



Human Kinetics: Laboratory Course Requirements

Laboratory Course	
Fall: <input type="checkbox"/> APA 3114 <input type="checkbox"/> APA 3514	
Winter: <input type="checkbox"/> APA 2314 <input type="checkbox"/> APA 2714 <input type="checkbox"/> APA 4315 <input type="checkbox"/> APA 4715 <input type="checkbox"/> APA 4160 <input type="checkbox"/> APA 4560	
Name(Last): _____ (Given): _____	
Student Number: _____ Year of admission: 20 _____	
Phone #: _____ E-mail: _____	
Date of birth (yy/mm/dd): ____/____/____ <input type="checkbox"/> Male <input type="checkbox"/> 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): ____/____/____ <input type="checkbox"/> Negative <input type="checkbox"/> Positive (attach lab report)	
3. Proceed with the following directions according to the blood test results: If anti-HBs titer \geq 10IU/L and HBsAg is negative, you are immune. No further action is required If anti-HBs titer <than 10IU/L and HBsAg is negative, you are non-immune. Proceed to Part B If anti-HBs titer <than 10IU/L and HBsAg is positive, you must consult a health care professional and complete the <i>Positive HBsAg follow-up form</i>*	
Part B: If you are identified as non-immune (anti-HBs <than 10IU/L) and HBs Ag 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 <u>30 days</u> following booster vaccine, NO EARLIER	
anti-HBs titer: Date (yy/mm/dd): ____/____/____ Result: _____IU/L If \geq 10IU/L you are immune. No further action is required If < than 10IU/L you must complete and submit the <i>Hepatitis B second immunization series and serology follow-up form</i>*	
*Forms are available on our website at http://www.uottawa.ca/services/ehss/CPRM-Forms.html	
Attesting Signature of Health Care Professional (HCP)	
Name: _____	Stamp:
Signature: _____	
Title: _____	
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>