HÔTEL-DIEU GRACE
ESTD HEALTHCARE 1888

OCCUPATIONAL HEALTH AND SAFETY
HÔTEL-DIEU GRACE HEALTHCARE HEALTH CLEARANCE

Last Name: _____ First Name: _____

Mailing Address: _____

Telephone #: _____ _____
(home) (other)

Date of Birth: _____ Health Card #: _____

Both Box A and Box B are to be completed by a physician:

A

TO BE COMPLETED BY HEALTH PROFESSIONAL PROVIDING AND READING TB TEST
2-STEP MANTOUX (TO BE DONE NO LESS THAN 7 DAYS TO 4 WEEKS AFTER 1ST STEP IS DONE)

STEP 1

☐ **PPD 0.1 cc Intradermal** **To be read in 48 hours**

Site: RT Forearm: _____ LT Forearm: _____ Time Given: _____

Lot Number: _____ Mfr.: _____Exp. Date: _____

Given by: _____ _____ Date: _____
Signature

Read by: _____ _____ Date: _____
Signature

Skin Test Result in mm:_____mm

STEP 2

☐ **PPD 0.1 cc Intradermal** **To be read in 48 hours**

Site: RT Forearm: _____ LT Forearm: _____ Time Given: _____

Lot Number: _____ Mfr.: _____Exp. Date: _____

Given by: _____ _____ Date: _____
Signature

Read by: _____ _____ Date: _____
Signature

Skin Test Result in mm:_____mm

If the TB skin test was positive a chest x-ray is required

Date of Chest X-ray: _____ Result of Chest X-ray: _____

B

SEROLOGY TESTING: Measles, Mumps, Rubella, Varicella, Hepatitis B immunity levels

Date of testing: _____ please indicate immune/not immune below

MEASLES: _____ MUMPS: _____ RUBELLA: _____

VARICELLA: _____ HEPATITIS B: _____

C

COVID-19 VACCINATION REQUIREMENT

☐ COVID VACCINATION 2nd dose proof: Date Completed:____ _____

☐ COVID Vaccine exemption on file and approved by HDGH Health Office: _____

SIGNATURE/STAMP of Medical Doctor _____