Listowel Wingham Hospitals Alliance
Occupational Health: Pre-placement Health Review

Instructions:

A pre-placement health assessment is a condition of both employment and volunteering.

Employees:
Complete this form prior to booking your appointment with Occupational Health Services. You may consult your physician's office, your employer's occupational health department and/or your local Public Health Unit to assist you with obtaining the information. This process must be completed prior to commencing your employment

To book your appointment with Occupational Health call 519-357-3210 ext 5279 or email Pauline.Daugherty@lwha.ca

Volunteers and High School Students:
Complete sections A, B, C and F and return this form to the Human Resources Department

I, _____ agree to release the information contained in this form to Occupational Health Services at the Listowel Wingham Hospitals Alliance. I understand that my Manager will receive a pre-placement health clearance form indicating whether I am fit, unfit or fit with limitations for work. I understand that the information below will also be used to determine if I can perform essential duties of my position and to determine any accommodation that may be required for this purpose.

Signature _____ Date_____

Immunization Requirements for Employment

Vaccine or Test	Requirements
Tetanus/Diphtheria (Td) Tetanus/Diphtheria/Pertussis (Tdap)	Documentation of Td or Tdap vaccination within the last 10 years
Measles, Mumps, Rubella	Documentation of 2 Measles, Mumps and Rubella vaccinations OR laboratory evidence of immunity
Varicella	Documentation of 2 Varicella vaccinations OR Laboratory evidence of immunity
Hepatitis B	Hepatitis B vaccination is not mandatory but we do recommend it for staff who are coming in contact with blood or body fluids
Influenza	Documentation of an annual Influenza vaccination
Tb Skin Test (TST)	Health care workers (HCWs) whose TST status is unknown, and those previously identified as tuberculin negative, require a baseline two-step TST with PPD/5TU, unless they have: • documented results of a prior two-step test, or • documentation of a negative TST within the last 12 months, or • 2 or more documented negative TST at any time but the most recent was >12 months ago, in which case a single-step test may be given.

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Section A: Personal Information	
Last Name	First Name
Site and Department	Staff Member ☐ Volunteer ☐ Student ☐
Address	Phone Number
Date of Birth	SIN (staff only)
Emergency Contact Name and Phone Number	

Section B: Immunization Requirements

Tetanus/Diphtheria/Polio (required every 10 years)

Most recent booster date:_____
Type of vaccine received:

☐ Tetanus/Diphtheria/Polio ☐ Tetanus/Diphtheria/Pertussis ☐ Tetanus/Diphtheria

MMR (Measles, Mumps, Rubella)

MMR immunization dates: 1st_____ 2nd _____
Serology enclosed Yes ☐ No ☐

Chicken Pox (Varicella)

a) Laboratory evidence of immunity ☐ Yes ☐ No
b) Vaccination: 1st _____ 2nd _____
c) Serology enclosed ☐ Yes No ☐

Hepatitis B

a) Dates of vaccinations: Dose 1_____ Dose 2 _____ Dose 3
b) Serology enclosed ☐ Yes No ☐

Seasonal Influenza Vaccine

a) Vaccination Date: _____

****If you have any Medical exceptions to immunizations please explain and provide documentation****

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Section C: TB Skin Testing

Two Step TB Skin Test:
(Definition of a 2 step is: TB skin test is given, read 2-3 days later and if negative the process is repeated in other arm within 1 to 4 weeks)
1st step: date given: _____ date read: _____Result: mm induration _____
2nd step: date given: _____ date read: _____Result: mm induration _____

or One step TB Skin Tests
Date given: _____Date read: _____Result: mm induration _____
Date given: _____Date read: _____Result: mm induration _____

Chest x-ray: Required if TB skin test is positive (greater than 10 mm in-duration).

Date: _____ Attach copy of result

Section D: Functional Ability

Walking	Restrictions - Yes ☐ No ☐ If yes - Limit to _____hrs/mins
Standing	Restrictions - Yes ☐ No ☐ If yes - Limit to _____hrs/mins
Sitting	Restrictions - Yes ☐ No ☐ If yes - Limit to _____hrs/mins
Bending/Twisting	Restrictions - Yes ☐ No ☐ If yes - Limit to _____hrs/mins
Pushing/Pulling	Restrictions - Yes ☐ No ☐ If yes - Limit to _____hrs/mins
Reaching	Restrictions - Yes ☐ No ☐ If yes - Limit to _____hrs/mins
Climbing	Restrictions - Yes ☐ No ☐ If yes - Limit to _____hrs/mins
Lifting	Restrictions - Yes ☐ No ☐ If yes - Limit to _____hrs/mins
→ Floor to waist	Restrictions - Yes ☐ No ☐ If yes - Limit to _____kgs
→ Waist to shoulder	Restrictions - Yes ☐ No ☐ If yes - Limit to _____kgs
→ Above shoulder	Restrictions - Yes ☐ No ☐ If yes - Limit to _____kgs

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Section E: Allergies and Medications	
Allergies: Yes ☐ No ☐ Describe:	Sensitivities: Yes ☐ No ☐ Describe:
Are you currently taking any medications which may affect your ability to perform the duties of your job? Yes ☐ No ☐ If yes please explain:	

1. Are you aware of any medical condition which you have or have had in the past which may affect your ability to perform the duties of your position: Yes ☐ No ☐
2. 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:

Section F: Consent
I have read and declare the information I have provided to be accurate to the best of my knowledge. My signature provides my consent to complete this evaluation as part of my pre-placement assessment. I understand that providing inaccurate or misleading information may lead to the termination of my employment or volunteering. Signature: Date: