Appendix A Policy 02-210

**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)* and KHSC Policy,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.

*Note- where there is a medical contraindication to any of the required vaccinations listed below, or there is a bona fide exemption under the Human Rights Code based on a protected ground, documentation will be required and our ability to safely accommodate any approved exemption will be assessed.*

# GENERAL INSTRUCTIONS:

# 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.

# 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, see the options below. Be sure to bring your OHIP card. There will be a fee associated with services not covered by OHIP (e.g. TB testing) and for completion of forms.

# Kingston Travel Vaccination Clinic- 902 Portsmouth Ave., Kingston, 613-546-2321 <https://www.kingstontravel.ca/>

By Appointment only

**CDK Walk-in Clinic (2 Locations)-** 175 Princess Street, Kingston OR 105 Sutherland Dr, Kingston 613-766-0318 <https://www.cdkmd.com/> Walk-In times available at the Princess St. location only

**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 2nd 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,

 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

**Acelluar Pertussis – only the following is acceptable:**

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

**COVID-19** -**the following is the minimum accepted:**

* Documentation of having received the COVID-19 primary vaccine series.

**Strongly Recommenced for All Employees:**

**Influenza Vaccination-** 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 Hotel Dieu Hospital site

613-549-6666 x 4389 613-544-3400 ext 2264

 **Pre-Placement Communicable Disease Screening Form**

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

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

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| **To be completed by Attending Health Care Provider**  |

# 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

1. **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)
1. **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)

**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Rubella**
* 1 dose of Rubella vaccine on or after first birthday:

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

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

1. **Varicella (chicken pox)**
* Laboratory confirmation of disease (Result) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (dd/mm/yy), OR
* Dates of Varicella Vaccination #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (dd/mm/yy)

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

* Varicella titre: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Result) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (dd/mm/yy), OR

*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.*

1. **ACELLULAR PERTUSSIS (Tdap) BOOSTER**

□ 1 Adult dose received on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(dd/mm/yy)

1. **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)

 *\* Hep B vaccination will be provided by Occupational Health for those ‘at risk’ staff who have not been immunized.*

 **8. COVID-19 PRIMARY VACCINE SERIES is required**

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| □ 1st Dose Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(dd/mm/yy)□ 2nd Dose Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(dd/mm/yy)COVID-19 Booster doses within 6 months are *strongly recommended:*□ Last Booster Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(dd/mm/yy) |

 **9. INFLUENZA VACCINE- is strongly recommended**

□ 1 dose of current year’s vaccine received on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(dd/mm/yy)

1. **RESPIRATOR (N95) FIT TEST \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** (dd/mm/yy) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Model/Size

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

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| 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  |

 Revised Feb 17, 2023