North Bay Regional Health Centre | Centre régional de santé de North Bay

Student Placement Requirement Checklist

To be completed and signed by the Educational Institute

Placement Information	
Student Name:	Program:
Placement Start date: Finish:	Department:
Preceptor Name:	
Educational Institute Information	
Name:	Contact Email:
Phone #:	Contact Phone #
Student Contact Information	**Emergency Contact Information**
Email:	Next of Kin:
Date of Birth:	Phone #:
Address:	Relationship:
City:	**Physician Contact Information**
Postal Code:	Name:
Phone #:	Phone #:
Required Documentation (the following items have been verified)	
Immunization Records Immunization/testing requirement (every category is met and signed by a GP/NP/RN)	Yes: ☐
Confidentiality Agreement (signed and attached)	Yes: ☐
Code of Conduct Reviewed	Yes: ☐
Police check with vulnerable sector (Completed within 12 months of placement start date)	Negative: ☐ Positive: ☐ (follow up required) Contact the student placement office ASAP
Mask Fit Testing within 2 years (when applicable)	Date: Make/Model:
CPR certification within 1 year (when applicable)	Expiry Date :
Influenza vaccination (when applicable)	Date received:
Educational Institute Required Documentation	
Affiliation agreement signed and in good standing	Date signed:
Process for WSIB Coverage Information (attached)	Yes: ☐ No: ☐
Blood Borne Pathogen Exposure - I have reviewed and agree to as per the Affiliation Agreement	Yes: ☐ No: ☐

EDUCATIONAL INSTITUTE DECLARATION:
I hereby declare that the details furnished above are true and correct to the best of my knowledge and belief and I will immediately inform you of any changes.

For The (Name of the School): _____

Signature: _____ Print Name: _____

Title: _____ Date: _____

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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.

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 (18 yrs or older) dose of Tdap (Adacel/Boostrix) is recommended if no previous dose adult dose:

□ If received adult dose of 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

□ 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: _____

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

OHS FORM #73 (b) (Revised May 23 2014)

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Confidentiality Agreement

Name (Please Print) | Title (Please Print) | Company (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 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 and Title (Please Print)	Signature	Date
Name of Witness (Please Print)	Signature	Date