## Volunteer Immunization Record Submission

In compliance with the requirements set out in the *Public Hospital Act* Regulation 965 by-law 4(1) d. All mandatory requirements on the form must be completed by a licensed medical practitioner, **or** you may submit alternative authorised documentation that includes all of the required elements.

Women's College Hospital's Occupational Health, Safety and Wellness (OHSW) Department **does not** hold or maintain immunization records for volunteers. **It is the responsibility of the volunteer to retain this form or any supporting documents for their own records**.

| **First Name:** | **Last Name:** | **Date of Birth:** |
|---|---|---|

| ***Mantoux TB Skin Test Status** | **Mantoux TB Skin Test Results** | | |
|---|---|---|---|
| **2-Step TB Skin Test (TST)**<br>To be completed if there is no documented history of a 2-Step TB Skin Test on record. | 1. Date Given:<br><br>2. Date Given: | Date Read:<br><br>Date Read: | Result (mm):<br><br>Result (mm): |
| **1-Step TB Skin Test (TST)**<br>To be completed if 2-Step TB Skin Test is more than 12 months old **and** must provide dates of last 2-Step TB Skin Test. | Date Given: | Date Read: | Result (mm): |
| **Positive TB Skin Test**<br>Documentation of a Chest X-ray required. | Date of Positive TB test: | CXR Date: | □ Normal<br>□ Abnormal |

| ***MMR** | **MMR Results** | |
|---|---|---|
| **Measles** laboratory evidence of immunity | Date of Test: | □ Immune □ Not Immune |
| **Mumps** laboratory evidence of immunity | Date of Test: | □ Immune □ Not Immune |
| **Rubella** laboratory evidence of immunity | Date of Test: | □ Immune □ Not Immune |
| **OR** documentation of 2 doses of Measles, Mumps, and Rubella (MMR) vaccine | Date of 1st MMR: | Date of 2nd MMR: |

| ***Varicella (Chicken pox)** | **Varicella Results** | |
|---|---|---|
| **Varicella** laboratory evidence of immunity | Date of Test: | □ Immune □ Not Immune |
| **OR** documentation of 2 doses of Varicella vaccine | Date of 1st Dose: | Date of 2nd Dose: |

***Mandatory Requirements**

| **Completed by Licensed Medical Practitioner** | | |
|---|---|---|
| **Name (Please Print):** | **Address:** | |
| **Date:** | **Telephone:** | **Signature:** |

I consent to release the above information to the Occupational Health, Safety and Wellness Department, Women's College Hospital. I understand that no personal health information will be released by OHSW without my express consent. *Only my status regarding compliance or non-compliance* with communicable disease protocols will be provided to the Department of Medical Affairs/Human Resources/Management.

**Volunteer's Signature** _____ **Date:** _____

**Occupational Health, Safety & Wellness Department**
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