Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

Hôpital Hotel Dieu Hospital | KGH Hôpital Général de Kingston General Hospital

Volunteer Communicable Disease Screening

Proof of Immunity- Part 1

Name of Volunteer: _____ DOB: _____

Dear Physician/Health Care Practitioner:

As a prerequisite for volunteering at Kingston Health Sciences Centre (KHSC), individuals who carry on activities within the hospital must meet the communicable disease surveillance requirements as stipulated in the *Public Hospitals Act (Regulation 965*. In addition, KHSC policy currently requires full vaccination against COVID-19.

Note- where there is a medical contraindication to any of the above vaccinations 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.

Please confirm that the individual meets the following immunity requirements:

☐ I confirm **MEASLES IMMUNITY:** only the following is accepted as proof of immunity:

- documentation of having received 2 doses of live measles virus vaccine on or after the first birthday, or
- serologic evidence (bloodwork) verifying immunity to measles

☐ I confirm **MUMPS IMMUNITY:** only the following is accepted as proof of immunity:

- documentation of having received 2 doses of mumps vaccine (MMR) given at least 4 weeks apart on or after the first birthday, or
- serologic evidence (bloodwork) verifying immunity to mumps, or
- documentation of laboratory confirmed mumps

☐ I confirm **RUBELLA IMMUNITY**: only the following is accepted as proof of immunity:

- serologic evidence (bloodwork) verifying immunity to rubella, or
- documented evidence of immunization with live rubella virus vaccine on or after the first birthday

☐ I confirm **VARICELLA IMMUNITY:** only the following is accepted as proof of immunity:

- documentation of 2 doses of chicken pox vaccine, or
- laboratory evidence confirming your immunity to chicken pox, or
- record showing evidence (date) that you were ill with chicken pox

Note- A self- provided history of having had the chicken pox cannot be used as evidence of immunity.

☐ I confirm **PERTUSSIS IMMUNITY:** only the following is accepted as proof of immunity:

- immunization as an adult with one dose of T-dap (Tetanus-diphtheria acellular pertussis)

☐ I confirm **COVID-19 VACCINATION :** only the following is accepted:

- completion of the COVID-19 primary vaccine series at least 14 days ago.

KHSC strongly recommends *up-to-date COVID-19 booster doses and annual Influenza vaccination.*

I am aware of the communicable disease screening requirements as outlined above and certify that

_____ meets all requirements.

(Name of Applicant)

_____ _____

Signature of Physician/Other Health Care Provider **Date**

Health Care Professional's Last Name		First Name	
Full Address (No, Street)	City	Province	Postal Code
(Area Code) Telephone#	(Area Code) Fax #		

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Volunteer Communicable Disease Screening

Tuberculosis (TB) Screening (skin test) - Part 2

Name of Volunteer: _____ DOB: _____

Dear Physician/Health Care Practitioner:

As a prerequisite for volunteering at Kingston Health Sciences Centre (KHSC), individuals who carry on activities within the hospital must meet the communicable disease surveillance requirements as stipulated in the *Public Hospitals Act (Regulation 965).*

TUBERCULOSIS SCREENING

a) A **two-step TB test is required unless you have had:**

- Documented results of a previous two-step skin test in the past, OR
- Documentation of a negative single step Mantoux Skin Test within the past 12 months
  In which case a single step Mantoux Skin test should be given.

b) For individuals who are known to be tuberculin positive, or for those who are tuberculin skin test positive when tested in (a) above, further assessment should be done which may include a chest radiograph (depending on when last done) and/or evaluation by the individual's health care provider to rule out active disease.

I am aware of the communicable disease screening requirements as outlined above and certify that

_____ meets all requirements.
(Name of Applicant)

_____ _____
Signature of Physician/Other Health Care Provider **Date**

Health Care Professional's Last Name	First Name		
Full Address (No, Street)	City	Province	Postal Code
(Area Code) Telephone#	(Area Code) Fax #		