Alberta Health Services

Communicable Disease Assessment

This information will be used to ensure your ability to work safely without risk of spreading or contracting communicable diseases. This form must be completed **in full** and submitted to your local Workplace Health and Safety (WHS) Office/Occupational Health Nurse (OHN) **prior** to your start date with Alberta Health Services (AHS). Records are kept confidential within WHS.

Last Name	Given Name	Birthdate *(yyyy-Mon-dd)*	
Home Phone	Cell Phone	Personal Email	
Home Address		City	Province Postal Code
AHS Employee Number *(if available)*	Start date *(yyyy-Mon-dd)*	Title/Position	
Department		AHS Site/Facility	AHS Zone
Name of AHS Manager			

Have you been previously employed by AHS or any of its former entities?

☐ No

☐ Yes ▸ Complete this information ▸

Dates of service *(from/to)*
Location/Facility

Communicable Disease History

Have you ever had Varicella *(Chicken Pox or Shingles)* after age 1? ☐ No ☐ Yes ☐ Unknown

Immunization Status ***(Include a copy of your current immunization records)***

If you do not have your records, you may be able to obtain them from the following:

- Alberta Public Health *(if you received your vaccinations in AB)*
- Health agency where you received your vaccinations
- Your previous education facility
- Your previous employer/healthcare employer
- Your physician

Attach all immunization, blood work records and test results for the following *(if applicable)*
(a titre is a blood test that measures antibodies in your body against a virus)

- Measles/Mumps/Rubella (MMR) Immunization
  - Measles titre results
  - Rubella titre results
- Varicella *(Chicken Pox)* Immunization
  - Varicella titre results
- Pertussis (Whooping Cough) (DTap or Tdap) Immunization
- Hepatitis B Immunization
  - Hepatitis B antibody titre results
- Tetanus Diphtheria (Td) Immunization
- Most recent skin test for Tuberculosis

For Laboratory Workers

- Polio Immunization
- Meningococcal Immunization
- Typhoid Immunization

Alberta Health Services

Last Name	Given Name	Date of Birth *(yyyy-Mon-dd)*

I have read and declare that the above information provided by myself is complete and accurate to the best of my knowledge.

Signature	Date *(yyyy-Mon-dd)*

In some areas the OHN may be able to access your immunization records electronically. I give my permission for the WHS Occupational Health Nurse to access my electronic record for immunization records or lab results to assess immunity if required.

☐ No ☐ Yes If yes, Personal Health Number _____

Signature	Date *(yyyy-Mon-dd)*

Witness *(please print)*	Witness *(signature)*	Date *(yyyy-Mon-dd)*

For WHS Office Use Only

OHN Signature	Date *(yyyy-Mon-dd)*