IMS/CREMS & Other University Stipend Student Forms for **Student**

CREMS/IMS & Other University Student Checklist

ORIENTATION AND TRAINING:

1. All Students must complete online Orientation and Training prior to registering: https://students.smh.ca/course/ResearchVolunteerOrientation/player.html. At the end of the orientation, there are links to 4 training modules. Depending on the type (i.e, Clinical, Dry Bench -Health Science or Wet Lab – Laboratory) of Student you are you will be required to complete different training modules (please refer to checklist below). Completed certificates are required in order to register. If you do not know what type of student you are please ask your Investigator.

IN PERSON REGISTRATION

2. Students are to pre-register by the Sunday before the in-person registration session they are planning to attend at https://www.surveymonkey.com/s/ORA_pre_registration

3. The Student must personally bring all PI and Student Forms, Certificates and Documentation to the in person registration. Students must arrive promptly at the start of a session with ALL their completed paperwork.

REGISTRATION TIMES* & LOCATION:
Tuesdays 10:00 & 2:00
Thursdays 10:00 & 2:00
Location: (250 Yonge Street - 6th floor - Through the glass doors)

If you cannot come to register during either of these times, please contact the Research Employment Coordinator (contact info below) to make an appointment. DO NOT drop-in outside of registration times without a confirmed appointment. You will not be registered.

PLEASE ENSURE YOU HAVE ALL OF DOCUMENTATION BELOW BEFORE YOU COME TO REGISTER

*please do not staple your forms and print single sided

FORMS TO BE PROVIDED/COMPLETED & SIGNED BY INVESTIGATOR

- □ Access ID Card Request
- □ Copy of CREMS/IMS or Other University Registration/Agreement (signed by both PI and student)

FORMS TO BE COMPLETED & SIGNED BY STUDENT

- □ Personal Information form
- □ Privacy and Confidentiality Agreement
- □ Letter of Representation of Compliance with the Code of Business Conduct
- □ Research Training Centre (RTC) Registration
- □ 2015 Personal Tax Credits Return (TD1)
- □ 2015 Ontario Personal Tax Credits Return (TD1ON)
- □ Corporate Health and Safety Services – including:
  - o Corporate Health and Safety Health Questionnaire form
  - o Staff Immunization and Surveillance Record form
  - o N95 Respirator Medical Questionnaire form
  - o Fit Testing Working Sheet / Instructions for Respirator Fit Testing

TRAINING CERTIFICATES/PRINTED SCREEN SHOTS REQUIRED

All Volunteers to Complete:	Clinical and Dry Bench (Health Science) Volunteers to ALSO complete:	Wet Bench (Laboratory) Volunteers:
□ Workplace Violence and Workplace Harassment Prevention □ Customer Service for People with Disabilities	□ WHMIS □ Fire Safety	• Will be required to complete New Worker Safety Training in person after registration (more details will be provided upon registration).

STUDENT ALSO BRING THE FOLLOWING DOCUMENTATION:

- □ Photocopy of the following:
  - o Student ID Card
  - o (2) pieces of government-issued ID (scroll down for Acceptable ID for Security)
  - o Social Insurance Card (SIN) (or Confirmation of SIN Letter)
- □ (2) pieces of government-issued ID (scroll down for Acceptable ID for Security)
- □ Social Insurance Card (SIN) (or Confirmation of SIN Letter)
- □ Void Cheque with address or print of banking information from bank (bank name/location/transit/account number)
- □ Work Permit if applicable.

Questions? Cordelia Cooper, Research Employment Coordinator (416 864-3077 / cooperc@smh.ca)

ACCEPTABLE ID FOR SECURITY

As per eHealth Ontario specifications, individual seeking security credentials at St. Michael's must present an identity document chosen from the list of Primary Identity Documents below, and a second document chosen from either of the lists below.

Primary Identity Documents	**Secondary Identity Documents**
· Birth Certificate issued by a Canadian Province or Territory · Canadian Certificate of Birth Abroad · Certificate of Canadian Citizenship · Canadian Certificate of Indian or Metis Status · CANPASS · Citizenship Identification Card · Driver's Licence · Firearm Registration Licence · Certification of Naturalization · Nexus · A valid Passport issued by a foreign jurisdiction · Canadian Passport · Confirmation of Permanent Resident (IMM 5292) · Permanent Resident Card · Statement of Live Birth from Canadian Province (Certified Copy) · Citizenship and Immigration Canada-Refugee Protection Claimant Document · Canadian Permanent Resident Card · Ontario Photo Card	· BYID Card (Formerly Age of Majority Card) · Canadian Convention Refugee Determination Division Letter · Canadian Employment Authorization · Canadian Immigrant Visa Card · Canadian Minister's Permit · CNIB (Canadian National Institute for the Blind) Photo Registration Card · Canadian Police Force Identification Card · Canadian Student Authorization · Certificate issued by a government ministry or agency · Current Employee Card from a Sponsoring Organization · Federal, Provincial, or Municipal Employee Card · Other Federal ID Card, including Military · Judicial ID Card · Document showing the registration of a legal change of name accompanied by evidence of use or prior name for the preceding 12 months. · Old Age Security Card · Ontario Ministry of Natural Resources Outdoors Card · Current Registration Document from the College of a Health Profession · Current Professional Association Licence/Membership Card for any Regulated Health Profession · Record of Landing (IMM 1000) · Student Identification Card · Union Card · Blind Persons Right Act ID Card

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Personal Information Form

Last Name _____ First Name _____ Initial _____ Title _____ English Name (if applicable) _____

Address – street name and number _____

Date of Birth _____
Day Month Year

City _____ Province _____ Postal Code _____

Primary Phone No. _____ ☐ Cell ☐ Home

Secondary Phone No. _____ ☐ Cell ☐ Home

Email _____

Do you or have you ever worked at St. Michael's?

☐ Yes

☐ No

Please explain:

EMERGENCY NOTIFICATION

Name _____ Home Phone _____

Relation _____ Cell Phone _____

Please bring to Registration:

- Social Insurance Card (SIN) (or Confirmation of SIN Letter) and Photocopy
- Void Cheque with address or print of banking information from bank (bank name/location/transit/account number)

Please Note:

- You are responsible for declaring the stipend income when you submit your annual taxes. The stipend is broken down into bi-weekly payments made through payroll over the term of your engagement. You are NOT considered an employee of the hospital and as such do NOT qualify for hospital benefits.

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Privacy and Confidentiality Agreement

I acknowledge and understand that:

- St. Michael's Hospital (the **"Hospital"**) has in place policies and procedures respecting privacy, confidentiality and security (the **"Policies and Procedures**"),

- the Policies and Procedures are available to me upon request where I have any questions relating to my obligations hereunder,

- all personal health information [i.e., *information identifying an individual and relating to the provision of health care to that individual*] and/or confidential information [i.e., *information relating to the business of the Hospital*] that I have access to or learn through my employment, relationship or affiliation with The Hospital is to be treated as strictly private and confidential.

- as a condition of my employment, relationship or affiliation with The Hospital, I must comply with the Hospital's Policies and Procedures, and

- if I fail to comply with these obligations, the Hospital may terminate my employment, relationship or affiliation with the Hospital and that I may be subject to legal action taken against me by the Hospital and others, and/or to report to the appropriate college or regulatory body

I agree that I will access, use or disclose any personal health information and/or confidential information that I learn of or possess because of my employment, relationship or affiliation with The Hospital, only if it is necessary for me to do so in order to perform my duties as assigned by the Hospital. I also understand that under no circumstances may personal health information and/or confidential information be communicated either within or outside of The Hospital except to such other persons as are authorized by The Hospital to receive such information.

I agree that I will not alter, destroy, copy or interfere with this information, except with authorization and in accordance with the policies and procedures.

I agree to keep any computer access codes assigned to me (for example, passwords) confidential and secure. I also agree to safeguard physical access devices (for example, keys, badges) and the privacy and confidentiality of any information being accessed.

I agree that I will not lend my access codes or devices to anyone and will not attempt to use those of others. I understand that access codes come with legal responsibilities and that I am accountable for all work done under these codes. I am aware that work done using such codes may be audited. If I have reason to believe that my access codes or devices have been compromised or stolen, I agree to immediately contact the Hospital's Help Desk (ext. 5751).

Name (Please Print) SMH Barcode Number

Signature Date

Form No. 69709 Rev Mar 15, 2010

Letter of Representation of Compliance with the Code of Business Conduct

I wish to formally confirm that I am to the best of my knowledge and belief, fully compliant in all respects with the St. Michael's Hospital "Code of Business Conduct".

In the performance of my duties, I will:

- Comply to the best of my knowledge with all applicable laws and regulations.
- Make no payments or provide gifts to government officials or suppliers of goods and services.
- Maintain proper accounting records.
- Make no false or misleading statements to auditors or other external regulatory bodies.
- Not become involved in an outside activity which significantly encroaches on the time or attention which I should devote to the Hospital.
- Have no conflict of interest with those of St. Michael's other than those reported on separately in writing, and
- Deal appropriately with all confidential information.

I understand and accept the commitments stated above.

NAME: _____

SIGNATURE: _____ DATE: _____
(dd/mm/yyyy)

2 Shuter – Rm 2-053
Tel: (416) 864-5013
Fax (416) 864-5405

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CORPORATE HEALTH AND SAFETY SERVICES
HEALTH QUESTIONNAIRE

PRINT NAME

	☐ ☐
☐ ☐ ☐	

HEALTH HISTORY:

1.a) Do you have any allergies? No ☐ Yes ☐ If yes, explain

_____

b) Do you have an allergy to Latex? No ☐ Yes ☐ If yes,

explain _____

2. Are you currently, or have you recently, been under a doctor's care for an illness or health complaint that could possibly affect your ability to do your job? No ☐ Yes ☐ If yes, explain _____

3. Are you currently taking any prescription or non-prescription medication which affects your level of concentration or makes you feel sleepy? No ☐ Yes ☐ If yes, explain _____

_____

***OCCUPATIONAL HISTORY*:**

In your previous occupations or hobbies please indicate of you have been exposed to any of the following:

	Y	N		Y	N
Lead			**Radiation**		
Isocyanates			**Active TB**		
Noise			**Mineral dust(coal)**		
Heavy Metals (nickel, mercury)			**Fumes (welding, chemical)**		

If yes, explain _____

_____

_____

I understand that my declarations are confidential and will be kept in the Corporate Health and Safety Services. I certify my answers to the above questions are correct and complete.

Employee Signature: _____ **Date**: _____

Reviewed by: _____ **Date:** _____

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Staff Immunization and Surveillance Record

Corporate Health and Safety Services – St. Michael's Hospital

In order to comply with the Communicable Disease Surveillance Protocols for Ontario Hospitals, you must have the following form **completed and signed by your physician or, if appropriate, your previous employer prior to commencing your employment at St. Michael's Hospital**

Name: _____ Date of Birth: _____
(please print) (m/dy/yr)

Home Telephone# _____ Expected Start Date _____ Dept _____

Tuberculin Skin Testing: 2 Step required. 2nd step must be given 7 to 21 days after 1st test in the opposite arm if the 1st test is negative

Date of 1st step test: _____ Result: □ negative □ positive Induration in mm: _____

Date of 2nd step test: _____ Result: □ negative □ positive Induration in mm: _____

Chest X-Ray: Required if TB skin test is positive i.e. greater than 10mm induration. Chest x-ray must have been done within the last year.
Chest X-Ray Date: _____ Result: _____

Immunization:

Measles/Mumps/Rubella 1 MMR after 1st birthday plus an additional measles booster or a 2nd MMR

MMR Date (if available): Measles Booster or 2nd MMR Date: _____

Laboratory Evidence of Immunity (Titres)

Measles: Date of Titre _____ Result □ immune □ non-immune

Mumps: Date of Titre _____ Result □ immune □ non-immune

Rubella: Date of Titre _____ Result □ immune □ non-immune

Varicella:

Laboratory Evidence of Immunity (Titres)

Varicella: Date of Titre _____ Result □ immune □ non-immune
or
Varicella Vaccine 1st Dose Date _____ 2nd Dose Date _____
(2 doses required)

Hepatitis B Immune Status

Have you received Hepatitis B Vaccine? □ No □ Yes Dates: _____

Laboratory evidence of immunity to Hepatitis B (Hepatitis B Antibody Titre): □ Yes □ No Date: _____
□ immune □ non-immune

Influenza Vaccine Date of last immunization:

Tetanus, Diptheria/Pertussis **Date of last immunization:**

Completed by:

Physician/OHN/RN _____ Signature _____ Date _____
(please print)

Physician/OHN/RN Address _____

Physician STAMP

I, _____ agree to release the above information to Corporate Health and Safety Services.. I understand that my manager will be allowed to know the status of my compliance.

Witness (signature) _____ Date: _____

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Corporate Health and SafetyServices

N95 Respirator Medical Questionnaire - Staff

This confidential form is prepared in compliance with Directive ACO 03-05 and C.S.A. Standard Z94.4-02 – Selection, Use, and Care of Respirators.

Name of Unit/Department:		
Name (last, first, middle):	Job title:	Employee ID no.
Today's date:	Contact telephone number: Daytime: ( )	Evening: ( )
The best time to phone you at this number: Between and		

In the event that CHSS staff needs to contact you, we do need a phone, cell or pager number where you can be reached. If we can only reach you through your manager, please indicate this and be sure to include that phone number as well.

1. Have you ever worn a respirator? ☐ Yes ☐ No
   - If 'yes', check which types: ☐ N95 particulate respirator ☐ Air purifying respirator

2. If you have worn a respirator in the past did you have any difficulties? ☐ Yes ☐ No
   - If 'yes', did you have:
   - eye irritation? ☐ Yes ☐ No
   - skin irritation? ☐ Yes ☐ No
   - other, please describe: _____

3. Do you have trouble tasting? ☐ Yes ☐ No

4. Do you have asthma? (if you take medication for asthma, please remember to bring them with you) ☐ Yes ☐ No

5. Do you have any other lung or breathing problems? ☐ Yes ☐ No
   - If 'yes', please indicate which ones you have:

6a. Do you have any of the following medical conditions that might interfere with the use of a respirator? (please check those that apply) ☐ Yes ☐ No

☐ Diabetes mellitus ☐ Epilepsy or seizure disorder ☐ High blood pressure
☐ Fainting spells ☐ Heart problems

6b. Besides the medical conditions listed in 6a, are you currently taking a prescription and/or over the counter medication with full symptoms that may interfere with wearing a respirator – such as: (please check those that apply) ☐ Yes ☐ No

☐ Shortness of breath ☐ Difficulties breathing ☐ Heart problems
☐ Chest pain ☐ Light headedness ☐ Blackouts

7. Do you have an allergic reaction that may interfere with your breathing? ☐ Yes ☐ No

8. Do you have:
   - latex sensitivity? ☐ Yes ☐ No
   - latex allergy? ☐ Yes ☐ No
   - other allergies, please describe: _____

If you have indicated any medical concerns, you will be contacted by an Occupational Health Nurse from CHSS.

Staff Signature: _____ Witness: _____ Date: _____

FIT-TESTING WORKSHEET

Date of fit-testing: _____

(this section to be completed by the Fit-tester)

Fit Test Challenge				
Qualitative Bitrex □	**Qualitative Saccharin** □		**Quantitative (PortaCount)** □ **PortaCount #** _____	
Group 9	**Mask Code**	**Model #**	**Pass**	**Fail**
	C	1860	☐	☐
	D	1860s	☐	☐
	E	1870/9210	☐	☐
	F	8110s	☐	☐
	G	8210	☐	☐
		9210+	☐	☐
		1870+	☐	☐
			☐	☐

Staff signature: _____

Name of Fit-tester: _____

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Fit-test Clinic
Corporate Health and Safety Services
2nd floor Shuter Wing, 30 Bond Street
Toronto, ON M5B 1W8
Telephone: (416) 864-6060 extension 6944
Fax: (416) 864-5405
Email: maskfitting@smh.toronto.on.ca

Instructions for Respirator Fit-testing

Step 1:

- Complete the N95 Respirator Medical Questionnaire form (double-sided) and sign the bottom
- Make sure that you have clearly indicated your contact information on the form
- Be sure to read through all the instructions

Step 2:

- Please call the Fit-test Clinic to book your appointment
- You will need to bring a copy of your completed questionnaire on the day of your appointment

Step 3 (day of your appointment):

- **20 Minutes** before your fit-testing, **do not**:
  - **eat**
  - **drink** (only permitted to drink water)
  - **smoke**
  - **chew gum**

IMPORTANT: We will not perform respirator fit-testing under the following conditions:

1. **If we have not received and cleared your N95 Respiratory Medical Questionnaire. Please ensure that a copy has been sent to Corporate Health & Safety Services prior to booking your appointment**
2. **Staff must be CLEAN SHAVEN. A proper seal with the respirator cannot be formed if there is any facial hair. Razors will be provided upon request.**

THANK YOU AND PLEASE DO NOT HESITATE TO CONTACT US FOR ANY FURTHER QUESTIONS REGARDING RESPIRATOR FIT-TESTING.

Directions to the Fit-test Clinic:

- The Hospital is located on the intersection of Queen and Victoria Street
- Enter the Hospital through the Shuter St. entrance and take the Shuter elevator (immediately located to the right after entering and go to the 2nd floor
- Register for your appointment at the CHSS reception desk