COUNTY OF SIMCOE Paramedic Services

1110 Highway 26, Midhurst, Ontario L9X 1N6
Tel: 705-726-9300 | **Toll Free:** 866-893-9300

Paramedic Services Recruitment Documentation Requirements

Note: ***The following documents are required to be submitted to be considered for an interview***

*College Diploma:
Please bring a copy along with the original diploma to present for verification. If you do not have your diploma, a letter from the college must be presented outlining successful completion of the Primary Care Paramedic Program or Advance Care Paramedic Program stating the expected date of graduation.

*AEMCA or ACP Certificate:
Please bring a copy along with the original certificate to present for verification. If you do not have your AEMCA Certificate, a letter of successful completion or proof of enrollment to write the exam must be presented.

*First aid and BLS CPR Certification: Certification must be approved by the WSIB Ontario guidelines.
AEMCA Certified Candidates: Please bring original BLS CPR certification current within 1 year of your interview.
AEMCA Pending Candidates: Please bring original Standard First Aid certification current within 3 years of your interview AND BLS CPR certification current within 1 year of your interview.

Note: *****The following documents are required to be submitted at the time of acceptance of job offer***

Criminal Record Check with Vulnerable Sector Screening:
The original document must be presented for verification. If you have requested a CRC with VSS and have not yet received it, a receipt must be provided. ***Please ensure your CRC with VSS is dated no more than one month prior to your interview.***

Driver's Licence: A Class F or equivalent Driver's License must be presented for verification. A copy of both front **AND** back sides of the card must be provided.

Ontario Ministry of Transport Driver's License Abstract: A current 3-year uncertified driver's abstract must be provided. **Document must be current within 1 year of your interview.**

Communicable Disease Self-Declaration: The original signed document must be provided.

County of Simcoe Paramedic Services Health Screening Record:
An original document signed by a Practitioner indicating 'The Health Screening Record' meets the current version of Ambulance Service Communicable Disease Standards requirements **as well as** the submission of serology to support the current immunization records.

Immunization Status Report: An original document signed by a Practitioner as a Certificate indicating immunization compliance under the current version of Ambulance Service Communicable Disease Standards.

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COMMUNICABLE DISEASE SELF DECLARATION

This form is being requested to comply with the conditions as described by clause 6(1)(g) of O. Reg 257/00 under the *Ambulance Act;* which states that each paramedic employed by an ambulance service must be free from all communicable diseases.

NOTE:

All reportable communicable disease must be **reported immediately** to CSPS Infection Control Officer.

As of this date, I, ________________, declare that I am free from the any
(Print Paramedic Name)
Communicable Disease.

Paramedic Signature:________________________Date: ________________________

Please bring this completed declaration to your interview. Thank you!

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IMMUNIZATION STATUS REPORT

This is to certify, ______________________________________ has been immunized against the listed diseases in

Table 1 – Part A of the Ministry of Health – Ambulance Service Communicable Disease Standards, Version 2.1, or, such immunization is medically contraindicated, or, there is laboratory evidence of immunity, or, there is medically documented diagnosis or verification of history.

TABLE 1 – PART A		
Disease	**Schedule**	
Tetanus Diphtheria	Primary series (3 doses) if unimmunized. Td booster doses every 10 years.	**Date:**
Pertussis	1 single dose of tetanus diphtheria acellular pertussis (Tdap) vaccine regardless of age if not previously received in adulthood.	
Polio	Primary series (3 doses) if previously unimmunized or unknown polio immunization history.	
Varicella (Chickenpox)	2 doses if no evidence of immunity.	
Measles	2 doses if no evidence of immunity regardless of age.	
Rubella	1 single dose if no evidence of immunity.	
Mumps	2 doses if not evidence of immunity.	
Hepatitis B	2 - 4 age appropriate doses and post-immunization serologic testing.	

List exceptions to immunization:

____

____

____
Practitioner's Name

Signed by ___________________________________ on _____ day of __________________ of 20___________
Practitioner's signature

This form complies with the conditions of the *Ambulance Act,* Ontario Regulation 257/00, Part III of the Regulations (Qualifications of EMA's and Paramedics) **clause 6(1)(h)** which states an EMA and/or a Paramedic employed by an ambulance service must hold a valid certificate signed by a physician, nurse practitioner or other person authorized to administer the relevant vaccine that states that the person is immunized against diseases listed in Table 1 to the document entitled Ambulance Service Communicable Disease Standards, published by the Ministry, as that document may be amended from time to time, or that such immunization is contra-indicated.

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County of Simcoe Paramedic Services Health Screening Record

Completion of a Health Screening Record is a condition of employment for the County of Simcoe Paramedic Services (CSPS). **Review the requirements carefully to ensure accuracy and avoid delay in your application.**

- The requirements in this Record are in accordance with the Ambulance Service Communicable Disease Standards Version 2.1 set by the Emergency Health Services Branch of the Ministry of Health. All sections are mandatory. Exemptions will only be permitted for medical reasons, in which case a letter from a physician or nurse practitioner must be included.
- This Record must be completed by a physician, nurse practitioner, nurse or other person (Practitioner) authorized to administer the relevant vaccine**. Please ensure that the yellow highlighted sections * are completed and initialed by a practitioner.**
- Every Practitioner who completes any part of this Record must complete the Practitioner Information Section on page 2 and initial all applicable sections. Practitioner initials verifies they are confident that the patient demonstrates immunity to the infectious agent or, if the applicant is medically contraindicated, the Physician or Nurse Practitioner must complete and initial Section 8.
- Immunization status must be declared for the following communicable diseases: *Tetanus, Diphtheria, Pertussis, Polio, Tuberculosis, Measles, Mumps, Rubella, Varicella, and immunity to Hepatitis B.*
- Attach copies of supporting documentation such as reports of laboratory proof of immunity, official vaccination records, records from other institutions (if they have been signed by a Practitioner), or a letter from a Practitioner if applicable.
- Submit the entire CSPS Health Screening Record along with your supporting documentation. Be sure to complete and sign the applicant information section.
- Documents submitted to CSPS are not returned. Please keep copies for your personal records.

If you have any questions, please contact County of Simcoe Paramedic Services at **(705)-726-9300 ext. 1186**

Candidates are required to provide a USB stick containing a scanned original of this document and supporting documentation. Present the originals for verification purposes, along with hard copies for your employee file on the day of your interview.

The County of Simcoe Paramedic Services Department values your privacy. Personal information and supporting documentation provided on this Record is collected pursuant to the *Freedom of Information and Protection of Privacy Act of Ontario*, and protected by the Personal Health Information Protection Act. This information will be held in strict confidence within the County of Simcoe Paramedic Services Department Office and only disclosed as needed with the consent of the applicant.

Name: ______________________________

APPLICANT INFORMATION:

Surname: ____________________________ First Name: ____________________________

Phone Number: ________________________ Date of Birth: ____________________________
(dd/mm/yyyy)

Email: ______________________________

- ☐ I verify that this Record and all supporting documentation are true copies of the original and that to the best of my knowledge the information provided is accurate.
- ☐ I understand that it is my responsibility to retain the original documentation related to the Health Screening Record for the duration of my employment at CSPS.
- ☐ I understand that failure to complete the requirements on this Record, plus any future new requirements, may result in delays and/or removal from participation in employment at CSPS.

Signature: ____________________________ Date: ____________________________
(dd/mm/yyyy)

PRACTITIONER INFORMATION:

Every physician, nurse practitioner or other person authorized to administer the relevant vaccine who completes any part of this record must complete this section. Practitioner's initials verify they are confident the patient demonstrates immunity to the infectious agent. Practitioner must verify that immunization is medically contraindicated (attach additional sheet if required). If medically contraindicated, please complete Section 8.

Practitioner #1

Name: ______________________________________ Initials: ______________________

Address: ____

Telephone: ___________________________________ Fax: ___________________________

Signature: ___________________________________ Date: __________________________

Practitioner #2

Name: ______________________________________ Initials: ______________________

Address: ____

Telephone: ___________________________________ Fax: ___________________________

Signature: ___________________________________ Date: __________________________

Practitioner #3

Name: ______________________________________ Initials: ______________________

Address: ____

Telephone: ___________________________________ Fax: ___________________________

Signature: ___________________________________ Date: __________________________

Name: ______________________________

Section 1. TUBERCULOSIS (TB): Complete A and/or B

A. **TB Skin Tests: (History of a Two-step baseline AND a recent One-step are both required)**

- Document record of previous Two-step baseline TB skin test given at any time in the past (two tests 7-28 days apart).
  - TB skin tests must be spaced at least 7 days apart and read by a after 48-72 hours.
- Document record of previous One-step TB skin test given within the last 6 months (read within 48-72 hours).
- Positive tests requires a recent medical evaluation stating patient is **clear of active tuberculosis** and clinical symptoms.

	Date Given dd/mm/yyyy	Date Read dd/mm/yyyy	mm Induration	Interpretation	Practitioner's Initials
Step One of Two-step*					
Step Two of Two- step*					
Step One *(most recent)**					

B. **Complete if POSITIVE TB skin test or history of active TB disease**

	Date Given dd/mm/yyyy	Date Read dd/mm/yyyy	mm Induration	Interpretation	Practitioner's Initials
Positive Test					

	Date Given dd/mm/yyyy	Interpretation	Practitioner's Initials
Medical Evaluation			

Section 2. MEASLES, MUMPS & RUBELLA: Two doses of vaccine OR Laboratory proof of immunity

	Two doses vaccine at least 4 weeks apart #1 dd/mm/yyyy	#2 dd/mm/yyyy	Practitioner's Initials	OR	Laboratory proof of immunity	Practitioner's Initials
Measles*				**OR**	Reactive Measles IgG Ab*	
Mumps*				**OR**	Reactive Mumps IgG Ab*	
Rubella*				**OR**	Reactive Rubella IgG Ab*	

Section 3. VARICELLA: Two doses of vaccine OR Laboratory proof of immunity

If a history of chicken pox or shingles exists, laboratory proof of immunity to naturally acquired varicella/zoster is required.

	Two doses vaccine at least 6 weeks apart #1 dd/mm/yyyy	#2 dd/mm/yyyy	Practitioner's Initials	OR	Laboratory proof of immunity	Practitioner's Initials
Varicella*				**OR**	Reactive Varicella IgG Ab	

Name: ________________________________

Section 4. POLIO: Three doses of vaccine OR Two doses of vaccine with life-time booster

Three dose vaccine OR two dose vaccine with life-time booster. One polio vaccine must be have been given when age 4 years or older.

	#1 dd/mm/yyyy	#2 dd/mm/yyyy	#3 (or life-time booster) dd/mm/yyyy	Practitioner's Initials
Polio*				

Section 5. HEPATITIS B (HBV): Primary vaccination series PLUS Laboratory proof of immunity

- **Hepatitis B Primary Vaccination Series**
- **Hepatitis B Laboratory Proof of Immunity → REQUIRED**
- **If Not Immune (≤ 10 IU/L)**
  - STEP 1 → **HBV booster required followed by a repeat serology**
  - STEP 2 → **Repeat Anti-HBs serology one month after booster #1**
- **If Not Immune (≤ 10 IU/L) after 1 booster dose**
  - STEP 1 → **Continue with second series boosters 2 & 3 followed by a repeat serology**
  - STEP 2 → **Repeat Anti-HBs serology one month after booster #3**
- **STOP if any serology result ≥ 10 UI/L (immune)**
- **If Not immune (≤ 10 IU/L) after a full secondary series of boosters, it is at the discretion of the Practitioner to deem the patient as a Non-Responder**
- **Non-Responders→ Shall require a letter signed by their Practitioner confirming their immunization history**

	#1 dd/mm/yyyy	#2 dd/mm/yyyy	+ / - #3 dd/mm/yyyy	Practitioner's Initials
HBV primary series*				
HBV boosters				

	Date	Result	Practitioner's Initials
Anti-HBs serology #1*			
Anti-HBs serology #2			
Anti-HBs serology #3			

Section 6. PERTUSSIS: Tdap vaccine (Adacel, Boostrix, Repevax, DTCoq)

All adult paramedics **(≥ age 18 years)**, are required to receive a single dose of pertussis vaccine (Tdap), if not previously received **in adulthood** *(even if not due for a tetanus diphtheria booster)*. The adult dose is in addition to the routine adolescent pertussis booster.

Tdap vaccine name	Date	Age (years)	Practitioner's Initials

Name: ________________________________

Section 7. TETANUS & DIPHTHERIA: Primary vaccination series **PLUS** boosters if required

- Document record of tetanus and diphtheria vaccinations received to date – full primary series is recommended (3 doses).
- Require at least one tetanus diphtheria vaccination in last 10 years, in primary series or booster.

	# 1 dd/mm/yyyy	#2 dd/mm/yyyy	#3 dd/mm/yyyy	Practitioner's Initials
Tetanus, Diphtheria*				
	+/- #4 dd/mm/yyyy	+/- #5 dd/mm/yyyy	+/- #6 dd/mm/yyyy	Practitioner's Initials

Section 8. MEDICAL CONTRAINDICATIONS (if applicable):

If any vaccinations are medically contraindicated, please indicate which vaccines here:

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____

____

Practitioner's Initials: __________________