Postgraduate Medical Education Health Screening Record

Mar 2025

SUBMIT COMPLETED FORM TO THE FHS HEALTH SCREENING OFFICE (HSO)
AT LEAST 8 WEEKS PRIOR TO YOUR START DATE

Instructions for submission/HSO website: https://fhs.mcmaster.ca/healthscreening/postgraduate_medical_students.html

∗ Learners must be cleared by the Health Screening Office before they may start their program/elective ∗

LEARNER INFORMATION: PRINT CLEARLY

Name (last): _____ Name (first): _____

McMaster start date: _____ Date of birth (Year/Month/Day): _____

Email (required): _____

Current country of residence: _____

☐ NEW RESIDENT: Level (PGY1-PGY6) _____

☐ NEW FELLOW

☐ VISITING ELECTIVE/CORE ROTATION: Are you visiting from another Canadian University? ☐ NO ☐ YES

Home school _____ Home school PG program start date (Month/Year) _____

CONFIDENTIALITY: The FHS Health Screening Office (HSO) is collecting your personal information to clear you for entry into your program. The HSO will not share your personal information unless requested by you in writing or as permitted under FIPPA.
NOTE: all documentation will be maintained by the HSO as per the McMaster's Policy for Handling of Personal Health Information.

COMMUNICATION: The FHS Health Screening Office will need to communicate with you regarding the status of your health screening and detail outstanding requirements for clearance. If your preferred method of communication is via email please grant us permission and acknowledge that email is not a secure means for sharing confidential information, by signing and dating below.

Learner signature: _____ **Date:** _____

If you do not wish to communicate via email please specify your preferred method: _____

TB RISK ASSESSMENT: Please answer ALL questions.

1. Have you been in a country other than Canada:
- New Resident, Fellow, International Elective: **Within the last 12 months**?
- Visiting Elective from another Canadian University: **Since your last TST**?

☐ No ☐ Yes – Country/Dates _____

2. Have you been notified that you had significant exposure to an individual with active TB disease:
- New Resident, Fellow, International Elective: **Within the last 12 months**?
- Visiting Elective from another Canadian University: **Since your last TST**?

☐ No ☐ Yes – Dates _____

3. Do you currently have any symptoms of active TB disease (persistent cough or fever lasting three or more weeks, hemoptysis, night sweats, unexplained weight loss)?

☐ No ☐ Yes – Medical assessment and letter from a physician required.

4. Will you be in a country other than Canada between now and your program/elective start?

☐ No ☐ Yes – Country/Dates _____

Learner signature: _____ **Date:** _____

Checklist:

- Page 1 of the form MUST be submitted, with:
  1. Backup documentation addressing the requirements listed below. Backup documentation can be any combination of the following: Public health records, lab reports, previously completed UGME/PGME/AFMC forms, occupational health records, etc. Note: New vaccines/tests can be recorded on page 3 (Appendix A).
     *** OR ***
  2. Page 3 (Appendix A) can be completed by a qualified health care professional (do not complete this page yourself). HCP initials/signature verify the HCP has either provided the service or reviewed the learner's adequately documented records.
- Attach supporting documentation or a letter from a physician if unable to complete any requirement(s) due to a medical reason.
- Submit your completed form to the HSO ON TIME. Make sure your name is on EVERY PAGE submitted and keep a copy of all documents for your files.

Mandatory prior to program/elective start:

1. **TUBERCULOSIS (TB):** ONE OF THE FOLLOWING: **Complete BEFORE any new MMR/Varicella vaccines are given.**
   a) Baseline two-step tuberculin skin testing (TST) from any time in the past (two separate skin tests given between 7 days and 12 months apart and read after 2-3 days, requiring 4 visits to the HCP).
   AND additional single (one-step) TST if not already included in the baseline two-step test:
   - Within the last 12 months for new residents, fellows, and international visiting electives.
   - Within 12 months prior to the home school PG program start date for visiting electives from other Canadian Universities (please submit the most recent TST).

   Note: TST must be given either BEFORE or at least 28 days AFTER a live vaccine (MMR, Varicella).
   b) **OR** Positive TST or other positive TB history (e.g. blistering TST reaction, positive IGRA serology, previous diagnosis and/or treatment for TB infection); AND a chest x-ray report dated after the positive TST or other positive TB history.
   c) **OR** Report for negative IGRA serology dated within the last 12 months as an alternative to TST for international learners unable to access TST prior to their start date ONLY. **Note:** IGRA must be tested either BEFORE or at least 28 days AFTER a live vaccine (MMR, Varicella).
2. **MEASLES, MUMPS, RUBELLA, VARICELLA:** VACCINES **OR** SEROLOGY
   TWO measles vaccines, TWO mumps vaccines, ONE rubella vaccine, TWO varicella vaccines, given at age 12 months or older and spaced at least 28 days apart **OR** Positive IgG antibody serology. Vaccines ONLY preferred for measles/mumps/rubella without checking IgG antibody serology either before or after vaccination, although positive IgG antibody serology will be accepted. Varicella IgG antibody serology recommended only if no record of previous vaccines. **Note:** MMR and Varicella vaccines must be given either at the same time or spaced at least 28 days apart.
3. **COVID-19:** Primary vaccination series according to the Canadian Immunization Guide. Documentation must include vaccine type for each dose.
4. **ONE-TIME PERTUSSIS VACCINE (Tdap) AGE 18 YEARS OR OLDER:** Mandatory for learners even if not due for a booster. If not available in current country of residence, this must be completed in Canada prior to program/elective start.

May be in process after program/elective start:

5. **TETANUS, DIPHTHERIA, POLIO:** Primary vaccination series; AND tetanus-diphtheria booster in last 10 years (minimum 3 doses, minimum one month between the first two doses, minimum 6 months between the last two doses, Tdap above counts as one tetanus/diphtheria dose).
6. **HEPATITIS B (HB):** Vaccination series AND post-immunization serology for immunity (anti-HBs/HB surface antibody).
   Booster dose(s) of vaccine and repeat anti-HBs serology recommended if not immune after the primary vaccination series.
   Note: If no laboratory proof of immunity, passive immunization with immune globulin may be required in the event of possible exposure (e.g. needle stick injury, human bite, or mucosal splash); it is important report an incident immediately as the efficacy of immune globulin decreases significantly 48 hours after exposure. Vaccines and lab requisitions are available at Occupational Health Services after registration.
7. **INFLUENZA:** Immunization with current seasonal vaccine for placements occurring between November and June. Submit documentation directly to the clinical placement site.

Blood Borne Viruses: Hepatitis B surface antigen (HBsAg), HIV, Hepatitis C

Serologic testing for blood borne viruses is NOT required by the Health Screening Office. Learners who have been tested must SELF-REPORT any positive serology to the Associate Dean of Postgraduate Medical Education PRIOR to program/elective start; reports are not required by the Health Screening Office.

PGME Health Screening Record
Appendix A- Optional Form for Documentation

HCP may document requirements below and/or provide separate documentation.

Learner name (last): _____ **(first):** _____

1. TUBERCULOSIS (TB): **Complete BEFORE any new MMR/Varicella vaccines are given.**

Date TST given (yyyy/mmm/dd)	HCP Initials	Date TST read (yyyy/mmm/dd)	mm induration	Interpretation	HCP Initials

Positive TST or other positive TB history documented: ☐ Chest x-ray report attached

International learners unable to access TST: ☐ Report for IGRA serology attached

2. MEASLES, MUMPS, RUBELLA, VARICELLA: VACCINES **OR** SEROLOGY

	Date Vaccine1 (yyyy/mmm/dd)	HCP Initials	Date Vaccine2 (yyyy/mmm/dd)	HCP Initials		Report for IgG antibody serology attached
Measles					OR	☐
Mumps					OR	☐
Rubella					OR	☐
Varicella					OR	☐

3. COVID-19: Primary vaccination series according to Canada Immunization Guide; must include date & type for each dose.

Date Vaccine (yyyy/mmm/dd)	Vaccine type (required)	HCP Initials

4. ONE-TIME PERTUSSIS VACCINE (Tdap) AGE 18 YEARS OR OLDER:

Date Vaccine (yyyy/mmm/dd)	Vaccine type (required)	Age (years)	HCP Initials

5. TETANUS, DIPHTHERIA, POLIO: Document the last 3 vaccines that meet minimum spacing requirements.

	Tetanus/Diphtheria (yyyy/mmm/dd)	HCP Initials	Polio (yyyy/mmm/dd)	HCP Initials
Last				
Previous				
Previous				

6. HEPATITIS B (HB): ☐ Report for anti-HBs/HB surface antibody serology attached

Date HB vaccine (yyyy/mmm/dd)	+/- Vaccine type	HCP Initials	Date HB vaccine (yyyy/mmm/dd)	+/- Vaccine type	HCP Initials

Health Care Professional (HCP) Information: Initial each item documented above and complete the information below:

HCP Name: _____

Profession: _____ Initials _____

Signature: _____

Date: _____

Office stamp or Address/Telephone