Students interested in applying for a placement at the hospital (North Bay Regional Health Centre) must ensure the following documents are submitted to the CLP office:

Please ensure these items are completed and delivered to the CLP office (RSAC 201A) as soon as your placement has been confirmed. When all items have been submitted, required student training will be scheduled by hospital administrators. Students should ensure they make two copies of each document.

- ☐ ***Immunization clearance card information. Students must print the associated form found on following pages.***
  Immunization documentation may be obtained through the Campus Health Clinic in Room C211.
  Phone 705.474.7600 x 5261

  OR
  North Bay Parry Sound Health Unit
  http://www.myhealthunit.ca/

- ☐ ***Mask Fit Testing (the mask fit must be completed within the last 2 years)***
  Contact:
  SPI Health and Safety
  755 Wallace Rd. North Bay, ON P1A 0E7
  Telephone: 1-705-474-1933
  Fax: 1-705-474-1986

  OR: Glorianne Papolis glorianne@hotmail.ca

- ☐ ***Police Check (completed within the last 6 months) including vulnerable sector***

- ☐ ***Confidentiality Agreement – students are required to print forms on following pages***

- ☐ ***Photocopy of current CPR***

- ☐ ***Emergency contact information – students are required to print forms on following pages***

- ☐ ***Flu shot / H1N1 vaccine (required for F/W term placements)***

Immunization/Testing Requirements for

STUDENTS LEARNERS/CONTRACT WORKERS

It is the responsibility of the educational institution/contract provider to ensure that the individuals attending NBRHC are free of all active communicable illness. Students/contract workers that are ill with communicable respiratory, gastrointestinal illness or any other communicable illness are not to attend to their duties during the contagious period of illness. Information regarding some common restrictions due to illness will be outlined at the end of this information. Student/contract workers should advise their supervisor and education/contract facility if they are ill so that the appropriate restrictions can be put in place.

In order to prevent the spread of communicable illness the OHA/OMA has developed Communicable Disease Surveillance Protocols for Ontario Hospitals in compliance with Regulation 865 under the Public Hospitals Act. The immunization/testing requirements below are based on these guidelines.

STUDENT NAME: _____ SCHOOL: _____

Tuberculosis Testing

Students/contract workers who are skin test negative require completion of a two-step TB test at the start of first year of their program. Annual testing is not required. However, students with known TB exposures or communicable symptoms must be followed by their educational/contract facility to ensure they are free of active tuberculosis before placement with NBRHC.

□ I confirm proof of two-step Tb test at start of first year of program

Signed by GP/NP/RN: _____ Date: _____

Students who are positive TB positive reactors require proof from a health care provider that they are free of active Tuberculosis.

□ I confirm that this individual who is a positive TB reactor is free of active TB:

Signed by GP/NP/RN: _____ Date: _____

Measles/Mumps/Rubella Immunity and/or Immunization

Confirmation of one of the following is required:

□ Proof of 2 doses of MMR after first birthday

□ Lab evidence of immunity to Measles/mumps/rubella

I confirm one of the above:

Signed by GP/NP/RN: _____ **Date:** _____

Chicken Pox/Varicella Immunity and/or Immunization

Confirmation of one the following:

□ Lab evidence of immunity

□ Verification by Health care practitioner of confirmation of varicella/zoster illness

□ Documented proof of two varicella vaccinations

I confirm one of the above:

Signed by GP/NP/RN: _____ **Date:** _____

Tetanus/Diptheria/Pertussis Immunization

Confirmation of one of the following:

□ A single adult/adolescent dose of Tdap (Adacel/Boostrix) is recommended if no previous dose adolescent dose:

□ If received adult/adolescent Tdap but it is greater than 10yrs ago then TD is required

I confirm one of the above:

Signed by GP/NP/RN: _____ **Date:** _____

Hepatitis B Immunization

□ Students to provide proof of completed series of Hepatitis B immunization. Contract workers exposed to bodily fluids to provide proof of series

Signed by GP/NP/RN: _____ **Date:** _____

Influenza Immunization: This is only required during flu season

□ Students: as per NBRHC Student policy the influenza vaccine is required annually

I confirm receipt of annual influenza immunization:

Signed by GP/NP/RN: _____ **Date:** _____

□Contract workers must follow NBRHC Influenza Protocol ADM 17 which indicates proof of influenza vaccine in order to work during influenza protocol

I confirm receipt of annual influenza immunization:

Signed by GP/NP/RN: _____ **Date:** _____

Please detach this form and have students keep in their possession until the end of their placement.

Work/placement restrictions for students/contract workers with communicable symptoms

Illness	Symptoms	Placement/Work Restrictions
Influenza-like illness	**Sudden onset of** Fever and cough: plus one or more of sore throat, muscle aches, bone aches, fatigue	Remain away from NBRHC until 5 days after onset (return on day 6)
Cold/Respiratory	**2 or more of:** nasal discharge, sore throat, cough, headache	Remain away from NBRHC until 3 days after onset (returning on day 4)
Gastrointestinal	Vomiting and/or diarrhea	Remain away until 48 hour symptom free
Conjunctivitis (bacterial)	Redness, discharge	Remain away until 24 hours after effective treatment and showing improvement
Conjunctivitis (adenovirus)	Swollen glands in front of ears, pain, watery discharge, photophobia, blurred vision, low grade fever	Remain away until 14 days after onset
Strep Throat	Sore red throat, white papules, usually absence of cough	Remain away until 24 hours after treatment

*Call your supervisor and school if you are sick and unable to attend your placement

References;

1. OHA/OMA Communicable Disease Surveillance Protocol

http://www.oha.com/services/healthsafety/pages/communicablediseasessurveillanceprotocols.aspx

2. PIDAC, Routine Practices and Addition Precautions in Health Care, Nov 2012

http://www.oahpp.ca/resources/documents/pidac/RPAP_2012%20Revision_ENGLISH_2012-12-24_FINAL.pdf

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Confidentiality Agreement

Name: _____

(Please Print)

Affiliation with the Health Centre _____

(for example: Employee, Clinician, Physician, Board Member, Volunteer, Student, Alternative Therapy Clinician, Researcher, Consultant, Vendor, Contractor)

1. During my association with the Health Centre, I may have access to information and material (electronic and manual records) relating to patients, medical staff, employees, or other individuals which is of a private and confidential nature. At all times, I shall respect the privacy of the information I may have access to as well as the privacy of the patients, employees, and all associated individuals whom I may encounter while associated with the Health Centre.

2. I shall treat all the Health Centre administrative, financial, patient, employee and other records as confidential information, and I will protect them to ensure full confidentiality. I shall not read records or discuss, divulge, or disclose such information about the Health Centre, unless there is a legitimate purpose related to my association with the Health Centre. This includes patient information from other facilities I may have access to as part of my regular duties. This obligation does not apply to information in the public domain.

3. I shall ensure that confidential information is not inappropriately accessed, used, or released either directly by me, or by virtue of my signature or security access to premises or systems.

4. I understand that access codes come with legal responsibilities and that I am accountable for all work done under these codes. If I have reason to believe that my access codes or devices have been compromised or stolen, I will immediately contact the appropriate department (i.e. I.S./Security etc.)

5. Violations of this policy include, but are not limited to:
   - accessing information that I do not require for job purposes;
   - misusing, disclosing without proper authorization, or altering patient or personnel information;
   - disclosing to another person my user name and/or password for accessing electronic records;
   - disclosing computer access codes (for example, door codes) that need to be kept confidential and secure;
   - failure to protect physical access devices (for example, keys and badges) and the confidentiality of any information being accessed.

6. I understand that the Health Centre will conduct periodic audits to ensure compliance with this agreement and its privacy policy.

7. I understand and agree to abide by the conditions outlined in this agreement as well as those outlined in the Corporate Privacy Policy, and they will remain in force even if I cease to have an association with the Health Centre.

8. I also understand that should any of these conditions be breached, I will be subject to corrective action up to and including termination of employment, loss of privileges, or termination of a contract or may be fined up to $50,000 as per the current Privacy legislation.

I have read and understand the information contained in the Corporate Privacy Policy

Name (Please Print)	Signature	Date
Name of Witness (Please Print)	Signature	Date

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Emergency Contact Form

Name _____ Email _____

Date of Birth / / _____ Phone Number _____

Day Month Year

Address _____ City _____ Postal Code _____

Emergency Contact Information

Name _____ Relationship _____ Phone Number _____

Physician _____ Phone Number _____

Please fill in all areas below

College / University Name: Nipissing University
Program: Bachelor of Physical and Health Education
Department/floor of placement: _____
Name of Supervisor: _____ **Extension:**_____
Dates of placement: _____ **to** _____

CODE OF CONDUCT AGREEMENT

Patient's, residents, clients/outpatients or visitors found to be engaged in violations of the code of conduct may be subject to remedy. Such remedies may include removal of visitation rights or discharge, if appropriate. A patient/client whose judgment is impaired (temporarily or permanently) on account of their mental or cognitive state (e.g. post-operative delirium, dementia, brain injury, psychoses, developmental delay/disability, and autism) may not be responsible for their actions. In such cases appropriate actions(s) will be as per the procedure for patients/clients, outlined in the organization's Workplace Violence and Harassment HS-10

I have reviewed and understand North Bay Regional Health Centre's Code of Conduct and will conduct myself with the standards outlined above.

_____ _____ _____

Print Name Signature Date