Perth County Paramedic Services
Health Questionnaire

The information collected in this form is solely for the purpose of verifying information required under the Ambulance Act and is a condition of employment. **This information will only be used by the County of Perth and will not be released to other agencies.**

Section 1: For Applicant Completion (please print clearly)

Name: _____ **Preferred Pronouns:** _____

Date of Birth: _____ **Gender:** _____

Address: _____

City: _____ **Province:** _____

Postal Code: _____

Phone Number: _____ **Alternate Phone Number:** _____

Email Address: _____

Applicant's Certificate and Release of Information

I certify that the foregoing information is to the best of my knowledge correct and I agree to this report and any future report derived from this information, being given only to Perth County Paramedic Services. The fee for the completion of this form is the sole responsibility of the applicant and not the responsibility of the County of Perth.

Applicant's Signature: _____ **Date:** _____

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Section 2: For Physician Completion Only

This is to certify, _____ **(Employee Name)** has been immunized against the listed diseases in Table 1 – Part A of the Ministry of Health and Long-Term Care – 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**.

Tetanus/Diptheria (Td)

A primary series of 3 doses, plus a Tetanus diphtheria (Td) booster every 10 years. If no Td booster within the last 10 years, a new booster must be obtained.:

Immunization Type	Date (MM/DD/YYYY)
First Dose:	
Second Dose:	
Third Dose:	
Most Recent Booster:	

Polio

A primary series of 3 doses. If no previous vaccination or unknown immunization history, a series of 3 doses for Polio are required:

Immunization Type	Date (MM/DD/YYYY)
First Dose:	
Second Dose:	
Third Dose:	

Pertussis (Tdap)

Single dose of tetanus diphtheria acellular pertussis (Tdap) required, regardless of age. If no previous immunization, 1 dose of Tdap is required:

Immunization Type	Date (MM/DD/YYYY)
First Dose:	

Physician's Initials: _____

Varicella

A series of 2 doses or a documented diagnosis with verification of Varicella immunity via serology submission. If no documented history of varicella, or serology results confirming immunity or 2 does series, a series of 2 doses for varicella are required.:

Immunization Type	Date (MM/DD/YYYY)
First Dose:	
Second Dose:	
Varicella confirmation:	
Serology Completed:	
Serology Titre Results (circle one):	Immune Indeterminate or not immune

Mumps

A series of 2 doses if no evidence of immunity, or immunity via serology submission. If no previous immunization or serology results indicating immunity; a series of 2 doses for mumps are required.

Immunization Type	Date (MM/DD/YYYY)
First Dose:	
Second Dose:	
Serology Completed:	
Serology Titre Results (circle one):	Immune Indeterminate or not immune

Rubella

Single dose or evidence of immunity via serology submission. If no previous immunization or serology results, 1 dose of rubella is required:

Immunization Type	Date (MM/DD/YYYY)
First Dose:	
Serology Completed:	
Serology Titre Results (circle one):	Immune Indeterminate or not immune

Physician's Initials: _____

Hepatitis B

2-4 dose series with serology testing within 1-6 months after completing the series to confirm immunity. If no evidence of immunity via serology testing, a series of 3 doses and serology testing within 1-6 months is required.

Immunization Type	Date (MM/DD/YYYY)
First Dose:	
Second Dose:	
Third Dose:	
Fourth Dose:	
Serology Completed:	
Serology Titre Results (circle one):	Immune Indeterminate or not immune

Measles

A series of 2 doses if no evidence of immunity, regardless of age, or immunity via serology. If no previous immunization or serology results, a series of 2 doses for measles are required.

Immunization Type	
First Dose:	
Second Dose:	
Serology Completed:	
Serology Titre Results (circle one):	Immune Indeterminate or not immune

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) Section 6 article (h), which states an EMA and/or a Paramedic employed by an ambulance service must hold a valid certificate signed by a physician 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 contraindicated.

Physician's Initials: _____

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A copy of the serology results demonstrating immunity to the following listed communicable diseases, is to be submitted along with the Perth County Paramedic Services Health Questionnaire.

- Varicella, Hepatitis B, Mumps, Rubella and Measles

Yellow immunization cards **will not be accepted** as proof of immunization.

Influenza

Must be current year.

Immunization Type	Date (MM/DD/YYYY)
First Dose:	

COVID-19

Immunization Type	Date (MM/DD/YYYY)
First Dose:	
Second Dose:	
Third Dose:	

If any of the above listed immunizations are not complete, an explanation is required:

Physician's Initials: _____

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Applicant's Name: _____

Physician's Name: _____

Physician's Address: _____

Please select the appropriate professional designation:

☐ Family Physician ☐ Nurse Practitioner ☐ Certified Specialist in: _____

How long has the Applicant been your patient: _____

Based on today's examination, there are no medical or physical reasons that would prevent this person from safely fulfilling the duties of a Paramedic in the Province of Ontario.

I, hereby certify the above information to be factual to the best of my knowledge.

Physician's Name: _____

Physician's License Number: _____

Physician's Signature: _____

Date: _____

Stamp with CPSO

Physician's Initials: _____