Professional Practice Health Form
School of Community Studies – EDS Year 2

Student Information

Name: ________________________________ **Student ID:**____________________

Email:________________________________ **Phone Number:**________________

Program Name:___________________________ **Year:**____________

Section A:

Non-Medical Requirements: The following non-medical requirements must be completed. If you have previously obtained one or more of these requirements, please verify the expiry date. If your certificate expires during the placement portion for your program, it is your responsibility to re-certify within one month from the time of expiration. **A copy of all certificates must be attached.**

CPR – Level C Certificate (every 3 years):

Valid Certificate: ☐ Yes

Standard First Aid Certificate (every 3 years):

Valid Certificate: ☐ Yes

Vulnerable Sector Police Check (annual):

Valid Certificate: ☐ Yes

Student Signature:________________________

Section B: To be completed by the student

Student Agreement:

I confirm that I have read this form and understand its purpose and the nature of its content. In particular, I understand that in order to comply with the Public Hospitals' Act and Ontario Hospital Association protocol, I need to demonstrate that certain health standards have been met in order for me to be granted student placement. I understand that the faculty in my educational program will be able to view the results from this form. I understand that I must have all sections of this form fully completed and reviewed by the identified due date. Failing to do so, may jeopardize my consideration for any student placement. All costs incurred for completion of this form are my sole responsibility. Should it be requested, it is my responsibility to share relevant information from this form with a hospital, nursing home, or other clinical placement agency relating to my program.

The personal information on this form is collected under the legal authority of the Colleges and Universities Act, R.S.O. 1980, Chapter 272, Section 5, R.R.O. 1990, Regulation 77 and the Public Hospital Act R.S.O. 1980 Chapter 410, R.S.O. 1986, Regulations 65 to 71 and in accordance with the requirements of the legal Agreement between the College and the agencies which provide clinical experience for students. The information is used to ensure the safety and well-being of students and clients in their care. The information in this form will be protected in accordance to the Freedom of Information and Protection of Individual Privacy Act.

Student Name:_________________________________ **Student ID:**________________________

Student Signature:______________________________ **Date (dd/mm/yy):** __________________