



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
COVID 19	Documentation of COVID 19 immunization



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Tb Skin Test (TST)	<p>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:</p> <ul style="list-style-type: none">• 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, <p>in which case a single-step test may be given.</p>
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Section A: Personal Information

Last Name	First Name
Site and Department	Staff Member <input type="checkbox"/> Volunteer <input type="checkbox"/> Student <input type="checkbox"/>
Address	Phone Number
Date of Birth	
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: _____

COVID 19 Vaccination

Name of Vaccine received: _____
 Dates of Vaccinations: Dose 1 _____ Dose 2 _____

****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 <input type="checkbox"/> No <input type="checkbox"/> If yes - Limit to _____ hrs/mins
Standing	Restrictions - Yes <input type="checkbox"/> No <input type="checkbox"/> If yes - Limit to _____ hrs/mins
Sitting	Restrictions - Yes <input type="checkbox"/> No <input type="checkbox"/> If yes - Limit to _____ hrs/mins
Bending/Twisting	Restrictions - Yes <input type="checkbox"/> No <input type="checkbox"/> If yes - Limit to _____ hrs/mins
Pushing/Pulling	Restrictions - Yes <input type="checkbox"/> No <input type="checkbox"/> If yes - Limit to _____ hrs/mins
Reaching	Restrictions - Yes <input type="checkbox"/> No <input type="checkbox"/> If yes - Limit to _____ hrs/mins
Climbing	Restrictions - Yes <input type="checkbox"/> No <input type="checkbox"/> If yes - Limit to _____ hrs/mins
Lifting	Restrictions - Yes <input type="checkbox"/> No <input type="checkbox"/> If yes - Limit to _____ hrs/mins
→ Floor to waist	Restrictions - Yes <input type="checkbox"/> No <input type="checkbox"/> If yes - Limit to _____ kgs
→ Waist to shoulder	Restrictions - Yes <input type="checkbox"/> No <input type="checkbox"/> If yes - Limit to _____ kgs
→ Above shoulder	Restrictions - Yes <input type="checkbox"/> No <input type="checkbox"/> If yes - Limit to _____ kgs



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Section E: Allergies and Medications

Allergies: Yes <input type="checkbox"/> No <input type="checkbox"/> Describe:	Sensitivities: Yes <input type="checkbox"/> No <input type="checkbox"/> Describe:
Are you currently taking any medications which may affect your ability to perform the duties of your job? Yes <input type="checkbox"/> No <input type="checkbox"/> 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: _____