uOttawa

Clinical Placement Risk Management

Positive Hepatitis B Surface Antigen (HBsAg) Follow-up

Program

Medicine ❒	**Medicine ❒**	**Pharmacy ❒**
❑ Undergraduate ❑ Undergraduate Elective □ Visiting Medical Student □ Canadian Studying Abroad □ International	❑ Postgraduate ❑ Postgraduate Elective ❑ Enhancement Year Program	❑ Undergraduate

Last name:_____ **First name:**_____

Student number:_____ **Year of admission:**_____

Email:_____ **Telephone:**_____

Date of birth (yyyy/mm/dd):_____/_____/_____

I understand that it is my responsibility to inform the Clinical Placement Risk Management (CPRM) team, my placement coordinator, and receiving agency of any communicable disease, special needs, or medical conditions that may place me at risk or pose a risk to others during my placement. My personal information is collected for the purposes of and those consistent with ensuring the health, safety, and security on campus, on the treating medical site, or the host institution, and for enabling continuity of learning and work of the University and the treating medical site or as otherwise required by law. My personal information on the *Clinical Placement Requirements Record* is kept confidential with the CPRM team.

For the duration of the program, I authorize the release of the records to the placement agency where the occupational exposure occurred (if requested), to the treating medical site or institution (if required), and to the Dean of the Faculty and/or the placement coordinator in which I am a student for the purposes stated above.

I am aware that should I have a notable police check or self-declaration for service with the vulnerable sector, all supporting documentation will be released to the Faculty/School delegate responsible for its review. The University reserves the right to revoke admission offers and/or registration at any time, based on the results of the police record check.

Signature:_____ **Date (yyyy/mm/dd):**_____/_____/_____

FOLLOW-UP

To be completed by the Healthcare Provider

Positive HBsAg:

Restrictions for clinical placement or future practice: Yes❒ No❒

If "Yes", please outline the restrictions:_____

_____

_____

Attesting Signature of Health Care Professional (HCP)

Name:_____ Signature:_____ Title:_____ Date (yyyy/mm/dd):_____/_____/_____	Stamp:

Please email this form to your corresponding Clinical Placement Risk Management Advisor at the University of Ottawa.