Occupational Health, Eastern Zones of NL Health Services must receive documented proof of primary and current vaccination against specified diseases, as well as the New Employee Health Screening Form & Tuberculosis Screening Form. This screening is performed as a prerequisite to enter any institutions related to NL Health Services. Screening, vaccination and testing is the learner’s responsibility and must be completed prior to your start date with NL Health Services. All students are required to complete Sections I, II & III. To complete outstanding requirements (MUN grads only), please contact MUN Student Health at 709-864-8500.

Completed forms must be emailed to [occhealth@easternhealth.ca](mailto:occhealth@easternhealth.ca)

Clearance to start work will not be granted until complete information is received.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Previous Names (if applicable): \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: dd-mmm-yyyy Contact #: Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Number/MCP: Allergies: \_\_

SECTION I:

**Provincial NL Student Form OR AFMC** ❑ Yes If **Yes**, please complete Sections II & III below

❑ No If **No,** please complete either [Provincial NL Student Form](https://www.mun.ca/medicine/media/production/medicine/documents/pgme/Provincial%20NL%20Student%20Screening%20Form.pdf) OR [AFMC Form](https://afmcstudentportal.ca/wp-content/uploads/2023/11/AFMC-Student-Portal-Immunization-and-Testing-Form-final-2023.pdf) as well as Sections II & III below

SECTION II:

1. **Complete & attach the “**[**New Employee Health Screening Form**](https://www.mun.ca/medicine/media/production/medicine/documents/pgme/OH%20New%20Employee%20Health%20Screening%20Form.pdf)**”**
2. **Complete & attach the “**[**Tuberculosis Screening Form**](https://www.mun.ca/medicine/media/production/medicine/documents/pgme/TB%20Screening%20Form%20for%20Staff.pdf)**”**

SECTION III:

**Tuberculin Skin Testing (TST)**: 2 step testing required (to be included in attached documentation. Please include most recent test below:

Date of Most recent TB test: dd-mmm-yyyy Result (in mm):

If **NEW** positive TST:

* Must include most recent TST results
* **Chest X Ray (CXR)**: Required if TST is positive (i.e. 10mm or greater induration)
* **CXR Date:**  dd-mmm-yyyy ❑ Must include CXR report

If **PREVIOUS** positive TST:

* Must include most recent TST results (above)
* Include most recent CXR Report. CXR Date: dd-mmm-yyyy
* Indicate if any TB exposures since most recent CXR. ❑ Yes ❑ No Date:
* Perform TB Symptom Check. Results: Date: dd-mmm-yyyy ❑ Positive ❑ Negative

**Respirator Fit Test**: Date: dd-mmm-yyyy Respirator type/size:

To be updated every two (2) years at minimum

Must provide confirmation of testing date, respirator type and size, along with a copy of the actual Fit Testing Certificate. **Respirator Fit Testing must be updated every 2 years at minimum.**

* Eastern Health utilizes 3M disposable respirators (3M 1860, 3M 1860S, 3M 1870+, 3M 8210) & Champak F550, 520M, & Champak PC 520L
* ***PLEASE NOTE:*** *The availability/supply of various masks may change prior to the start of your residency.*

**COVID-19 Vaccination**: Vaccine Name:­ Most recent Dose Date : dd-mmm-yyyy