Human Kinetics: Laboratory Course Requirements

Laboratory Course
Fall: [ ] APA 3114  [ ] APA 3514
Winter: [ ] APA 2314  [ ] APA 2714  [ ] APA 4315  [ ] APA 4715  [ ] APA 4160  [ ] APA 4560

Name(Last):_______________________________________ (Given):__________________________ Year of admission: 20______
Phone #:___________________________________ E-mail:__________________________
Date of birth (yy/mm/dd):______/______/______ □ Male □ Female

Hepatitis B (Hep B) vaccination and serology (blood test) requirements

Part A:
1. Provide dates of vaccine series
   Dose #1(yy/mm/dd):___/___/___  Dose #2(yy/mm/dd):___/___/___  Dose #3(yy/mm/dd) ___/___/___

2. Provide date and result of Hep B surface antibody (anti-HBs) AND Hep B surface antigen (HBsAg) test (Mandatory)
   anti-HBs titer: Date (yy/mm/dd):___/___/___  Result:_____ IU/L (attach lab report)
   HBsAg: Date (yy/mm/dd):___/___/___  □ Negative □ Positive (attach lab report)

3. Proceed with the following directions according to the blood test results:
   If anti-HBs titer ≥ 10IU/L and HBsAg is negative, you are immune. No further action is required
   If anti-HBs titer < 10IU/L and HBsAg is negative, you are non-immune. Proceed to Part B
   If anti-HBs titer < 10IU/L and HBsAg is positive, you must consult a health care professional and complete the Positive HBsAg follow-up form*

Part B: If you are identified as non-immune (anti-HBs < 10IU/L) and HBsAg is negative
   Obtain and provide date of booster vaccine (yy/mm/dd):___/___/___
   Provide date and result of anti-HBs titer test result (attach lab report)
   Blood test must be completed 30 days following booster vaccine, NO EARLIER
   anti-HBs titer: Date (yy/mm/dd):___/___/___  Result:_____ IU/L If ≥ 10IU/L you are immune. No further action is required
   If < 10IU/L you must complete and submit the Hepatitis B second immunization series and serology follow-up form*

*Forms are available on our website at http://www.uottawa.ca/services/ehss/CPRM-Forms.html

Attesting Signature of Health Care Professional (HCP)
Name:_________________________________________ Signature:__________________________
Title:_________________________________________ Stamp:__________________________
Date (yy/mm/dd):______/______/______

Student’s Consent to Release Information:
I understand that it is my responsibility to inform the appropriate personnel of any communicable disease, special needs or medical conditions that may place me at risk or pose a risk to others during my clinical placements. The information on the Clinical Placement Requirements Record will be kept confidential within the Clinical Placement Risk Management Team. However, under the following circumstances and for the duration of the program, I authorize the release of the Clinical Placement Requirements Record to: the clinical site where occupational exposure occurred; the treating medical site/institution (if required) or the clinical placement site (if requested).
Signature:_________________________________________ Date (yy/mm/dd):______/______/______

Please return this form to:
Clinical Placement Risk Management Team 840-1 Nicholas, Ottawa, ON K1N 7B7 Fax: 613-789-5711
You may also email this form to your corresponding Risk Management Nurse.
http://www.uottawa.ca/services/ehss/CPRM.html

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