uOttawa

Office of Risk Management

CLINICAL PLACEMENT REQUIREMENTS RECORD

Program

Medicine ❐	Nursing ❐	Human Kinetics ❐	Nutrition ❐	Rehabilitation ❐	Other ❐
□ Undergraduate □ Postgraduate □ Visiting Medical Student (VMS)	□ Generic o Ottawa o Woodroffe o Pembroke □ Post-RN □ 2nd Entry □ MScN □ MScN [NP]	□ Undergraduate □ Postgraduate	□ Undergraduate	□ Audiology □ Occupational Therapy □ Physiotherapy □ Speech Therapy	Specify

Name: (Last) ____________________ (Given) ____________________

Student Number: ____________________ Health Card number: __________ (place of issue) ____

Admission year: ____________________ Phone Number: ______________

DOB: (yy/mm/dd): ____/____/____ E-mail:____________________

Tetanus/Diphtheria: Childhood primary series or adult primary series: Yes ❐ No ❐ Record attached ❐
OR Serology results- Date (yy/mm/dd): ____/____/____ Positive ❐ Negative ❐ Attached ❐
Booster (within last 10 years): Vaccine: ______________ Date (yy/mm/dd): ____/____/____ Record attached ❐

Polio: Childhood primary series or adult primary series: Yes ❐ No ❐ Record attached ❐
Last booster dose date (yy/mm/dd): ____/____/____ Record attached ❐

Tuberculin Skin Test (TST): Proof of two-step TST: Yes ❐ No ❐ Record attached ❐
Date of test #1 (yy/mm/dd): ____/____/____ Reading(48-72hrs) (yy/mm/dd): ____/____/____ Result: ________ mm
Date of test #2 (yy/mm/dd): ____/____/____ Reading(48-72hrs) (yy/mm/dd): ____/____/____ Result: ________ mm
(If step one is negative proceed to step two within 1-4 weeks)

If a two-step TST was previously completed, provide documentation of a one-step for the academic year:
Date of one-step (yy/mm/dd): ____/____/____ Reading(48-72hrs) (yy/mm/dd): ____/____/____ Result: ________ mm

If induration is ≥10mm a Chest x-Ray is required: (yy/mm/dd): ____/____/____ Result: ______________
Provide copy of report within the past 6 months: Yes ❐ No ❐ Attached ❐

IGRA: QuantiFERON ❐ or T-SPOT-TB assay ❐ Date (yy/mm/dd): ____/____/____ Result: ________

Varicella (Chicken Pox): VZV Titre - Date (yy/mm/dd): ____/____/____ Result: Positive ❐ Negative ❐ Attached ❐
Or history of disease: Date (yy/mm/dd): ____/____/____
Adult primary series of 2 doses is required if there is inadequate immunity
Dose #1: Vaccine: ______________ Date (yy/mm/dd): ____/____/____

Dose #2: Vaccine: ______________ Date (yy/mm/dd): ____/____/____

Measles, Mumps and Rubella (MMR): 2 documented MMR: Yes ❐ No ❐ Record attached ❐
MMR #1: Date (yy/mm/dd): ____/____/____ ____________ MMR #2 : Date (yy/mm/dd): ____/____/____

OR Measles serology: Date (yy/mm/dd): ____/____/____ Positive ❐ Negative ❐ Attached ❐
Mumps serology: Date (yy/mm/dd): ____/____/____ Positive ❐ Negative ❐ Attached ❐
Rubella serology: Date (yy/mm/dd): ____/____/____ Positive ❐ Negative ❐ Attached ❐

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Hepatitis B: Primary Series complete: Yes ❒ No ❒ Record attached ❒

Immunization series #1: (yy/mm/dd): ____/____/____ #2:(yy/mm/dd): ____/____/____ #3 (if required) :(yy/mm/dd): ____/____/____

AND Hepatitis B Surface Antibody Serology: Date (yy/mm/dd): ____/____/____ Result: ________ mIU/ml Positive ❒ Negative ❒ Attached ❒

Hepatitis B Surface Antigen Serology: Date (yy/mm/dd): ____/____/____ Positive ❒ Negative ❒ Attached ❒

Booster(s) if required: ___________ #4: (yy/mm/dd): ____/____/____ #5: (yy/mm/dd): ____/____/____ #6: (yy/mm/dd): ____/____/____ AND

Post Vaccination Hepatitis B Surface Antibody Serology: Date(yy/mm/dd): ____/____/____ Result: ____ mIU/ml Positive❒ Negative❒ Attached❒

Influenza *(for the academic year):* Proof of vaccination Attached ❒ To follow ❒
Vaccine: ____________ Date: (yy/mm/dd): ____/____/____

Attesting Signature of Health Care Professional (HCP)

Name:____

Signature:____________________________________

Title:______________________________

Date: (yy/mm/dd): ____/____/____

Stamp:

Attesting Signature of Health Care Professional (HCP)

Name:____

Signature:____________________________________

Title:______________________________

Date: (yy/mm/dd): ____/____/____

Stamp:

If required by your program: see web site http://www.uottawa.ca/services/ehss/CPRM.html and verify deadlines page

Cardiopulmonary Resuscitation (CPR) Level C: Attached ❒
Date of issue: (yy/mm/dd): ____/____/____

Police Record Check (a CPIC check and vulnerable sector check including amongst other things, a check for Pardoned Sexual Offences):
Date: (yy/mm/dd): ____/____/____ Original record provided ❒

Nursing license to practice Attached ❒

Student signature and authorization for disclosure of information:

I understand that it is my responsibility to inform the appropriate personnel of any communicable disease, special needs or medical conditions that may place me at risk or pose a risk to others during clinical placements. The information on the Clinical Placement Requirements Record will be kept confidential within the Clinical Placement Risk Management Team. However, under the following circumstances and for the duration of the program, I authorize the release of the Clinical Placement Requirements Record to: the clinical site where occupational exposure occurred; the treating medical site/institution or the clinical placement site.

Signature: ____

Date: (yy/mm/dd): ____/____/____