placement for New Hires

Please bring the below immunization requirements to your pre-placement assessment. Please arrive on time as lateness may result in appointment having to be rescheduled.

1. ***Communicable Disease Health Clearance Requirements include:***
   a. Proof of one adulthood **Tetanus, Pertussis and Diphtheria vaccination**. After that, Tetanus and Diphtheria vaccination every 10 years.
   b. Proof of two doses of **Measles, Mumps, Rubella**. If employees do not have a record of immunization, they must provide history of laboratory confirmed infection or laboratory evidence of immunity.
   c. Proof of two doses of **Varicella**. If employees do not have a record of immunization they must provide evidence of immunity or laboratory confirmation of disease.
   d. Proof of **Hepatitis B series** or provide documented proof of immunity. If an employee has received a full series of immunization but has an anti-HBs titre of less than 10IU/L a booster is required.
   e. Proof of **Tuberculosis (TB) screening**. A one-step Tuberculosis skin test (TST) within 3 months of start is required for those who meet the following criteria:
      i) Documented results of a prior two-step TST with a result of <10mm at any time in the past,
      ii) Documented, single negative TST result within the past 12 months or
      iii) Two or more documented negative TST results at any time, the most recent one being less than 12 months ago

      Employees who do not meet the above criteria must provide a two-step TB skin test. A TB two-step is defined as: TB one-step requires that you come in for the test, and return 48-72 hours later have it read. The TB two-step involves a first step and reading as described above, and then it is repeated at least 1-4 weeks later.

      Employees with a positive TST do not need to be retested. Employees must provide a chest x-ray within the previous 12 months. Screening for active TB disease will be assessed by the occupational health nurse.
   f. Proof of **COVID-19 vaccine** (series OR current dose of XBB 1.5).
   g. Proof of **Influenza vaccine** during Current/ most recent flu season.

2. ***Mask Fit testing***

   All employees who work in Infectious Disease Prevention and Environment Health will require mask fit testing every two years, or when there is a change in facial shape such as weight loss or gain. Before you can be tested for mast fit testing:

   - You must not smoke, eat, chew gum, drink any liquids (except water) at least 20 minutes prior to the test, to ensure an accurate, successful respirator mask fit test
   - You must be clean shaven for the Respirator Protection Training testing procedure

3. ***Pre-Placement Health Review*** is a condition of employment and is used to determine whether candidates are medically fit for the position following a conditional offer of employment being extended, but before they have been placed in the position. Complete **Pre-Placement Medical Questionnaire as well as Communicable Disease Health Clearance Requirements** prior to appointment with OHN and bring with at time of appointment.

   ***Please speak to the occupational health nurse if you require a medical exemption from any of the above Immunization or mask fit testing or have any further questions. OHSW@providencecare.ca

Communicable Disease Clearance Requirements
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As a prerequisite for working at Providence Care, individuals who carry on activities at a facility must meet the communicable disease surveillance requirements as stipulated in the *Ontario Public Health Standards*. This also includes the requirement to have completed your primary vaccine series for COVID-19. These requirements are outlined in the attached document entitled ***"Communicable Disease Health Clearance Requirements."***

In cases where individuals interface with patients/clients/residents who are on airborne precautions (e.g. tuberculosis), they will be required to don an N95 respirator. To do so, the CSA standard and Providence Care policy requires the user to have been fit tested, trained, and medically cleared for respirator usage current within 2 years. N95 respirators are available for use at Providence Care for those who have been fit tested & trained on their use. Occupational Health, Safety & Wellness conducts fit testing where it needs to be done or updated,

Should you have any questions specific to the requirements for applicants coming to Providence Care, please contact Occupational Health, Safety & Wellness (OHSW) at Providence Care Hospital 613-544-4900 x 53564.

Your application will remain inactive and your privileges pending until required clearance by a Physician/Nurse Practitioner (NP) is provided to our office. Please have your family physician/NP complete the following form and return to the OHSW at Providence Care Hospital or Providence Manor as applicable to your hire location.

If you do not have a family physician, you may contact the CDK Walk-In Clinic at 175 Princess Street (Phone: 613-766-0318) or the Kingston Travel Clinic at 797 Princess Street (Phone: 613-817-9841) to set up an appointment to assist with immunization testing, if required. You should bring any immunization paperwork with you. The visit may be charged to OHIP (if you have OHIP coverage) however, there will be a cost incurred for completion of the form and additional testing, if required. Note: The CDK clinic accepts cash, Debit card, Visa, Mastercard and will provide a receipt as proof of payment.

Name: ______________________ **Date (YYYY/MM/DD):** ______________

Department of: ______________________

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FOR USE BY HEALTH CARE PROFESSIONAL PROVIDING CLEARANCE TO APPLICANT

REQUIRED:

1. **Tetanus, Diphtheria, and Pertussis**

Tetanus and Diptheria	Initial primary series completed:	☐ Yes ☐ No ☐ Record attached		
	Date series completed (yy/mm/dd):			
	OR Boosters completed:	☐ Yes ☐ No ☐ Record attached		
	Dates of boosters (yy/mm/dd):	#1:	#2:	

Acellular Pertussis	Initial primary series completed:	☐ Yes ☐ No ☐ Record attached
	Date series completed (yy/mm/dd):	
	If "**No**" – Date Adacel or equivalent given as an adult (18-65) within the past 10 years (yy/mm/dd):	

2. **Measles, Mumps, and Rubella (MMR)**

Measles	Laboratory evidence of immunity (titres):	Result: __________ ☐ Immune ☐ Not immune	
	Date of test (yy/mm/dd):		
	OR 2 MMR Vaccines	☐ Yes ☐ No ☐ Record attached	
	Dates of vaccines (yy/mm/dd):	#1:	#2:

Mumps	Laboratory evidence of immunity (titres):	Result: __________ ☐ Immune ☐ Not immune	
	Date of test (yy/mm/dd):		
	OR 2 MMR Vaccines	☐ Yes ☐ No ☐ Record attached	
	Dates of vaccines (yy/mm/dd):	#1:	#2:

Rubella	Laboratory evidence of immunity (titres):	Result: __________ ☐ Immune ☐ Not immune	
	Date of test (yy/mm/dd):		
	OR 2 MMR Vaccines	☐ Yes ☐ No ☐ Record attached	
	Dates of vaccines (yy/mm/dd):	#1:	#2:

3. **Varicella**

Varicella	Laboratory evidence of immunity (titres):	Result: __________ ☐ Immune ☐ Not immune	
	Date of test (yy/mm/dd):		
	OR 2 Varicella Vaccines	☐ Yes ☐ No ☐ Record attached	
	Dates of vaccines (yy/mm/dd):	#1:	#2:

4. Hepatitis B

Hepatitis B						
	Primary Series Complete:	☐ Yes ☐ No ☐ Record attached				
	Dates (yy/mm/dd): #1:		#2:		#3:	
	Surface Antibody Result:	☐ Immune ☐ Not Immune ☐ Record attached				
	Date of test (yy/mm/dd):					
	Surface Antigen Result:	☐ Immune ☐ Not Immune ☐ Record attached				
	Date of test (yy/mm/dd):					
	Booster(s), if required:	☐ Yes ☐ No ☐ Record attached				
	Dates (yy/mm/dd): #1:		#2:		#3:	
	Post-Vaccination Serology:	Result (mIU/ml): ________	☐ Immune ☐ Not immune ☐ Record attached			
	Date of test (yy/mm/dd):					

5. Tuberculosis

Initial 2-Step TST	Date Given (yy/mm/dd)	Lot # and Expiry Date (yy/mm/dd)	Date Read (yy/mm/dd)	Result: # mm Induration
1st Step				
2nd Step				
One-Step				
One step				
One Step				

If any TST is positive (10 mm induration or more), please evaluate the following: OR if high risk and a 5mm increase in induration:				
1.	**Signs & Symptoms of TB:**	☐ No ☐ Yes – describe: ____________________		
2.	**Chest X-Ray results**	☐ Negative ☐ Positive	Date (yy/mm/dd):	
3.	**History of documented BCG?**	☐ No ☐ Yes	Date (yy/mm/dd):	
4.	**History of Disease?**	☐ No ☐ Yes		
5.	**INH Prophylaxis?**	☐ No ☐ Yes		
6.	**Specialist Referred**	☐ No ☐ Yes		

6. COVID-19

Initial series or doses of XBB 1.5 (yy/mm/dd):	#1:		#2:	
Most recent Covid-19 Vaccine received (yy/mm/dd):				

7. Influenza

Most recent Seasonal Flu Vaccine received (yy/mm/dd):	
Other Vaccine received (yy/mm/dd):	

8. **Other (optional)**

Vaccine	Date (yy/mm/dd)
Meningococcal (not required unless works in lab)	
Pneumococcal (not required unless chronic illness or > 65 yrs)	
Hepatitis A	
Other: ______________________	

9. **Respirator (N95 or N100) Fit Test**

Respirator fit test booked?	☐ No ☐ Yes, date of appointment (yy/mm/dd): __________		
Previous fit test:	Date (yy/mm/dd): __________	Mode: __________	☐ Record attached
Record of CPR or Standard First Aid (optional)	☐ Record attached		

I, ______________________ certify that ______________________

Print Name of Healthcare Professional Providing Clearance   *Print Name of Applicant*

has met the above communicable disease screening requirements for placement at Providence Care.

Health Care Professional Information	
Last Name:	**First Name:**
Full Address (No., Street, City, Province, Postal Code):	
Telephone No. (include Area Code):	**Fax No. (include Area Code):**
Signature:	**Date completed (YYYY/MM/DD):**

Reviewed by Occupational Health Nurse (OHN):	
Print Name of OHN:	
Signature:	**Date completed (YYYY/MM/DD):**