Professional Practice Health Form
School of Health Sciences – Returning Students

Student Information

Name: _____ **Student ID:** _____

Email: _____ **Phone Number:** _____

Program Name: _____ **Year:** _____

Section A: To be completed by Health Care Provider

Health Care Provider Signature and Office Stamp

Name: _____

Signature: _____

Date (dd/mm/yy): _____

OFFICE STAMP

Tuberculosis: The student must provide proof of a two-step Tuberculosis Mantoux skin test. If there is record of a two-step TB skin test in the past, dates and results must be recorded and followed up with a one-step TB skin test (if more than 12 months have passed). Documentation of the tuberculosis skin test is required regardless of receiving the BCG vaccine. Students with a positive skin test (10mm or more in duration) must have a chest x-ray.

One Step Tuberculosis Skin Test

Step 1: Date Given (dd/mm/yy): _____

Date Read (dd/mm/yy): _____ **Result:** _____**mm**

Students with a positive skin test (10mm or more in duration) must have a chest x-ray. ***A copy of the chest x-ray must be attached.***

Date of x-ray (dd/mm/yy): _____ **Results:** _____

Influenza: An annual seasonal flu shot is not mandatory but highly recommended. Any student without the vaccination may be in jeopardy of a successful completion of the clinical course in the event of an outbreak at your placement. The influenza vaccine is available from October to March. **Documentation of the influenza vaccine clearly indicating the date received must be attached.**

Influenza Vaccine Received (dd/mm/yy): _____

Section A: To be completed by Health Care Provider

COVID-19 Vaccine: This vaccine is mandatory. **Documentation of the COVID-19 vaccine clearly indicating the date received must be attached**

Dose 1 received (dd/mm/yy):

Dose 2 received (dd/mm/yy):_____

_____

Section B: To be completed by the student

Non Medical Requirements: The following non medical requirements must be completed. If you have previously obtained one or more of these requirements, please verify the expiry date. If your certificate expires during the placement portion for your program, it is your responsibility to recertify within one month from the time of expiration. **A copy of all non medical documents/certificates must be attached.**

CPR – BLS Certificate (annual recertification)
Valid Certificate: ☐ Yes ☐ No **Certificate Attached:** ☐ Yes ☐ No

Standard First Aid Certificate (every 3 years):
Valid Certificate: ☐ Yes ☐ No **Certificate Attached:** ☐ Yes ☐ No

Mask Fit Testing (every 2 years):
Valid Certificate: ☐ Yes ☐ No **Certificate Attached:** ☐ Yes ☐ No

Vulnerable Sector Police Check (annual):
Valid Certificate: ☐ Yes ☐ No **Certificate Attached:** ☐ Yes ☐ No

Student Signature: _____

Section B: To be completed by the Student

Student Agreement:

I confirm that I have read this form and understand its purpose and the nature of its content. In particular, I understand that in order to comply with the Public Hospitals' Act and Ontario Hospital Association protocol, I need to demonstrate that certain health standards have been met in order for me to be granted student placement. I understand that the faculty in my educational program will be able to view the results from this form. I understand that I must have all sections of this form fully completed and reviewed by the identified due date. Failing to do so, may jeopardize my consideration for any student placement. All costs incurred for completion of this form are my sole responsibility. Should it be requested, it is my responsibility to share relevant information from this form with a hospital, nursing home, or other clinical placement agency relating to my program.

The personal information on this form is collected under the legal authority of the Colleges and Universities Act, R.S.O. 1980, Chapter 272, Section 5, R.R.O. 1990, Regulation 77 and the Public Hospital Act R.S.O. 1980 Chapter 410, R.S.O. 1986, Regulations 65 to 71 and in accordance with the requirements of the legal Agreement between the College and the agencies which provide clinical experience for students. The information is used to ensure the safety and well-being of students and clients in their care. The information in this form will be protected in accordance to the Freedom of Information and Protection of Individual Privacy Act.

Student Name:_____ **Student ID:** _____

Student Signature:_____ **Date (dd/mm/yy):**_____