



Professional Practice Health Form
School of Health Sciences – Returning Students (VTT)

Student Information

Name: _____	Student ID: _____
Program Name: _____	

Section A: To be completed by Healthcare Provider

<p>Healthcare Provider Signature</p> <p>Name: _____</p> <p>Signature: _____</p> <p>Date (dd/mm/yy): _____</p>	<p>OFFICE STAMP</p>
--	----------------------------

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 report must be uploaded to Synergy.

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

Rabies: Students previously vaccinated with the three dose pre-exposure series, will require serology showing immunity.

Immunity to Rabies: Evidence of immunity to Rabies. **A copy of the lab report must be uploaded to Synergy.** Serology will be accepted if done within 10 years.

Date blood work completed (dd/mm/yy): _____

Rabies Immunity: Yes No



Section A: To be completed by Healthcare Provider

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 can be uploaded to Synergy.**

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

COVID-19 Vaccine: **COVID-19 Vaccine:** This vaccine is highly recommended but not mandatory. **Documentation of the COVID-19 vaccine clearly indicating the date received can be uploaded to Synergy.**

Dose 1 received (dd/mm/yy): _____ **Dose 2 received (dd/mm/yy):** _____

Additional vaccines may be required at the request of the placement agency. It is the student's responsibility to ensure they are following the agency health and safety policies.

Additional dose received (dd/mm/yy): _____

Section B: Non-Medical Requirements - Student Reference

Non-Medical Requirements: The following non-medical requirements must be completed. If you have already obtained any of these, please ensure they are still valid by checking the expiry dates. Any requirements set to expire during the academic year/placement period must be recertified before the pre-placement clearance/Synergy due date. **A copy of all non-medical documents/certificates must be uploaded to Synergy.**

Please use the check boxes as a reference to ensure you have all of the mandatory non-medical requirements.

- | | |
|--|--|
| <input type="checkbox"/> Standard First Aid Certificate | <input type="checkbox"/> WHMIS Certificate |
| <input type="checkbox"/> CPR Level C | <input type="checkbox"/> WSIB Declaration |
| <input type="checkbox"/> Criminal Record Check | <input type="checkbox"/> Crisis Intervention Training, x2 |
| <input type="checkbox"/> Pledge of Confidentiality | <input type="checkbox"/> Worker Health and Safety Awareness in 4 Steps |
| <input type="checkbox"/> Placement Agreement | <input type="checkbox"/> International Student Declaration, if applicable |



Section C: Must 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 Signature: _____ **Date (dd/mm/yy):** _____