uOttawa

Clinical Placement Risk Management

POLICE VULNERABLE SECTOR SCREENING CHECK
SELF-DECLARATION
VISITING MEDICAL STUDENTS

Last Name: _____ **First Name:** _____

Date of birth (YYYY-MM-DD)**:**____/____/____ **Student number: _____**

E-mail: _____

DISCLOSURE:

Please check off the appropriate boxes:

Have you had any of the following occurrences within Canada or elsewhere?

1. ☐ YES ☐ NO Convicted of a criminal offence for which a pardon has not been granted?

If Yes, please provide the following information for each charge: (a) Name of office; (b) Date and place of conviction; (c) sentence

2. ☐ YES ☐ NO Criminal charges pending against you?
By "criminal", we mean an offence or charge under the Criminal Code of Canada or under another federal statute (which includes drug, tax, customs and military laws) or foreign equivalent.

If Yes, please provide the name of offence and details of the charge

3. ☐ YES ☐ NO Are you or have you been the subject of any disciplinary actions arising from previous or ongoing association with any professional body?

If Yes, please provide particulars.

If you answered *YES* to either question, you must provide details on ALL incidents on a separate document and submit this by fax to the Clinical Placement Risk Management office at 613-241-1527.

I attest that the above information is correct and up-to-date. I understand that I am obligated to inform the Clinical Placement Risk Management office should there be a change in my Police Vulnerable Sector Screening Check status during my attendance with the University of Ottawa.

Please note that the discovery of any information provided on this form to be false or misleading, or that information has been concealed or withheld may result in the suspension of clinical activities.

If required by the University, in its discretion, I hereby consent and agree to apply for and obtain an appropriate criminal record check at my expense and provide the written results of such a criminal record check to the University. I agree that the University, in turn, may be required to disclose the information that I provide in connection with this form or the information obtained as a result of such a check to other institutions and organizations which are involved in and for the purposes of my educational activities while at the University.

Signature of Student: _____ Date: _____

Include this completed form with your elective application.

Should you have any questions, please contact the Clinical Placement Risk Management office at vms_csa_immunise@uottawa.ca.