Hennick Bridgepoint Hospital
Sinai Health

Staff Immunization and Surveillance Policy
INFORMATION SHEET

For the purposes of the Sinai Health Immunization & Surveillance Policy, the term "Staff" refers to all persons carrying out work activities within the hospital and includes all employees, physicians, researchers, learners, observers, volunteers, and contractors. All Staff are required to comply with the Sinai Health Immunization & Surveillance Policy, which is based upon the OMA/OHA Communicable Disease Surveillance Protocols for Ontario Hospitals.

The attached IMMUNIZATION FORM is for use by Staff on the hospital payroll only (i.e., employees). It is to be *completed by a Primary Care Provider or the Occupational Health Nurse at a previous employer*, and must be returned to Occupational Health & Safety (OHS) by fax: 416-470-6725 or e-mail: ohs.hbh@sinaihealth.ca no later than 12:00 pm (noon) on the Thursday *before* your start date.
No Staff will be allowed to start work without clearance through OHS.

Staff must complete and submit documentation of tuberculosis screening, as well as proof of immunity to Measles, Mumps, Rubella, and Varicella (chickenpox) *prior to their start date*. Hepatitis B, Tdap/Td, Influenza, and COVID-19 immunization status must also be provided

Tuberculosis – Staff are required to have had a documented baseline Tuberculosis (TB) skin test completed prior to their start date. It is essential to have accurate baseline information as this is the comparison that is used in the event of an exposure. Testing is required despite having a past history of vaccination for TB (called BCG).

- Staff who have not previously had a TB skin test are required to complete and submit results of a baseline 2-step TB skin test. This involves the planting of a TB skin test in the forearm and having it read by a Primary Care Provider or Occupational Health Nurse 2-3 days later. If negative, the process will be repeated in the other arm 1-3 weeks later. If positive, see below for instructions.
- Staff who have previously had a NEGATIVE baseline 2-step TB skin test are required to submit the results. If the 2-step TB skin test was done more than 12 months prior to their start date, the result of a repeat 1-step TB skin test dated within the last 12 months must also be provided.
- Staff who have a documented POSITIVE skin test (i.e. greater than 10mm induration) are required to submit the results, as well as the report of a CHEST X-RAY completed post-positive test.
- TB tests can be affected by some types of vaccines. TB skin tests should be complete before or 4 weeks after receiving live vaccines, such as MMR (Measles, Mumps, Rubella) or Varivax (chickenpox vaccine).

Measles – Any one of the following is acceptable:

- Documentation of receipt of 2 doses of live Measles virus vaccine (or trivalent Measles-Mumps-Rubella [MMR] vaccine) on or after the first birthday, given at least four weeks apart, **OR**
- Laboratory evidence of immunity.

Mumps – Any one of the following is acceptable:

- Documentation of receipt of 2 doses of live Mumps virus vaccine (or trivalent Measles-Mumps-Rubella [MMR] vaccine) on or after the first birthday, given at least four weeks apart, **OR**
- Laboratory evidence of immunity.

Rubella – Any one of the following is acceptable:

- Documentation of receipt of 1 dose of Rubella vaccine (or trivalent Measles-Mumps-Rubella [MMR] vaccine) on or after the first birthday, **OR**
- Laboratory evidence of immunity.

Varicella (Chickenpox) – Any one of the following is acceptable:

- Documentation of receipt of 2 doses of Varicella vaccine, given at least 4 weeks apart, **OR**
- Laboratory evidence of immunity.

Hepatitis B Vaccine – Highly recommended for any Staff who work with patients and/or may have contact with human blood, body fluids, or contaminated items (e.g., laundry, housekeeping, central reprocessing, etc.). It is essential for OHS to know Staff immunity status (i.e., Hepatitis B surface antibody titre) in the event of an exposure so that protective action can be taken promptly.

Tetanus/Diphtheria/Pertussis – Staff who have not received a dose of Pertussis vaccine as an adult (18+) should receive one dose of Tdap (Tetanus/Diphtheria/Pertussis vaccine for adults) prior to working in the hospital. Additionally, Tetanus/Diphtheria vaccine (Td) should be received every 10 years.

Influenza Vaccine – Offered by OHS and highly recommended for all Staff annually. If not received at Sinai Health, Staff must inform OHS of their influenza vaccination status (i.e. vaccine declination for medical or personal reasons, or if they received their vaccination elsewhere) on an annual basis.

COVID-19 Vaccine – Full vaccination for all Staff prior to start date. Staff who are unable to receive the vaccine due to medical contraindications must provide evidence to support the contraindication.

N95 Mask Fit Testing – Staff who interact with patients or the patients' environment and/or equipment are required to complete N95 Mask Fit Testing every 2 years. Staff should submit proof of a current mask fit to OHS or complete N95 training during orientation.

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IMMUNIZATION FORM

INSTRUCTIONS: Take the INFORMATION SHEET and this FORM to your Primary Care Provider or an Occupational Health Nurse to complete in full and sign. Relatives are not permitted to complete this form. Any costs associated with completion of this form are your responsibility. In order to fulfill the terms and conditions of your employment offer, the following information must be provided to Occupational Health & Safety (OHS) no later than 12:00pm (noon) on the Thursday prior to your start date. Incomplete forms and late submissions will delay your start date. Submit the completed form to OHS by **fax: 416-470-6725 or e-mail: ohs.hbh@sinaihealth.ca.** Retain a copy for your records.

LAST NAME:	FIRST NAME:	SIN:
HOME PHONE:	CELL PHONE:	DOB (DD/MM/YYYY):
JOB TITLE:	EMAIL:	
START DATE:	DEPARTMENT:	SUPERVISOR:

I agree to release the information below to OHS at Sinai Health. I understand that Human Resources and my Manager will be informed of my compliance status (compliant/non-compliant) in relation to the mandatory requirements of the Staff Immunization and Surveillance Policy as outlined in my hire letter.

By submitting this form via e-mail, I am authorizing Sinai Health OHS to exchange details of my personal health information with me using the e-mail address from which this form was submitted. I understand that e-mail correspondence outside of the Sinai Health network is not a secured or confidential means of communication. Furthermore, I acknowledge that I have been given the option to fax my form should I have concerns about corresponding via e-mail.

New Staff Signature: _____ Date: _____

TUBERCULOSIS SCREENING (Required)

Results of a baseline 2-step must be provided, unless 1st step is positive (see POSITIVE instructions below). If 1st step is NEGATIVE: 2nd step must be given 7 to 21 days after 1st test in opposite arm.			
1st step:	Date planted:	Date read:	Result (+ or -) and (mm):
2nd step:	Date planted:	Date read:	Result (+ or -) and (mm):
History of a BCG vaccine: ☐ Yes ☐ No		If answered yes, when was BCG administered:	
If the above NEGATIVE 2-Step TB test was NOT completed within the last 12 months, a 1-Step TB skin test must ALSO be completed.			
1st step:	Date planted:	Date read:	Result (+ or -) and (mm):
If test is POSITIVE (i.e. > 10mm induration), a chest x-ray is required. Document positive test result above and submit chest x-ray report.			
Chest X-ray:	**Date:**	**Result:**	

IMMUNIZATION STATUS (Required, marked with **). Please attach a copy of your laboratory reports†, as applicable.

**** Measles:**	Laboratory evidence of immunity†	Date of test:		Result: ☐ Immune ☐ Not Immune
**** Mumps:**	Laboratory evidence of immunity†	Date of test:		Result: ☐ Immune ☐ Not Immune
**** Rubella:**	Laboratory evidence of immunity†	Date of test:		Result: ☐ Immune ☐ Not Immune
	OR MMR vaccine (2 doses)	Date of MMR #1:		Date of MMR #2:
**** Varicella:**	Laboratory evidence of immunity†	Date of test:		Result: ☐ Immune ☐ Not Immune
	OR Varicella vaccine (2 doses)	Date of vaccine #1:		Date of vaccine #2:
Hepatitis B:	Laboratory evidence of immunity†	Date of test:	Titre Level:	Result: ☐ Immune ☐ Not Immune
	Series #1 Vaccination Dates	Vaccine #1:	Vaccine #2:	Vaccine #3:
	Series #2 Vaccination Dates	Vaccine #1:	Vaccine #2:	Vaccine #3:
Influenza:	Date of vaccine:	**Tetanus/ Diphtheria/ Pertussis:**	☐ Tdap ☐ Td	Date of vaccine:
****COVID-19:**	**Date of vaccine #1:	Vaccine Type (e.g., Pfizer):		Lot #:
	**Date of vaccine #2:	Vaccine Type:		Lot #:

PRIMARY CARE PROVIDER / OCCUPATIONAL HEALTH NURSE (OHN) SIGNATURE (Required)

Primary Care Provider / OHN: _____
Print Name & Discipline (e.g. MD, RN)

Signature: _____ Date: _____

Regulatory College No. / Phone / Address

Primary Care Provider or Occ. Health OFFICE STAMP