Immunization and Surveillance Policy – Information Sheet

Sinai Health's Immunization and Surveillance Policy helps to minimize the risk of exposure and possible transmission of communicable diseases to all Sinai Health people and patients. Sinai Health's Immunization and Surveillance Policy applies to all persons carrying out work activities within the hospital, including employees, physicians, researchers, scientists, learners, observers, volunteers, and contractors. All Sinai Health people are required to meet the immunization requirements and comply with the Policy as a condition of employment.

IMPORTANT: All employees, scientists, researchers (on hospital payroll), and volunteers are required to obtain immunization clearance by Occupational Health and Safety (OHS) in order to start work and to attend Orientation.

Steps for Obtaining Immunization Clearance

1. Take the **Information Sheet** (pages 1-2) and **Immunization Form** (pages 3-6) to your Primary Care Provider or an Occupational Health Nurse at a previous employer to complete and sign.
2. Return the completed **Immunization Form and supporting documentation** to OHS by fax (416-361-2663) or email (ohsmsh@sinaihealth.ca), no later than **12 p.m. (noon) on the Wednesday before your start date**.
3. Await an email response from OHS. In order to start work, you **must receive** an email from OHS confirming that you are cleared to start work.

Occupational Health Immunization Requirements

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

Tuberculosis – Employees, scientists, researchers on hospital payroll, and volunteers 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).

- Those 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.
- Those 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.
- Those 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 skin tests can be affected by some types of vaccines and 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.
COVID-19 Vaccine	Proof of full vaccination against SARS-COV-2 (at least 2 doses in a 2 dose series or 1 dose in a 1 dose series) prior to start date.
Hepatitis B Vaccine	Highly recommended for any person who works 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 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	Those who have not received a dose of Pertussis vaccine as an adult 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 annually. If not received at Sinai Health, all employees, scientists, and researchers on hospital payroll, and volunteers must inform OHS of their influenza vaccination status (i.e., vaccine declination for medical or personal reasons, or if they received their vaccination elsewhere) annually.

Immunization Form

INSTRUCTIONS:

In order to fulfill the terms and conditions of your employment offer, the following must be completed before your start date:

1. Take the **Information Sheet** (pages 1-2) and this **Immunization Form** (pages 3-6) to your Primary Care Provider or an Occupational Health Nurse at a previous employer 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.
2. Return the completed **Immunization Form and supporting documentation** to OHS by fax (416-361-2663) or email (ohsmsh@sinaihealth.ca), no later than **12 p.m. (noon) on the Wednesday before your start date**. Incomplete forms and late submissions will delay your start date.
3. Await an email response from OHS. In order to start work, you **must receive** an email from OHS confirming that you are cleared to start work.

SECTION A – IDENTIFICATION (to be completed by the Employee, Scientist, Researcher or Volunteer)

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

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 Immunization and Surveillance Policy as outlined in my offer letter.

By submitting this form via email, I am authorizing Sinai Health OHS to exchange details of my personal health information with me using the email address from which this form was submitted. I understand that email 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 email.

New Employee/Volunteer Signature: _____ Date: _____

SECTION B -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 any TB skin test is POSITIVE (i.e. > 10mm induration), a chest x-ray is required. Document positive test result on previous page and submit chest x-ray report.			
Chest X-ray:	**Date:**	**Result:**	

REQUIRED

PRIMARY CARE PROVIDER / OCCUPATIONAL HEALTH NURSE (OHN) SIGNATURE
By signing below, you are verifying that the information in Section B is accurate.

Primary Care Provider / OHN:_____ *Print Name and Discipline (e.g. MD, RN)* Signature: _____ Date: _____	Regulatory College No. / Phone / Address Primary Care Provider or Occ. Health OFFICE STAMP

SECTION C – VACCINATIONS AND/OR PROOF OF IMMUNITY

Please attach a copy of your laboratory reports†, as applicable.

REQUIRED

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:
COVID-19:	Attach record of all COVID-19 doses received to date.		

REQUIRED

PRIMARY CARE PROVIDER / OCCUPATIONAL HEALTH NURSE (OHN) SIGNATURE
By signing below, you are verifying that the information in Section C is accurate.

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

Signature: _____ Date: _____

Regulatory College No. / Phone / Address

Primary Care Provider or Occ. Health
OFFICE STAMP

SECTION D – IMMUNIZATION STATUS

Please provide the status of the following:

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:	

REQUIRED

PRIMARY CARE PROVIDER / OCCUPATIONAL HEALTH NURSE (OHN) SIGNATURE (Required)
By signing below, you are verifying that the information in Section D is accurate.

Primary Care Provider / OHN:_____ *Print Name and Discipline (e.g. MD, RN)* Signature: _____ Date: _____	Regulatory College No. / Phone / Address Primary Care Provider or Occ. Health OFFICE STAMP