Markham Stouffville Hospital
Oak Valley Health

New Volunteer Health: Mandatory Requirements

Community and Volunteer Resources

Markham Stouffville Hospital requires all new volunteers to provide current immunization records that meet our organizational policy and the minimum standards for all Ontario hospitals (OHA/OMA Guidelines). The purpose of these requirements are to limit the risk of exposure and transmission of communicable diseases for staff, patients and volunteers and support a healthy and safe work environment.

- Form A must be fully completed by employee.
- Form B: To be completed by a licensed medical practitioner.

The medical information collected will be maintained in confidence and will remain part of your volunteer records.

FORM A: Health History

To be completed by volunteer:

Name: _____ **Date of Birth:** _____
(Last Name, First Name) (DD/MM/YYYY)

List any Allergies or sensitivities (eg. Latex, rubber, food, medications, environmental):

_____

Do you have any permanent restrictions or limitations? If so, please describe:

_____

Do you have restrictions that require accommodation related to your personal safety in the event of an emergency? Yes ☐ No ☐

_____

_____

I hereby declare that this information as well as the information I provided prior to being hired is true and complete. I understand that all medical information provided by me will be kept confidential as per the MSH Confidentiality Policy.

Volunteer's Signature: _____ **Date:** _____

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FORM B: Immunization Status Record

To be completed by a medical practitioner:

Full Name: _____ **Date of Birth (DD/MM/YYYY):** _____

Mantoux (TB) Skin Test Status	A 2-step TB skin test (TST) is mandatory unless previously tested positive (5 TUPPD 0.1cc ID) or have documentation of a previous two-step TST, in which case a one- step TST within the past 12 months is required. CHEST X-RAY required if skin test is positive (unless contraindicated for medical reasons) valid within 5 years. Persons who have had previous BCG vaccine should be assessed as above.

	Date given (DD- MM-YYYY)	**Which Arm?**	**Date read (DD- MM-YYYY)**	**Results (mm induration)**	**Signature (by healthcare practitioner)**
Step 1:					
Step 2:					
Annual:					

Chest X-Ray

Date:_____ Result:_____ I have attached a copy of the results (YES or NO)

Evidence of Immunity to Measles, Mumps and Rubella	2 doses of MMR vaccination OR laboratory evidence of immunity are required.

Immunization	**Date (DD-MM-YYYY)**	**Results (please check one)**		
Measles Titre		☐ Immune	☐ Non-Immune	☐ Indeterminate
Mumps Titre		☐ Immune	☐ Non-Immune	☐ Indeterminate
Rubella Titre		☐ Immune	☐ Non-Immune	☐ Indeterminate

OR

Immunization	**Date Given (DD-MM-YYYY)**
MMR Dose #1 Date:	
MMR Dose #2 Date:	
MMR Booster Date:	

Tetanus, Diphtheria	Valid for 10 years

	Date given (DD-MM-YYYY)
Td Date:	
TdaP Date:	

Varicella	2 doses of Varicella vaccination OR laboratory evidence of immunity are required.

Immunization	**Date (DD-MM-YYYY)**	**Results (please check one)**		
Varicella Titre		☐ Immune	☐ Non-Immune	☐ Indeterminate

OR

Immunization	**Date Given (DD-MM-YYYY)**
Varicella Dose #1 Date:	
Varicella Dose #2 Date:	

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COVID-19			
	Date given (DD-MM-YYYY)		
1st Dose Date:			
2nd Dose Date (if applicable):			
Manufacturer:			
If not yet vaccinated, would you like to be? (circle one)	Yes	No	

Hepatitis B	This section is only required for staff who will work with patients and/or may be exposed to blood, bodily fluids or infectious waste.

Immunization	Date (DD-MM-YYYY)	Results (please check one)		
Hepatitis B Titre		☐ Immune	☐ Non-Immune	☐ Indeterminate

OR

Immunization	Date Given (DD-MM-YYYY)
Hep B Dose #1 Date:	
Hep B Dose #2 Date:	
Hep B Dose #2 Date:	
Hep B Booster Date:	

If non-responder to immunization:

	Date given (DD-MM-YYYY)			
HbSAg Date:		☐ Immune	☐ Non-Immune	☐ Indeterminate

Information collected on this form will be maintained in confidence. Only information that confirms that you have met these requirements will be shared with your manager.

Health Practitioner's Signature _____ **Date** _____

(OFFICE STAMP HERE)

Volunteer's Signature _____ **Date** _____