



## Pre-Placement Communicable Disease Screening For New Employees

As a condition of employment at Kingston Health Sciences Centre (KHSC), and in compliance with the *Public Hospitals Act (Regulation 965)*, you are required to provide documented evidence of your immunity (as described below) to the Occupational Health Department at the time of your scheduled Pre-Placement Health Screen. It is your responsibility to carefully review the instructions below to ensure you comply with all requirements.

### **GENERAL INSTRUCTIONS:**

1. Documents that will be accepted as proof of immunity include provincial Immunization records, print outs from your school, and/or laboratory reports showing vaccination dates and/or bloodwork (titre) results. The attached **Pre-Placement Communicable Disease Screening Form** should be completed by your Health Care Provider where these records do not exist or are incomplete. Any costs associated with the completion of this form are the responsibility of the employee.
2. If you do not have the required documentation showing proof of your immunity, OR you do not have a physician/health care provider or cannot see them in advance of your scheduled pre-placement health appointment, you may visit the CDK walk-in-clinic (see below). Be sure to bring your OHIP card. There will be a fee associated with services not covered by OHIP (e.g. TB testing).

### **CDK Walk-in Clinic**

175 Princess Street, Kingston ON, 613-766-0318

<http://www.cdkmd.com>

Walk-In times: Monday through Friday 9 am- 5 pm and Saturdays 10am- 2 pm

## **Communicable Disease Screening Requirements**

### **Required for All Newly Hired Employees:**

#### **Tuberculosis (TB)**

A) A 2 step TB skin test is required, unless you have had:

- a previous two-step skin test in the past, OR
- a negative single-step TB skin test within the last 12 months

#### **in which case a one-step TB skin test is required.**

*Note: The 2 step TB skin test requires you to have a one-step TB test in your forearm, have it read by your health care provider 48-72 hours later, and then have a 2<sup>nd</sup> TB test repeated in 1-4 weeks.*

B) A single-step TB skin current within 3 months of your employment start date is required.

C) For individuals who are known to be TB skin test positive, or who test positive in (A) or (B) above, please provide TB test result (induration), date of last chest x-ray and result, any referral/treatment details.

**Measles- one of the following is acceptable:**

- Documentation of 2 doses of Measles vaccine (MMR) on or after your first birthday, or
- Laboratory evidence confirming your immunity to measles

**Mumps- one of the following is acceptable:**

- Documentation of 2 doses of mumps vaccine (MMR) on or after your first birthday, or
- Laboratory evidence confirming your immunity to mumps, or
- Record of a laboratory confirmed case of mumps illness

**Rubella- one of the following is acceptable:**

- Documentation of 1 dose of rubella vaccine (MMR) on or after your first birthday, or
- Laboratory evidence confirming your immunity to rubella

**Varicella (Chicken Pox) - one of the following is acceptable:**

- Documentation of 2 doses of varicella-containing vaccine, or
- Laboratory evidence confirming your immunity to chicken pox, or
- Laboratory confirmation of disease

**Acellular Pertussis – the following is acceptable:**

- Documentation of having received one single dose of tetanus, diphtheria, pertussis vaccine (Tdap) as an adult (≥18 years).

**Influenza Vaccination-** is strongly recommended:

- It is highly recommended that all staff be immunized each year with the annual influenza (flu) vaccine. If you are not immunized, the vaccine can be administered at the time of your pre-placement health screen.

**Required for Some Employees:**

**Hepatitis B**

- For employees at risk of exposure to blood/ body fluids due to the nature of their work, immunization with the Hepatitis B vaccine series is recommended with post vaccination bloodwork to verify the presence of Hepatitis B antibodies. This series, if incomplete, can be administered by KHSC Occupational Health, Safety & Wellness at the time of your pre-placement health screen.

**Respirator (N95) Fit Test**

- For certain staff who provide patient care/work in a patient care area, and for those working with airborne contaminants, a N95 respirator will be required. If you have a record of a previous respirator (N95) fit test, current within 1 year, please bring it to your pre-placement appointment. If you have not been fit tested or your test is older than 1 year, it will be performed as part of your KHSC orientation.

**Should you have any questions about the above requirements, please contact the Occupational Health, Safety & Wellness Department at your primary work site.**

Kingston General Hospital site  
613-549-6666 x 4389  
Armstrong 1, Mon-Fri 0700-1600

Hotel Dieu Hospital site  
613-544-3400 ext 2264  
Mary Alice 2 Mon-Fri 0800-1600

## Pre-Placement Communicable Disease Screening Form

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Department: \_\_\_\_\_ Position: \_\_\_\_\_

### To be completed by Attending Health Care Provider

#### 1. TUBERCULOSIS SCREENING

*\*Note: Previous vaccination with BCG is NOT a contraindication for Mantoux skin testing.*

##### A) A baseline **two-step TB (Mantoux) skin test** is required unless there is:

- Documented results of a prior two-step test, or (please provide results below)
- Documentation of a negative PPD within the last 12 months (please provide results below)

**in which case a single-step test is required**

##### Two Step TB Skin Test Results:

Step I \_\_\_\_\_ (dd/mm/yy) Result \_\_\_\_\_ mm induration

Step II \_\_\_\_\_ (dd/mm/yy) Result \_\_\_\_\_ mm induration

##### B) Single Step TB (Mantoux) skin test is required to be current within 3 months of your start date.

Single Step: (dd/mm/yy) \_\_\_\_\_ Result \_\_\_\_\_ mm induration

##### C) If TB Skin Test is positive or previously positive (induration >10mm):

Date of Positive Mantoux Test: \_\_\_\_\_ Induration: \_\_\_\_\_ mm

Chest x-ray: \_\_\_\_\_ (dd/mm/yy)

Chest x-ray Result \_\_\_\_\_

Undergone treatment?  No  Yes Duration of treatment: \_\_\_\_\_

History of BCG? \_\_\_\_\_ (dd/mm/yy)

Any signs or symptoms of TB:  none  persistent cough (for example, lasting > 3 weeks),  bloody sputum,  night sweats,  weight loss,  anorexia or  fever

#### 2. Measles

- 2 doses of live Measles virus vaccine on or after the first birthday:

#1: \_\_\_\_\_ (dd/mm/yy)

#2: \_\_\_\_\_ (dd/mm/yy) OR

- Laboratory evidence: Measles titre: \_\_\_\_\_ (result) \_\_\_\_\_ (dd/mm/yy)

#### 3. Mumps

- 2 doses of Mumps vaccine given at least 4 weeks apart on or after first birthday:

#1: \_\_\_\_\_ (dd/mm/yy)

#2: \_\_\_\_\_ (dd/mm/yy) OR

- Documentation of laboratory confirmed Mumps: \_\_\_\_\_ OR

- Laboratory evidence: Mumps titre: \_\_\_\_\_ (result) \_\_\_\_\_ (dd/mm/yy)

#### 4. Rubella

<input type="checkbox"/> 1 dose of Rubella vaccine on or after first birthday: #1: _____(dd/mm/yy) OR Laboratory evidence: Rubella titre: _____ (result) _____ (dd/mm/yy)
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#### 5. Varicella (chicken pox)

<input type="checkbox"/> Laboratory confirmation of disease (Result) _____ (dd/mm/yy), OR <input type="checkbox"/> Dates of Varicella Vaccination #1: _____ (dd/mm/yy) #2: _____ (dd/mm/yy), OR <input type="checkbox"/> Varicella titre: _____ (Result) _____ (dd/mm/yy), OR
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*In cases where the individual has not had chicken pox or is uncertain, they should be screened through bloodwork; where non-immune, they should be immunized with the chicken pox vaccine.*

#### 6. ACELLULAR PERTUSSIS (Tdap) BOOSTER

<input type="checkbox"/> 1 <u>Adult</u> dose received on: _____(dd/mm/yy)
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#### 7. HEPATITIS B IMMUNITY (for those at risk of exposure to blood/body fluids)

Hepatitis B vaccine series: (dd/mm/yy) #1 _____ #2 _____ #3 _____ AND Anti HBs titre: _____ Result _____(dd/mm/yy)
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*\* Hep B vaccination will be provided by Occupational Health for those 'at risk' staff who have not been immunized.*

#### 8. INFLUENZA VACCINE

<input type="checkbox"/> 1 dose of current year's vaccine received on: _____(dd/mm/yy)
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#### 9. RESPIRATOR (N95) FIT TEST \_\_\_\_\_ (dd/mm/yy) \_\_\_\_\_ Model/Size

*\* employee to attach copy of fit test record if available.*

Name of Attending Health Care Provider completing this form					
Full Address (No, Street)	City	Province	Postal Code	(Area Code) Telephone#	(Area Code) Fax #
Signature			Date completed		