Humber River Hospital Lighting New Ways in Healthcare

Humber River Hospital Volunteer Occupational Health and Safety Requirements

Dear Humber River Volunteer,

The attached health screening form must be completed before you can begin volunteering in the hospital. Please **start this testing as soon as possible** as it does take time to complete.
You have two options for completing the OHS requirements:

1. **Occupational Health & Safety, Humber River Hospital:** you can complete your health assessment form in the Occupational Health & Safety office located on Level 4 (West) at the Wilson Site of Humber River Hospital. You will need to book an appointment by clicking on this link: http://www.hrh.ca/bookohs. Upon clicking this link, please select "Create Account" to make a new account. You must create an account to book and view your appointment. The department is open Monday - Wednesday and Friday between 8am - 3pm. *You cannot book a TB test on Thursday, Saturday or Sunday*. Please bring a copy of this form with you to your appointment. For any questions on booking your appointment, please contact Occupational Health at 416-242-1000 x 82701.

2. **Family Physician/Walk-In Clinic**: you can take your health assessment form to your family physician or walk-in clinic for completion. Please note that any fees associated to the health assessment are the responsibility of the volunteer. Before submitting your completed form to the Volunteer Services office, please take extra time to ensure you have included all the documents and information required. Incomplete health screening and documentation will delay volunteer service start date.

Dear Physician,

The Public Hospitals Act, Regulation 965, Section 4.1.e, requires that health surveillance and communicable disease surveillance be conducted on 'all persons carrying on activities in the hospital', including employees, physicians, nurses, contract workers, students, post-graduate medical trainees, researchers and **volunteers.**

Your patient has applied to be a volunteer at Humber River Hospital. In order to begin their volunteer service, a Health Assessment must be completed **PRIOR** to commencing any work at the hospital.

If possible, please waive any fees associated with this testing.

If you have any questions or concerns about this document please contact the Humber River Hospital, Occupational Health at 416-242-1000 ext. 82701.

Thank you!

Humber River Hospital
Lighting New Ways in Healthcare

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
PHONE (H):	PHONE (C):	DATE OF BIRTH: DD/MM/YYYY
EMAIL ADDRESS:		

Ways to help expedite your OHS requirements:

- Have your family physician complete and sign/stamp Section D on the attached form.
- Contact your current or past employer/organization and request a copy of your record from the Occupational Health Department.
- Contact your health care training school program and request a copy of your immunization record from Student Health Services.
- Contact the Public Health Department in the school district that you attended for a copy of your vaccination record. https://tph.icon.ehealthontario.ca/#!/welcome
- Bring your childhood record (yellow immunization card) or obtain from your family doctor or parents.

Bleach Sensitivity

Humber River Hospital uses bleach based solutions to clean, disinfect and safeguard our patient environments as part of our infection prevention program. *Please identify if you are sensitive to bleach products.*

☐ Yes, I am sensitive to bleach. Describe your symptoms:____

☐ No, I am not sensitive to bleach.

I have read and declare the information I have provided on all pages to be accurate to the best of my knowledge. As a volunteer, I am aware that I risk exposure to infectious diseases, and will not hold Humber River Hospital responsible for any adverse effects to myself and/or my family

Volunteer SIGNATURE: ______________________________ DATE: ______________________

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Volunteer Vaccination Requirements – To be completed by a medical practitioner OR you may attach documentation of your immunization records that include all the required elements below.

Name:	**Date of Birth:**	**Age:**

COVID-19 Vaccination: include 3rd and 4th dose if applicable. Please attach a copy of the Vaccine Receipts.

1st Dose Date:_____________ Lot #:_______________ 2nd Dose Date:_____________ Lot #:_______________

3rd Dose Date:_____________ Lot #:_______________ 4th Dose Date:_____________ Lot #:_______________

Tetanus, Diphtheria, Acellular Pertussis (TdaP) or Tetanus, Diphtheria (Td) *1 dose of TdaP over the age of 18 is required	**Record of Immunization** 1. Tdap □ Td □ Date:_________________
Measles, Mumps and Rubella (MMR) *2 valid doses of MMR vaccination **OR** laboratory evidence of immunity is required.	**Record of MMR Immunization** 1. Date:_________________ 2. Date:_________________ **Laboratory evidence of Immunity** (Attach lab reports) Measles Date: Result: Mumps Date: Result: Rubella Date: Result:
Varicella (chickenpox) *2 valid doses of Varicella vaccination **OR** laboratory evidence of immunity is required.	**Record of Varicella Immunization** 1. Date:_________________ 2. Date:_________________ **Laboratory evidence of Immunity** (Attach lab reports) Date:_________________ Result:_________________
Hepatitis B Evidence of Immunity (RECOMMENDED) *Laboratory evidence of immunity is required. Laboratory evidence of Immunity Date:____________________ Result: Immune / non-Immune (circle one)	**Record of Hep B Immunization** 1st series 2nd series (if applicable) 1. Date:_________________ 4. Date:_________________ 2. Date:_________________ 5. Date:_________________ 3. Date: 6. Date: Non-Responder: Y / N

Influenza Vaccination (Annual Influenza vaccination is the responsibility of and is an expectation for HRH volunteers)

Date of Last Influenza Vaccine: ____________________

Mantoux (TB) skin test Evidence of a baseline 2 Step TB Skin Test (TST) is required.	**2 Step TST**	**Date Planted**	**Date Read**	**Induration(mm)**	**Result (+ or -)**
	Step 1				
	Step 2				
	Annual TB Test				

CHEST X-RAY report within the past 12 months is required (please attach report):

- If TB skin test is positive OR If you are a known positive reactor

Date of Chest X-ray: ______________________ Result: _________________

Physician's Signature: ________________________

Date: ________________________