WRHN
Waterloo Regional
Health Network

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Employee Health Pre-Placement Package

Welcome to Waterloo Regional Health Network.

As a condition of employment, you are required to complete the Employee Health Pre-Placement Health Package.

Please read the documents carefully as this package contains the following:

- New Employee Immunization and TB Skin Testing Requirements Checklist (Page 2)
- Pre-Placement Health Form (Page 3 and 4)
- Respiratory Health Screening Questionnaire (Page 5)

The Pre-Placement Health Form, New Employee Immunization and TB Skin Testing Requirements Checklist ***(including any supporting documentation of all Immunizations and TB Skin Testing)*** and Respiratory Health Screening Questionnaire are to be completed and brought to your New Employee Health Review appointment.

An Employee Health Nurse will review all your documents with you and advise if all requirements are met. Further directions will be provided if follow-up is required.

Thank you,

Employee Health, Safety and Wellness
Waterloo Regional Health Network

New Employee Immunization and TB Skin Testing Requirements Checklist

Waterloo Regional Health Network has a legal obligation in accordance with the Public Hospitals Act and the Ontario Hospital Association to ensure that all new and current employees comply with specific Communicable Disease Protocols. It is therefore necessary that you meet the requirements outlined below **and submit supporting documentation of all immunizations and TB Skin testing requirements upon your hire.**

Communicable Disease Vaccine or Test	Requirements
☐ Tuberculin Skin Test (TST) **Mandatory for All Staff (needs to be completed within 2 weeks of start date)**	Proof of a baseline 2-step TB skin test is required and if the: • 2-step testing was negative and completed within the past year, no further TB testing is required for the pre-placement **OR** • If the 2-step testing was negative and completed greater than one year ago, a 1-step TB skin testing is required **OR** • If a 2-step testing was positive (proof of the positive TB result is required) the employee must provide documentation of a negative chest x-ray ruling out TB and no further TB skin testing should be administered If the Employee has never had 2-step TB skin testing or cannot provide documentation of prior 2-step testing, they will require 2-step testing within 2 weeks of their start date.
☐ COVID-19 (Coronavirus) **Mandatory for All Staff** **Required prior to start date**	Proof of vaccination for COVID (fully vaccinated) as per Health Canada's Immunization Guide.
☐ Measles/Mumps/Rubella (MMR) **Mandatory for All Staff** **Required prior to start date**	Two doses of the MMR vaccine are required on or after the first birthday and at least 4 weeks apart, **OR** two doses of measles and mumps vaccine plus one dose of a rubella vaccine if provided separately, **OR** a copy of blood work (serology) confirming evidence of immunity for Measles, Mumps and Rubella (provide a copy of the results).
☐ Varicella Zoster (Chicken Pox) **Mandatory for All Staff** **Required prior to start date**	Documentation of 2 Varicella vaccinations are required given at least 4 weeks apart **OR** a copy of blood work (serology) confirming immunity (provide copy of results). A self-reported history of chickenpox or shingles (herpes zoster) is ***not*** sufficient to demonstrate immunity.
☐ Hepatitis B **Lab Value Mandatory** **Required prior to start date**	Lab value of Hepatitis B immunity status (blood test) regardless of vaccine history is required (provide a copy of the results). Hepatitis B vaccination is not mandatory but highly recommended to employees who do not have immunity and have the potential for exposure to blood and/or body fluids.
☐ Tetanus/Diphtheria (Td) Tetanus/Diphtheria/Pertussis (Tdap) **Highly Recommended**	Td booster doses are given every 10 years. A single dose of Tdap (Adacel) should be given to all health care workers who have not previously received an adult dose. Td and Tdap vaccines are not mandatory but highly recommended.
☐ Influenza (Seasonal Vaccine) **Highly Recommended**	**Influenza Information** *(please review)* • According to the National Advisory Committee on immunization (NACI) "influenza vaccination provides benefits to HCWs and to patients for whom they care. NACI considers the provision of influenza vaccination to be an essential component of the standard of care for all HCWs for the protection of their patients". • All staff are encouraged to attend annual influenza clinics to receive the influenza vaccine. • In the event of an influenza outbreak, staff in the outbreak area who have **not** received effective immunization or who refuse anti-viral prophylaxis will be granted unpaid time off work for the duration of the outbreak if reassignment is not feasible. • Those who have a medically recognized contraindication to the vaccine will be required to submit supporting documentation to Employee Health for review. • Please indicate if you have medical exemption: Yes ☐ No ☐ If yes, indicate the nature of exemption: _____

Pre-Placement Health Form

A. IDENTIFICATION (Please Print) – *To Be Completed by Employee*

Legal Last Name:	Legal First Name:	DOB (DD/MM/YYYY):
Telephone:	Email:	
Address:	City:	Postal Code:
Position:	Department:	Manager:
Start Date:	**Full Time ☐ Part Time ☐ Temporary ☐ Contract ☐**	

B. HEALTH HISTORY – *To Be Completed by Employee*

Please check (√) Yes or No to the following health conditions that you currently have or have had in the past.

Health Concerns	**Yes**	**No**	**Health Concerns**	**Yes**	**No**
Allergy: ▪ Medication(s):			**Mental Health Concerns**		
			Diabetes		
▪ Scents			**Blood Pressure/Heart Condition**		
▪ Latex			**Fractures/Sprains/Dislocations**		
▪ Chemicals			**Migraines/Headaches**		
▪ Other:			**Digestive**		
Epipen© Required			**Skin (rash/irritation)**		
Respiratory Issues (i.e. Asthma, Breathing Issues)			**Dizziness/Fainting/Vertigo**		
Arthritis/Bursitis/Tendonitis			**Hearing Loss**		
Epilepsy/Seizures			**Vision Loss**		
Other significant health issues (list):					

Major Hospitalizations/Surgeries (excluding pregnancy):

_____

_____

Have you ever received medical treatment for any of the following musculoskeletal issues? Please check all that apply:

☐ Spine (neck, upper back, mid back, low back) injury or pain

☐ Upper Limb (shoulder, elbow, wrist, hand) injury or pain

☐ Lower Limb (hip, knee, leg, ankle, foot) injury or pain

Do you have any skin conditions on your hands (i.e. redness, open areas, cracks, dryness, burning) that might impact your ability to follow proper hand hygiene requirements? Yes ☐ No ☐

If yes, please describe: _____

C. AUTHORIZATION – *To Be Completed by Employee*

I hereby declare that I have reviewed, understand, and completed the above to the best of my knowledge and agree that this information will become part of my confidential Employee Health file.

Employee Signature: _____ Date: _____

D. PREVIOUS WORK AND EXPOSURE HISTORY – *To Be Completed by Employee Health Nurse*

Have you ever had a work-related illness or injury? Yes ☐ No ☐

If yes, please explain: _____
_____

Do you have any permanent restrictions from a previous WSIB claim? Yes ☐ No ☐
If yes, please identify:

Date of Claim: _____ Present Status: _____

Name of Employer: _____

Please describe restrictions: _____

Have you previously (with another employer) been exposed to the following:

Exposure to toxic substances (i.e. lead)	Yes ☐ _____	No ☐
Exposure to noise (i.e. without hearing protection)	Yes ☐ _____	No ☐
Heavy lifting (i.e. without mechanical lifts)	Yes ☐ _____	No ☐
Repetitive movement (i.e. assembly line work)	Yes ☐ _____	No ☐

Limitations related to medical conditions that may need accommodation for my ability to work (e.g. physical, cognitive, and/or accessibility requirement): Yes ☐ No ☐ If yes, please explain: _____
_____
_____

Do you have restrictions that require accommodation related to your personal safety in the event of an emergency evacuation?
Yes ☐ No ☐ If yes, you will be referred to the Emergency Preparedness Team.

Employee Health Nurse Signature: _____ Date: _____

FOR EMPLOYEE HEALTH USE ONLY:

- ☐ Lead Surveillance - Radiation Department
- ☐ Hep B Antigen Surveillance – Renal Program
- ☐ MenC/MenB – Lab- Micro (MLT/MLA)

Waterloo Regional Health Network is committed to protecting your privacy. The personal information collected in this form is collected in accordance with the Occupational Health and Safety Act and the Workplace Safety and Insurance Act. It will be used and maintained by the institution, for the intended purpose of providing you with Employee Health and Safety services. If you have any questions about the collection, use and disclosure of the information provided on this form, please contact Employee Health at
WRHN@QueenBlvd: employeehealthandwellness@smgh.ca Phone: (519) 744-3311 Ext 1481
WRHN@Midtown/Chicopee: occupational.health@grhosp.on.ca Phone: (519) 749-4300 Ext: 2300

Respirator Health Screening Questionnaire

***To Be Completed by Employee* - contact your educator or manager if you are not certain whether you need a fit-test or not**

Last Name:	First Name:	
If contract employee/student, name of agency/school:		
Job Title:	Unit/Dept:	Work Extension:
Do you wear glasses? Yes ☐ No ☐	Facial hair: Yes ☐ No ☐ If Yes, describe: _____	Do you wear dentures? Yes ☐ No ☐
Are you pregnant? Yes ☐ No ☐		

Have you previously completed a Fit Test? Yes ☐ No ☐ If Yes, Model of Respirator: _____ Date Tested: _____

*If you were not fit tested to one of the style/sizes that WRHN carries, you will be required to get your fit test re-done to one of WRHN's styles/sizes.

Do you currently have, or ever had in the past, any of the following conditions?			
1. Allergies ……	☐ Now	☐ Past	☐ Never
2. Claustrophobia (fear of closed in spaces) ……	☐ Now	☐ Past	☐ Never
3. Difficulty smelling odors……	☐ Now	☐ Past	☐ Never
4. Lung conditions ex: Chronic Bronchitis, Pneumonia, Injuries……	☐ Now	☐ Past	☐ Never
5. Heart problems……	☐ Now	☐ Past	☐ Never
6. High blood pressure ……	☐ Now	☐ Past	☐ Never
7. Frequent pain or tightness in your chest ……	☐ Now	☐ Past	☐ Never
8. Shortness of breath ……	☐ Now	☐ Past	☐ Never
9. Persistent cough or wheezing……	☐ Now	☐ Past	☐ Never
10. Chest pain when you breathe deeply ……	☐ Now	☐ Past	☐ Never

If you checked "NOW" or "YES" to any of the above questions (1-10), please briefly explain your answers below.

Have you ever used a respirator? Yes ☐ No ☐			
If yes, did you experience any of the following:	☐ Now	☐ Past	☐ Never
	☐ Now	☐ Past	☐ Never
11. Eye irritation ……	☐ Now	☐ Past	☐ Never
12. Skin allergies or rashes ……	☐ Now	☐ Past	☐ Never
13. Anxiety ……	☐ Now	☐ Past	☐ Never
14. General weakness or fatigue ……			
15. Any other problem that interfered with your use of a respirator ……			

After carefully reviewing your completed form, do you have any reason to believe that you will be unable to use or wear a half-face respirator while performing your duties?

Signature:	**Date:**