Welcome to the Primary Care Paramedic (PCP) Program at Keyano College.

You have made a great choice in selecting Keyano College as the institution where you will obtain your Primary Care Paramedic (PCP) Certificate. Our program is unique because of small class sizes, which means, you, the student, will receive individualized attention and diverse clinical practicums. At Keyano College, you will work with experienced and knowledgeable faculty who are student focused, approachable, and flexible.

Throughout the PCP program, you will have an opportunity to participate in a variety of experiential learning activities. There are mandatory requirements needed for this learning. All students must complete the mandatory list of requirements below.

Please complete the CPR certification and Police Information Check over the summer because of the time-sensitive nature of the requests.

ALL REQUIRED DOCUMENTS ARE TO BE SUBMITTED TO THE NURSING AND ALLIED HEALTH STUDIES Department ON/OR BEFORE September 14, 2021. Please email all documents, EXCEPT the Police Information Check and Vulnerable Sector Check to nursing@keyano.ca.

❖ Alberta Health Services (AHS) Student Orientation, Confidentiality & User Training
Confidentiality is very important in health care. Alberta Health Services (AHS), one of the major providers of experiential learning, requires that ALL students complete the online Student Orientation modules. All information can be found at the Alberta Health Services Student Orientation webpage:
https://www.albertahealthservices.ca/careers/Page12728.aspx
• Please complete all components of the AHS Student Orientation and submit certificates to the Nursing & Allied Health Studies Department as proof of completion.

❖ CPR – Heart & Stroke Foundation – Basic Life Support Provider
All students are required to obtain CPR certification. Evidence of recertification in each subsequent year of your program is required. The CPR Certificate must be dated no earlier than June 1, 2021 and the associated costs are your responsibility. The Nursing & Allied Health Services department will ONLY accept Heart and Stroke Foundation: Basic Life Support Provider CPR as proof of CPR certification.
Police Information Check with Vulnerable Sector Clearance
You are required to provide Keyano College with a Police Information Check and Vulnerable Sector Check, annually. Please submit the original of your Police Information Check, with Vulnerable Sector Clearance to the Nursing and Allied Health Studies Department on/or before September 14, 2021. The associated costs are your responsibility.
ALL photocopies of Police Information Checks should be done prior to submission of originals – department will not provide photocopies at a later date.

During enrolment in the program, you must self-report any change in criminal convictions or criminal charges to the Chairperson of the Nursing & Allied Health Studies Department.

Where a Police Check shows any one or more boxes checked off indicating that information “may or may not exist” you will be directed to consult with the Program Coordinator and/or Chairperson of the Nursing & Allied Health Services Department for further information.

HSPnet Consent Form
The Health Sciences Placement Network (HSPnet) is a computer system used by the Nursing & Allied Health Services department to arrange all clinical placements for our students. Students should read the document Purposes and Handling of Personal Information in HSPnet and then sign and submit the Consent Form for Use and Disclosure of Student Information.

WHMIS Certification on Moodle
Each year students are required to complete the WHMIS Certification. This can be done through Moodle and a copy of the certificate must be printed and submitted. Note: You only have 3 attempts to receive your certificate. Access to Moodle will be provided to students with your Keyano College Student ID and email access.

Sign and Submit the Following Forms (attached to this email)
- Keyano College Student Consent;
- Keyano College Code of Conduct; and
- Personal Declarations for Nursing and Allied Health Studies.
- AHS User Confidentiality Form
Additional documents, as required, are to be submitted to the College Nurse, in the Health Services Department. Documents required are attached and include, but are not limited to a Health Assessment Form, Immunization History Form, and Mask Fit Testing results. Please refer to the enclosed information from the College Nurse. All information requested from the College Nurse must be hand-delivered to Health Services on/or before September 28, 2021. Their office is currently closed - regular office hours are anticipated to resume on Thursday, August 26th, 2021. Do not mail or email any medical requirement-related documentation to Keyano College.

Before starting the PCP Program there are a few items that you should be aware of:

1. Body Survey Guidelines – This is a guideline, which we use as a standard for patient examination at all levels for both trauma and medical patients. Please make sure you review it carefully and practice using it in scenarios prior to the program beginning. During the few weeks, you will be evaluated on your ability to perform this body survey to a graduate EMR level.

2. You will need to purchase your PCP textbooks/workbooks at the Keyano College Bookstore and have them with you for the orientation day.

3. Physical fitness is an integral component of our program. Attendance and successful completion of the physical fitness component is mandatory. Proper footwear and workout wear is needed. You will also be required to lift approximately 69 kg (150 lbs.) in weight. You will be required to run approximately 3km. If you cannot run or lift as outlined, start practicing now! Failure to pass the physical fitness requirement will make the student ineligible to proceed to the practicum portion and graduate from our program. Keyano takes the fitness portion of the program very seriously, do not underestimate it.

4. You will need to be in full uniform at all times during the program. We suggest that you have at least two uniform shirts and two pairs of uniform trousers. A duty jacket, although not required, is strongly suggested. You are to purchase your NAVY BLUE uniform shirt and trousers (no striping is suggested) and be in uniform the second week of class. College flashes must be centered on each sleeve ½ inch below the shoulder seam; you may purchase these crests at the Keyano bookstore. Enclosed you will find a Uniform Authorization Voucher for Mark’s Work Warehouse. Please take this voucher to your closest Mark’s store to order your uniform ASAP. Allow 2-3 weeks to fill your order before the program starts.
Course Orientation
Course orientation will be held during first week of classes – timetable will be on moodle prior to the end of August 2020. **Classes start August 30, 2021.**

I trust that you will find your experience at Keyano College both personally and professionally rewarding. I look forward to welcoming you as a student to our PCP Program. If you have any questions or need any assistance, please do not hesitate to contact [nursing@keyano.ca](mailto:nursing@keyano.ca) or myself at [arlene.starkes@keyano.ca](mailto:arlene.starkes@keyano.ca).

Sincerely,

Arlene Starkes, BSc, BNRN, MN
Chairperson
Nursing and Allied Health Studies Department

Candi Muise
Dr, Candi Muise, BScN, RN, MN, EdD
Program Coordinator- BScN, PCP & ACP Programs
Nursing and Allied Health Studies Department

AS: hd
Enclosure
It is mandatory that all students complete this form and return to the Nursing Office as it is a clinical information system requirement for AHS Student Computer Access and Student Placement process.

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>Keyano ID:</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name:</td>
<td>Keyano email address:</td>
</tr>
<tr>
<td>Middle Name:</td>
<td>Month of Birth (i.e. Jan):</td>
</tr>
<tr>
<td>Post-Secondary Name used:</td>
<td>Day of Birth:</td>
</tr>
<tr>
<td>Alias or Maiden Name (if applicable):</td>
<td></td>
</tr>
</tbody>
</table>

Do you currently work for AHS in any capacity? If YES, Please indicate the following:
- Your AHS Employee ID number:
- Your username when you sign into a computer:
- Your AHS email address:

If you do not currently work for AHS, have you ever worked for AHS or a former Health Region of AHS? If YES, Please indicate the following:
- The region you worked for (AHS, CHR, Capital Health etc.):
- Your site/area of employment and manager’s name:
- Your position:
- Dates you were employed during this time:
- Did you have access to computer or email during this time:
  - If yes, please provide your username name and email access:

In order to gain access to AHS network, all students must complete the following. Please indicate with “YES” or “NO” in the “completed” column.

| Completed  |
|-----------------------------|-----------------------------|
| Watch the Information Privacy & IT Security & Awareness video |
| Complete the online learning module |
| Submit the signed AHS Confidentiality and User Agreement |
| Meditech 5.67 Overview & Navigation – print certificate |
| Meditech 5.67 Enterprise Medical Record (EMR) Module – print certificate |
| Meditech 5.67 Order Entry (OE) – print certificate |

http://www.albertahealthservices.ca/info/Page10995.aspx
Ctrl + Click to follow this AHS link to gain access to Meditech training. Fill out the areas indicated with an asterisk (i.e. your first and last name and facility (use NLHC). (Note: AHS ID and Meditech ID not required).
Scroll down to the tab “eLearning courses and Materials” near the bottom of the page and click on it. The e-learning courses are listed. Scroll to the required title and click on it. You are required to do the following courses and PRINT OFF certificates and ATTACH to this form (there will be 3 certificates):
- Meditech 5.67 Overview & Navigation
- Meditech 5.67 Enterprise Medical Record (EMR) Module
- Meditech 5.67 Order Entry (OE)

Student’s Signature: ______________________________ Date: __________________________

Signing this form means you have read the contents and complied to the above requirements as per AHS student placement contract.
Document Checklist for Nursing and Allied Health Studies Students

Please submit all documents together listed below including this document to the Nursing and Allied Health Studies office. Once the checklist is completed in its entirety, attach all forms/documents and submit to the Nursing & Allied Health Office. Please note, we do not accept documents one by one.

Name: ____________________________
Program:  ACP BScN  HCA  PCP  PN

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Enclosed</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Police Information Check with Vulnerable Sector Clearance <strong>copy only</strong></td>
<td>□</td>
</tr>
<tr>
<td>2.</td>
<td>Child Intervention Record Check <strong>ONLY applies to 2nd Year BScN students</strong></td>
<td>□</td>
</tr>
<tr>
<td>3.</td>
<td>Heart and Stroke Foundation – Basic Life Support <strong>Only accept Heart &amp; Stroke, copy of certificate</strong></td>
<td>□</td>
</tr>
<tr>
<td>4.</td>
<td>Keyano College Code of Conduct Form</td>
<td>□</td>
</tr>
<tr>
<td>5.</td>
<td>Keyano College Student Consent Form <strong>Does not apply to ACP, PCP or HCA students</strong></td>
<td>□</td>
</tr>
<tr>
<td>6.</td>
<td>Personal Declarations for Nursing &amp; Allied Health Studies Students Form</td>
<td>□</td>
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<tr>
<td>7.</td>
<td>HSPnet Consent Form and Disclosure of Student Information</td>
<td>□</td>
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<tr>
<td>8.</td>
<td>Alberta Health Services Confidentiality and User Agreement Form</td>
<td>□</td>
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<tr>
<td></td>
<td>Alberta Health Services Orientation, Confidentiality &amp; User Training certificates:</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>• AHS Orientation certificate</td>
<td></td>
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<tr>
<td></td>
<td>• AHS Secure – Collect It, Protect It</td>
<td></td>
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<tr>
<td></td>
<td>• Code of Conduct</td>
<td></td>
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<td></td>
<td>• Safe Disclosure/Whistleblower Policy</td>
<td></td>
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<tr>
<td></td>
<td>• Musculoskeletal Injury Prevention</td>
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<td></td>
<td>• Move Safe Injury Prevention</td>
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<tr>
<td></td>
<td>• It’s Your Move</td>
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</tr>
<tr>
<td>9.</td>
<td>AHS Network Access for Keyano Students Form – Meditech <strong>attach 3 certificates</strong>. Does not apply to ACP and PCP students.</td>
<td>□</td>
</tr>
<tr>
<td>10.</td>
<td>WHMIS 2015 for Students – On Moodle <strong>copy of certificate</strong></td>
<td>□</td>
</tr>
<tr>
<td>11.</td>
<td>Anaphylaxis – On Moodle <strong>copy of certificate</strong></td>
<td>□</td>
</tr>
<tr>
<td>12.</td>
<td>Make an appointment with the College Nurse in Health Services</td>
<td>□</td>
</tr>
<tr>
<td>13.</td>
<td>Immunization requirements and Mask Fit Test Card</td>
<td></td>
</tr>
</tbody>
</table>

**WHMIS For Students** on Moodle

- Log onto the iLearn.keyano.ca site by using your Keyano username and password.
- Scroll down the page until you see “WHMIS for Students on the left side.” Select this.
- Even if you have taken WHMIS training elsewhere, you must complete this course on a yearly basis.
- You must print your certificate upon completion — if the printing feature fails, then please request a certificate by sending an email to chrissi.sheppard@keyano.ca
# Hepatitis B Endemic Countries List

Countries considered highly endemic (8% or higher HBsAg prevalence) for hepatitis B infection are listed by geographical areas.

<table>
<thead>
<tr>
<th>Africa – excludes Algeria, Egypt, Libya, Morocco and Tunisia</th>
<th>Pacific Islands</th>
<th>Southeast Asia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola</td>
<td>Malawi</td>
<td>American Samoa</td>
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<tr>
<td>Benin</td>
<td>Mali</td>
<td>Cook Islands</td>
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<tr>
<td>Botswana</td>
<td>Mauritania</td>
<td>Easter Island</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>Mauritius</td>
<td>Federated States of Micronesia</td>
</tr>
<tr>
<td>Burundi</td>
<td>Mozambique</td>
<td>Fiji</td>
</tr>
<tr>
<td>Cameroon</td>
<td>Namibia</td>
<td>French Polynesia</td>
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<tr>
<td>Cape Verde Islands</td>
<td>Niger</td>
<td>Guam</td>
</tr>
<tr>
<td>Central African Republic</td>
<td>Nigeria</td>
<td>Kiribati</td>
</tr>
<tr>
<td>Chad</td>
<td>Reunion Island</td>
<td>Marshall Islands</td>
</tr>
<tr>
<td>Comoros</td>
<td>Rwanda</td>
<td>Nauru</td>
</tr>
<tr>
<td>Congo (Brazzaville)</td>
<td>Saint Helena</td>
<td>New Caledonia and Dependencies</td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
<td>Sao Tome et Principe</td>
<td>Niue</td>
</tr>
<tr>
<td>Dem. Republic of the Congo (Kinshasa)</td>
<td>Senegal</td>
<td>Palau</td>
</tr>
<tr>
<td>Djibouti</td>
<td>Seychelles</td>
<td>Papua New Guinea</td>
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<tr>
<td>Equatorial Guinea</td>
<td>Somalia</td>
<td>Samoa</td>
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<tr>
<td>Eritrea</td>
<td>South Africa</td>
<td>Solomon Islands</td>
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<tr>
<td>Ethiopia</td>
<td>South Sudan</td>
<td>Tokelau</td>
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<tr>
<td>Gabon</td>
<td>Sudan</td>
<td>Tonga</td>
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<tr>
<td>Gambia</td>
<td>Swaziland</td>
<td>Trust Territory of the Pacific Islands</td>
</tr>
<tr>
<td>Ghana</td>
<td>Tanzania (United Republic of)</td>
<td>Tuvalu</td>
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<tr>
<td>Guinea</td>
<td>Togo</td>
<td>Vanuatu</td>
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<tr>
<td>Guinea-Bissau</td>
<td>Uganda</td>
<td>Wallis and Futuna Islands</td>
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<tr>
<td>Kenya</td>
<td>Western Sahara</td>
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<tr>
<td>Lesotho</td>
<td>Zambia</td>
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<tr>
<td>Liberia</td>
<td>Zimbabwe</td>
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<tr>
<th>Central and Eastern Europe</th>
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<tbody>
<tr>
<td>Albania</td>
<td>Kyrgyzstan</td>
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<tr>
<td>Armenia</td>
<td>Malta</td>
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<tr>
<td>Azerbaijan</td>
<td>Moldova (Republic of)</td>
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<tr>
<td>Bulgaria</td>
<td>Tajikistan</td>
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<tr>
<td>Georgia</td>
<td>Turkmenistan</td>
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<tr>
<td>Kazakhstan</td>
<td>Uzbekistan</td>
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<table>
<thead>
<tr>
<th>Canada (indigenous populations of)</th>
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<tbody>
<tr>
<td>North West Territories</td>
<td>Nunavut</td>
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<tr>
<td>Yukon</td>
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<table>
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<tr>
<th>Denmark (indigenous populations of)</th>
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<tbody>
<tr>
<td>Greenland</td>
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<tr>
<th>Middle East</th>
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<tbody>
<tr>
<td>Jordan</td>
<td></td>
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<tr>
<td>Saudi Arabia</td>
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</table>

<table>
<thead>
<tr>
<th>USA (indigenous populations of)</th>
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<tbody>
<tr>
<td>Alaska (native populations)</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Central and South America</th>
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<tbody>
<tr>
<td>Bolivia (Amazon Basin)</td>
<td></td>
</tr>
<tr>
<td>Brazil (Amazon Basin)</td>
<td></td>
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<tr>
<td>Colombia (Amazon Basin)</td>
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<tr>
<td>Dominican Republic</td>
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<tr>
<td>Haiti</td>
<td></td>
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<tr>
<td>Peru</td>
<td></td>
</tr>
<tr>
<td>Venezuela (Amazon Basin)</td>
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</tbody>
</table>

Hepatitis B Vaccine Recommendations Algorithm for Health Care Workers Not at High-Risk of Past Infection

*This algorithm is intended to be used in conjunction with the Standard for Immunization of Health Care Workers, Standard for Immunization of Post-Secondary Health Care Students and the Hepatitis B Vaccine Biological Page.

Assess for documented history of hepatitis B immunization series

- No
  - Provide Hepatitis B vaccine series

- Yes
  - Screen for evidence of immunity (Anti-HBs) minimum of 1 to 6 months after completion of vaccine series
    - Anti-HBs positive: Consider immune. No further vaccine or serological testing required
    - Anti-HBs negative: Recommend completion of second series. Repeat Anti-HBs 1 month later
  - Screen for evidence of immunity (Anti-HBs) greater than 6 months after completion of vaccine series
    - Anti-HBs positive: Consider immune. No further vaccine or serological testing required
    - Anti-HBs negative: Recommend one dose of Hepatitis B vaccine. Repeat Anti-HBs 1 month later

*Previous serology results can be utilized if testing was completed after the documented series of vaccine.

Notes:
- These recommendations apply to pre-exposure immunization only. Post-exposure recommendations fall under the notifiable disease management guidelines and blood/body fluid exposure protocols.
- Ideally post-immunization serology (Anti-HBs) should be done a minimum of 1 month to a maximum of 6 months following immunization. For clients where it has been longer than 6 months order the serology and follow this algorithm based on the result.
- If an anti-HBs titre of at least 10 IU/L is confirmed following completion of documented series (including HCW providing a copy of previous results), testing need not be repeated nor should further immunization be undertaken, with the exception of immunocompromised persons who may have further testing ordered through their attending physician.

Alberta Health Services
Immunization Program Standards Manual
Population, Public and Indigenous Health

February 15, 2018
Page 1 of 1
KEYANO COLLEGE STUDENT CODE OF CONDUCT

I __________________________ acknowledge that I am familiar with/or have read the Keyano College Student Code of Conduct.

Program Name and Year : _______________________________

Signature____________________

Date:_______________________

Witness:______________________
This form is to be completed by all employees, Medical Staff, residents, volunteers, researchers, students, educators, Board Members and midwives. Completion by all members of the Medical Staff is a prerequisite for medical staff appointment. Completed forms will be retained in the appropriate corresponding program files. Managers/Supervisors are to send the form of AHS employees to Human Resources by fax to 1-888-908-4408 or email at Hrdataadmin.ahs@albertahealthservices.ca. Completed forms received by HR are considered the legal record, all other copies can be securely destroyed.

Alberta Health Services (AHS) is responsible for protecting the confidentiality of information that it collects, uses, stores and discloses over the course of its operations. You will have access to AHS information as part of your job duties and responsibilities. This document describes how you, as an AHS Affiliate (defined under the Health Information Act), must handle AHS information, including AHS information systems, and will help you comply with relevant AHS policies. Refer to Information and Technology Management policies on www.albertahealthservices.ca/policies-bylaws.asp.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Job Title (e.g. Physician, Analyst, Nurse, etc)</td>
<td>Identification # (For physicians-CPSA #)</td>
</tr>
<tr>
<td>Role (submit your form to the office identified in brackets)</td>
<td>□ Volunteer (Volunteer Resources Coordinator)</td>
</tr>
<tr>
<td>□ Employee of AHS/subsidiary (Manager/Supervisor)</td>
<td>□ Researcher (Repository Owner)</td>
</tr>
<tr>
<td>□ Medical Staff, Medical Students, Residents (Zone Medical Office)</td>
<td>□ Student or Educator (Educational Institution Liaison)</td>
</tr>
<tr>
<td>□ Board Member (Board Office)</td>
<td>□ Midwives (Chief Nursing Officer)</td>
</tr>
</tbody>
</table>

It is required that you read and understand the above referenced policies and treat patient or other information as confidential. Confidentiality of information is governed by both AHS policy and provincial and federal law.

You must sign this Agreement before AHS will grant access to AHS information or an AHS System. This Agreement explains the rules and expectations related to securing and protecting AHS information and systems. You may be required to comply with additional terms and conditions before accessing specific AHS Systems.

**Agreement**

**System Security**

1. I will keep any AHS System login information such as my user password confidential and will not share this login information with anyone else.

2. I am responsible for any use of any AHS System performed under my login information.

3. I will not leave my workstation unattended without logging out or securing my workstation.

4. I will not use or obtain another person’s login information.

5. If I believe my login information may be known by another person I will immediately change my password and notify the AHS IT Security and Compliance Office.

6. I shall not download or install any application or program to an AHS System without the approval of the administrator for that particular AHS System.
Agreement (continued)

7. I shall only collect, access, use and disclose the *minimum* information necessary for the purpose of fulfilling my AHS job duties and responsibilities.

8. I will not access information for non-AHS purposes, including accessing my own health information, or the information pertaining to: a family member, friend, colleague, or anyone who is not within my scope of my duties and responsibilities. There are procedures in place in Health Records which would allow me or others to appropriately request access to health information.

9. I shall ensure that information I enter into an AHS System is complete and accurate to the best of my ability.

10. I shall dispose of any information I access from the AHS System (whether in electronic or paper form) in a secure manner as explained in AHS policies and procedures.

11. I shall use reasonable means to ensure that while I am accessing information on an AHS System it will not be viewed or obtained by unauthorized people. (e.g. secure my computer, be discreet when viewing data).

12. I understand that AHS retains ownership and control over all information contained in the AHS System (whether in electronic or paper form).

13. I shall not collect, use, transmit or disclose any AHS information except as allowed by AHS policies and procedures.

Confidentiality Provisions

14. I shall take reasonable actions to keep all information private and confidential and prevent the unauthorized collection, use and/or disclosure of all information that I come into contact with.

15. I accept that the obligation to keep AHS information confidential continues even after I leave the organization or my relationship with AHS ends.

16. If I become aware of a violation of a policy referenced above or a potential or actual breach of confidentiality, I will notify my Supervisor immediately. I will also notify the AHS Information & Privacy Office or IT Security & Compliance as soon as possible.

Audit and Sanctions

17. I understand and acknowledge that AHS conducts random audits of AHS Systems and may audit my use of any AHS System without notice.

18. I understand that AHS, in its sole discretion, may revoke or restrict my access to any AHS information or AHS System, for any reason.

19. I acknowledge that I have read the policies referenced above and understand the consequences for a violation of those policies and/or this Agreement.

I accept the rules and expectations described in this agreement:

Name *(print)*  |  Signature  |  Date *(yyyy-Mon-dd)*

07922(Rev2013-01)
DIRECTIONS FOR COMPLETING IMMUNIZATION REQUIREMENTS AND WORKSHEET

1. Fill out the attached worksheet and begin scheduling any outstanding immunizations/tests or physician appointments IMMEDIATELY. Some requirements take weeks and in some cases months to complete and this may affect clinical placements.

2. When visiting Public Health, please let them know that you are a Health Care Worker (HCW) student with Keyano College.

3. Please note that in accordance with new Alberta-wide guidelines, documentary evidence of immunizations and blood work is **required** for all vaccinations and tests. It is NOT sufficient to have a health professional sign the form indicating that the vaccines or blood work are completed. You **must** submit photocopied proof of these documents with the worksheet. If no documentary evidence is available, you will be required to undergo re-immunization, and/or repeat testing.

4. If you do not have your immunization record the following people/organizations, may be a useful resource:
   a. Alberta: Calgary Central Records (403) 214-3631/ Edmonton (780) 413-7985
   b. Outside of Alberta or Canada, contact your local health unit/hospital or healthcare professional/agency that immunized you
   c. Parents

5. All listed immunizations are **necessary** for you to work in hospitals or other health care facilities. **They are not optional.** If immunizations/tests are not completed, you MAY NOT be able to continue in the program.

6. To completed needed immunizations:
   a. Immunizations within Fort McMurray: make an appointment with the Public Health Unit (780) 791-6247 for an immunization review. (bring the completed immunization worksheet and a photocopy of your immunization record with you)
   b. Lab work within Fort McMurray: make an appointment with your local health clinic or physician. (bring the completed immunization worksheet and a photocopy of your immunization record with you)
   c. Immunizations & lab work outside of Fort McMurray: make an appointment with your local health clinic or physician (bring the completed immunization worksheet and a photocopy of your immunization record with you)

7. You may choose to mail or bring in all forms and photocopies to Keyano College-Health Services prior to the start of your program (even if incomplete):
   a. If incomplete, please attach a detailed plan outlining when you will be completing the outstanding requirements and include the dates these appointments are booked for
   b. All outstanding requirements are to be completed prior to the start of your program. The only exception is if you have to wait for an immunization or test because of scheduling. i.e: you had your second Hepatitis vaccination and now you need to wait 5 months to have your third vaccination.

Questions??
Refer to the requirements column on the Student Immunizations Worksheet where you will find information and rationale for each immunization is given
Email: health.services@keyano.ca
## IMMUNIZATION WORKSHEET

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>REQUIREMENTS</th>
<th>RESULTS</th>
</tr>
</thead>
</table>
| **Tetanus Diphtheria** | - Primary series of ≥ 3 doses of tetanus and diphtheria. If no proof of the ≥ 3 doses you will need to be revaccinated  
- A reinforcing dose of Td within the last 10 years. This will more than likely be given with your adulthood dose of pertussis in the form of dTap, Tdap | Primary series completed YES □ NO □  
Last does of Td vaccine:  
_________________________________________________  
Day/Month/Year |
| **Pertussis** | - One adulthood dose (on or after 18 years of age) of pertussis containing vaccine | Adulthood dose of dTap:  
_________________________________________________  
Day/Month/Year |
| **Polio** | In Alberta, a primary series of Polio is no longer assessed for health care students. However, if you have polio information please include it. If you do NOT have polio information you DO NOT need to have it done at this point | Primary series completed YES □ NO □  
Last does of Polio vaccine:  
_________________________________________________  
Day/Month/Year |
| **Measles Mumps Rubella** | - Two doses of MMR vaccine after your first birthday. If you don’t have proof of two doses you will need to be revaccinated  
- It is ok if the measles, Mumps and rubella vaccines have been given separately instead of together  
- Serological testing in not accepted; as the mumps titer is NOT considered valid. If you do NOT have documentation you will need to be revaccinated | MMR #1:  
_________________________________________________  
Day/Month/Year  
MMR #2  
_________________________________________________  
Day/Month/Year |
| **Varicella** | - If you are certain you have had chickenpox after your first birthday, please provide the year you had chickenpox  
- If you are unsure whether you have had chickenpox, have not had chickenpox or had chickenpox before your first birthday you will need to have a blood test done. If you are NOT immune you will need to be vaccinated  
- If you received the Varicella vaccine, provide dates of vaccination. Please note in Alberta if you received varicella vaccination before the age of 13 years of age prior to Aug 1/05 then only one doses is required | Year you had chickenpox: _______________  
OR  
Varicella Titer:  
_________________________________________________  
Day/Month/Year  
Result: Immune □ Not Immune □  
OR  
Varicella vaccine #1:  
_________________________________________________  
Day/Month/Year  
Varicella vaccine #2  
_________________________________________________  
Day/Month/Year |
<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Requirement</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hepatitis B</strong></td>
<td>• A complete Hep B series. A three dose series is the norm. However, a valid 2 or 4 does series will be accepted if it meets the appropriate timing intervals</td>
<td>Hep B vaccination &lt;br&gt;#1 _________________________ &lt;br&gt;#2 _________________________ &lt;br&gt;#3 _________________________ Day/month/year</td>
</tr>
<tr>
<td><strong>Hepatitis B Blood Testing</strong></td>
<td>• A Hep B antibody (anti-HBs) blood test must be completed a minimum of 1 month after your last dose of Hep B (blood work completed years after your last dose is acceptable)  &lt;br&gt;• If you are at higher risk of having past Hep B infection, you will need to have a Hep B antigen (HBsAg) and Hep B core (Anti-HBc) done as well. You are considered to be higher risk if you have: lived in an endemic country, have had repeated blood transfusions or blood products, have been on dialysis or have lifestyle risks  &lt;br&gt;• If HBsAg is positive, discuss results with your physician and have them forward this information to Communicable Diseases, Fort McMurray Public Health Unit (780) 791-6247. As well, students will need to meet with the College Nurse to discuss results</td>
<td>Anti-HBs titre:  &lt;br&gt;Date: _________________________ Day/month/year  &lt;br&gt;Result: Immune □ Not Immune □  &lt;br&gt;If required  &lt;br&gt;HBsAg titre:  &lt;br&gt;Date: _________________________ Day/month/year  &lt;br&gt;Result: Reactive □ Not reactive □  &lt;br&gt;Anti-HBc titre:  &lt;br&gt;Date: _________________________ Day/month/year  &lt;br&gt;Result: Reactive □ Not reactive □</td>
</tr>
<tr>
<td><strong>Tuberculosis Testing</strong></td>
<td>• A BCG is a vaccination for tuberculosis (not everyone has had this done and it is NOT required).  &lt;br&gt;• A TST is a test for tuberculosis. You need to have a current TST done (within one year of starting school)  &lt;br&gt;• If you have proof of a previously positive TST, do NOT have another TST. You will need to have a chest x-ray done instead. Please bring proof of previously positive tests with you to your appointment  &lt;br&gt;• If you have received a live vaccine such as varicella or MMR you must wait one month to have a TST done  &lt;br&gt;• If you have a positive reaction to your TST then you need to follow up with a chest x-ray and possibly TB services.</td>
<td>History of BCG:  &lt;br&gt;Yes □ No □ Unsure □  &lt;br&gt;TST read:               TST Result:  &lt;br&gt;_________________________        ______________  &lt;br&gt;Day/Month/Year                         Day/Month/Year  &lt;br&gt;If Required:  &lt;br&gt;Chest x-ray:  &lt;br&gt;_________________________  &lt;br&gt;Day/Month/Year  &lt;br&gt;Result of chest x-ray  &lt;br&gt;Normal □ Abnormal □  &lt;br&gt;Follow up required: ______________________</td>
</tr>
<tr>
<td><strong>Seasonal Influenza</strong></td>
<td>• Each fall a new seasonal influenza vaccine is released and it is highly recommended for students to receive this  &lt;br&gt;• Students are reminded that not having yearly seasonal influenza vaccine may impact clinical experience (ie: if there is an influenza outbreak, AHS may restrict facility access to those with seasonal influenza vaccination)</td>
<td>Proof of seasonal influenza can be provided to Health Services each fall once the new vaccine is available</td>
</tr>
</tbody>
</table>

**Remember to submit photocopies of ALL IMMUNIZATIONS RECORD and TEST RESULTS with this worksheet**
A. General Patient Information

Full Name: ____________________________________________________________

Phone: ________________________________________________________________

Address: __________________________________________ Postal Code: __________

Local address if different than above: ______________________________________

Country of Birth: __________________________ Date of Birth: ________________

B. Personal Medical History

Please indicate whether you have had any of the following conditions. Please indicate date for mumps, chicken pox and measles. (please circle all that apply)

1. Asthma
2. Skin Disease
3. Heart Disease
4. Diabetes
5. Cancer
6. Seizure Disorder
7. Nervous or Emotional Problem
8. Learning Disability
9. History of Concussion
10. Hearing Loss
11. Headaches
12. Physical Disability or restrictions
13. Back Problems
14. Lifting restrictions
15. Chicken pox
16. Tuberculosis
17. Allergies: __________

Epi Pen: Yes ____ No ___

Past Medical History – Please List

Other: ____________________________________________________________ Date:

Any Condition or limitation that may impact ability for fitness to participate.

Medications:

Please Complete and Sign the Reverse Page
Nursing and Allied Health Studies
Health Assessment

To Be Signed By Student

The Statements given on all pages of this form are true to the best of my knowledge and belief.

I, ________________________________, understand that mis-statement is grounds for dismissal from the program. I understand the college has the right to cancel my admission. Privilege on the basis of medical information submitted or withheld. I understand that it is my responsibility to inform the appropriate personnel of any communicable disease, special need, or medical condition which may place me at risk, or pose a risk to others at Keyano College or during clinical placement.

________________________________________    __________________________
Signature                                      Date

The personal information on this form is collected under the authority of the Colleges Act of Alberta, which mandates the provision of programs and services by public colleges as well as under the authority of Section 32(c) of the Alberta Freedom of Information and Protection of Privacy Act. The purpose of this personal information is to administer the Health Centre services to assess the health needs of the individual for the purpose of assessment/treatment and or health supervision. This personal information is protected by the provisions of the Freedom of Information and Protection of Privacy Act. If you have any questions about the collection or use of this information, please call the Coordinator Health Services at 780-791-4808, Keyano College, 8115 Franklin Avenue, Fort McMurray, AB, T9H 2H7.
Consent Form for Use and Disclosure of Student Information

Student Number: ___________________________ Educational Program: ___________________________
First Name: ___________________________ Middle Initial: _______ Last Name: ___________________________

1. Permission to Use and Disclose Your Student Related Personal Information and Personal Health Information

By signing this consent, you authorize your educational Program (Practical Nurse Program) to:

• Collect, use and/or disclose your personal information (name and student profile information that is under the custody and control of your Program) to authorized staff of Receiving Agencies for the purpose of locating and coordinating an appropriate placement experience (e.g. clinical practica, fieldwork, or preceptorship) as required by your educational program;

• Use your student related personal information and personal health information relating to placement prerequisites, for the purpose of tracking your compliance against Receiving Agency safety and infection control prerequisites for accepting students. Placement prerequisites that may be tracked include personal information such as CPR certification or criminal records check status, and personal health information such as immunity/immunization status of vaccine-preventable diseases. Placement prerequisite information is used only by staff involved with your educational program, and is never disclosed to users external to your educational program.

• Disclose your personal information to the owner and administrator of the HSPnet system, namely Provincial Health Services Authority British Columbia (PHSA), to allow PHSA to indirectly collect your personal information to provide HSPnet student placement services.

2. Consent Period

This consent is effective immediately and shall remain valid for up to six years, or shall be voided upon your completion of the Program, your formal withdrawal from the Program, or upon written request as described below.

3. Your Rights With Respect to This Consent

3.1 Right to Refuse Consent - You have the right to refuse to sign this consent, and if you refuse your placement will be processed manually at the earliest convenience of the Program and Receiving Agency.

3.2 Right to Review Privacy & Security Policies - A copy of the document entitled Identified Purposes and Handling of Personal Information in HSPnet, which summarizes Privacy and Security policies relating to how we may use and disclose your personal information via HSPnet, is distributed with this Consent Form. You may wish to review the complete Privacy and Security Policies for HSPnet before signing this consent. The Privacy and Security policies may be amended from time to time, and you can obtain an updated copy by contacting privacy@hspcanada.net.

3.3 Right to Request Restrictions on Use/Disclosure - You have the right to request that we restrict how we use and/or disclose your personal information or personal health information via HSPnet for the purpose of locating and coordinating a suitable placement experience. Such requests must be made in writing to the placement coordinator for your Program. If we agree to a restriction you have requested, we must restrict our use and/or disclosure of your personal information in the manner described in your request. If this restriction precludes our ability to coordinate your placement via HSPnet, then your placement will be processed manually at the earliest convenience of the placement coordinator and receiving agency.

3.4 Right to Revoke Consent - You have the right to revoke this consent at any time. Your revocation of this consent must be in writing to the placement coordinator for your Program. Note that your revocation of this consent, or the voiding of this consent upon your completion or withdrawal from the Program, would not be retroactive and would not affect uses or disclosures we have already made according to your prior consent.

3.5 Right to Receive a Copy of This Consent Form - You may request a copy of your signed consent form.

Collection of your personal information is done under the authority of the privacy legislation that applies to educational institutions in your province. For more information visit www.hspcanada.net/privacy/index.asp.

I hereby authorize my educational Program to use and/or disclose my personal information via HSPnet for the purpose of locating and coordinating appropriate student placement(s) as required by the curriculum.

_____________________________  ___________________________
Signature of Student  Date
Keyano College Immunization Clearance Form: requirements for Entry into a Program

*all forms must include immunization records, serology (blood work results) and/or chest x-rays attached*

**Tetanus, Diphtheria**

1. Requirements are met with no further action required if:
   - Primary series is documented as “Yes”
   - The “date of last does” (booster) is documented and is within last 10 years
   - The type of booster has been selected – either Td or dTap

   OR

   - The primary series is documented as “No” AND there is documentation of an adult tetanus-diphtheria series (3 doses) including 1 dose of dTap

2. Follow up required if:
   - The primary series “Yes” box is blank or “No” was selected (regardless of whether a booster is documented) and there is no documentation of an adult tetanus-diphtheria series (3 doses including 1 dose of dTap)
   - There is no “date of last does”
   - The “date of last dose” was over 10 years ago
   - The type of booster was not indicated

   **It is not possible to have a booster without having a primary series.**

**Pertussis**

1. Requirements are met with no further action required if:
   - There is documentation of a dTap booster when the student was ≥ 18 years old

2. Follow up is required if:
   - There is no dTap booster at ≥ 18 years old
   - The student was less than 18 years old at the time of the booster
   - The “date of last dose” is blank
   - It is not clear if the “date of last dose” was dTap

   **It is possible for the “date of last booster” in the tetanus/diphtheria sections to be the same date as the “date of last dose” in the pertussis section.**

**Varicella**

1. Requirements are met with no further action required if:
   - A definite history of varicella disease over the age of 12 months is documented
   - A positive Varicella IgG result is documented. A copy of the lab result MUST be included with the form
   - Age-appropriate varicella vaccination is documented. Only 1 dose is needed if the student was between 12 months up to and including 12 years old at time of vaccination. 2 doses are needed if the student was 13 years or older at the time of vaccination

2. Follow up is required if:
• No age documented as to when the student had varicella disease OR if the student was less than 12 months old when there were sick
• The student is unsure whether or not they had the disease
• Varicella IgG serology result is negative/indeterminate & there are no dates of vaccination
• Only 1 dose of varicella vaccine given when the student was 13 years or older

**Immunized students do not require blood work as proof of immunity.**

**Tuberculosis Screening Test (TST)**

1. Requirements are met with no further action required if:
   • 1-step TST result documented within 12 months of the program start date. The result must be documented in millimeters to be considered valid. For example, “negative” or “positive” is not an acceptable result – it must be an actual measurement i.e: “0 mm”
   • A positive TST is documented in millimeters (≥ 10 mm). This result can be accepted regardless of the date when it was done. The student should not be re-tested after a positive result.
   • If the TST result is positive (≥ 10 mm), a chest x-ray result within 6 months of the program start date must also be documented. A copy of the x-ray report must be included with the form

2. Follow up is required if:
   • Only a chest x-ray has been documented & there are no/incomplete TST results
   • The TST results are documented incorrectly as “positive” or “negative” without a measurement in millimeters
   • The TST was not done within 12 months of the program start date
   • The chest x-ray was not done within 6 months of the program start date
   • The chest x-ray report was abnormal

**A TST is still done regardless of whether a student has received a BCG vaccine in the past**

**Measles, Mumps, Rubella**

A) Measles:
   1) Requirements are met with no further action required if:
      • Documentation of 2 Measles doses at ≥ 12 months old

B) Mumps:
   1) Requirements are met with no further action required if:
      • Documentation of 2 Mumps doses at ≥ 12 months old

C) Rubella:
   1) Requirements are met with no further action required if:
      • Documentation of 1 Rubella dose at ≥ 12 months old

D) Follow up is required if:
   • The student does not have the correct amount of doses for each disease
   • If the 1st doses of Measles, Mumps, and/or Rubella was given BEFORE the students 1st birthday
   • Mumps IgG serology results are reported on the form (see below)
- If students do not have immunization records – serological testing should not be done. The student must be re-immunized
- If the student has had serology done for other purposes in the past & has copies of the lab results – positive Measles IgG & Rubella IgG results can be accepted as proof of immunity. The lab results must be included with the form
- Mumps IgG serology results will not be accepted as proof of immunity
- Rubella vaccination is legislated under the Alberta Public Health Act, Communicable Disease Regulations – all students who may have face-to-face contact with pregnant women must be vaccinated
- If a student is medically contraindicated to receive the MMR vaccine – serology and a letter from their physician regarding the medical contraindication is required. This information must be reviewed by the student’s faculty re: possible restrictions to be applied when the student is on medical placements.

Hepatitis B

**According to the 2015 Provincial Standards for Immunization of Post-Secondary Health Care Students; all students will be divided into 2 groups: A) Students of High Risk of Past Infections and B) Students Not At Risk

**Students at High-Risk:** Students from a Hepatitis B endemic country, those who have received repeated blood transfusions or blood products, those on dialysis & those who indicate lifestyle risks of infection

For step-by-step instructions – please refer to: Appendix A for a list of Hepatitis B endemic countries, Appendix B for Students Not At Risk Algorithm & Appendix C for Students at High Risk Algorithm.

A) Students Not At Risk
1. Requirements are met with no further action required if:
   • A series of Hepatitis B vaccine has been documented AND positive Anti-HBs serology results (≥ 10 IU/L). A copy of the serology results must be attached to the form. Positive Anti-HBs serology results alone may be accepted without documentation of vaccination.
   • Please refer to Appendix B: Hep B Vaccine Recommendations Algorithm for Individuals Not At Risk of Past Infection.
   • If the student is a non-responder AND/OR if HBsAg result is positive – a physician’s letter explaining the lab result and any results implications on the students clinical practice must be attached to the form along with the serology results
2. Follow up is required if:
   • The student has no documentation of Anti-HBs results so the results are negative (≥ 10 IU/L).
   • The algorithm was not followed correctly
   • The students has not fully completed the Hepatitis B requirements
   • The HBsAg results are positive AND/OR if the student is a non-responder and has not followed up with a physician. There must be a physician’s letter explaining the lab results attached to the form.

- Students who do not develop positive Anti-HBs results after 6 doses of vaccine results are considered non-responders. No further doses of vaccine are given. They are required to inform their program of this result. There must be a physician’s letter explaining the lab results attached to the form.
- Students who are HBsAg positive are required to inform their program/professional organization of their test result. There must be a physician’s letter explaining the lab results attached to the form.
B) Students At High-Risk

1. Requirements are met with no further action required if:
   - A series of Hepatitis B vaccine has been documented AND positive Anti-HBs serology results (≥ 10 IU/L). A copy of the serology results must be attached to the form. Positive Anti-HBs serology results alone may be accepted without documentation of vaccination.
   - Serology results for Anti-HBc and HBsAg are documented & attached to the form
   - Please refer to Appendix C: Hep B Vaccine Recommendations Algorithm for Individuals at High Risk of Past Infection

2. Follow up is required if:
   - 1 or more of the 3 required Hep B serology test results are not documented/missing. All 3 test results are required (Anti-HBs, HBsAg, Anti-HBc).
   - The algorithm was not followed correctly
   - The student has not yet fully completed the the Hep B requirements
   - If the HBsAg and/or Anti-HBc results are positive and/or if the student is a non-responder and the student has not followed-up with a physician. There must be a physician’s letter explaining the lab results attached to the form

- Students who do not develop positive Anti-HBs results after 6 doses of vaccine results are considered non-responders. No further doses of vaccine are given. They are required to inform their program of the result.
- Students who are HBsAg positive are required to inform their program/professional organization of their test results. There must be a physician’s letter explaining the lab results attached to the form
**Respirator Fit Test (mask fit testing)**

Prior to acute care clinical practice courses, all Allied Health Students must be fitted with a 3M- N95 Respiratory Masks in accordance with the contractual agreement with Alberta Health Services.

Mask fit testing is valid for two years but may require re-testing if you have any of the following as it may affect the fit of the mask.
- Dental work
- Face surgery
- Weight loss or gain

You must provide a photocopy of the result to the Health Services Department prior to the start of your program.

You are responsible for scheduling your own mask fit test with a qualified service provider. Ensure they test you with a mask that is supplied at the Northern Lights Regional Health Centre-AHS Fort McMurray, AB (1870+, 8210, 8110s, 9105-vflex, 9105s vflex).

The charge for this test range from $15.00 to $30.00 – confirm the cost with individual clinics before booking.

You can walk in or book your appointments with one of the following:

<table>
<thead>
<tr>
<th>Hines Health Services Inc.</th>
<th>DriverCheck Inc</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suite 106-9616 Franklin Ave</td>
<td>8217 Franklin Ave</td>
</tr>
<tr>
<td>Fort McMurray, AB T9H 2J9</td>
<td>Fort McMurray, AB T9H 4P4</td>
</tr>
<tr>
<td>Phone :( 780)790-6909</td>
<td>Phone: (780) 743-5351</td>
</tr>
</tbody>
</table>

When booking, identify yourself as an Allied Health Student at Keyano College by using your student ID card or your acceptance letter for the program.

The day of your test please prepare by:

- Arriving on time
- Clean shaven
- No eating or drinking other than water 30 minutes prior to your appointment time.
- Do not wear any scented products such as perfume or cologne.
- Long hair is to be tied back and off of face.

Contact Health Services department with any questions or concerns
Phone: 780-791-4808
Email: health.services@keyano.ca
Thank you,

Pam McPherson, RN
Health Services Keyano College
Keyano College
Purchasing Document

Suggested Quantities: Shirts 2 (Any Combination); Pants 2;
Students may purchase as many or as little of each item as they feel they require.

This document is to certify that the following is a student of
Keyano College

____________________________
Please Print Document Recipients Name

and is entitled to purchase the following product/products at a discount off regular retail as it appears in the table below.
Where an item is sale priced the lower price will apply

All items to be paid for at the point of sale by Cash, Debit Card, Visa, MasterCard, AMEX

<table>
<thead>
<tr>
<th>STYLE #</th>
<th>DESCRIPTION</th>
<th>COLOUR</th>
<th>QTY</th>
<th>SIZE</th>
<th>PROGRAM PRICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>8080</td>
<td>L/S ACRYLIC MILITARY RIB SWEATER</td>
<td>Navy</td>
<td></td>
<td></td>
<td>53.78</td>
</tr>
<tr>
<td>CP180</td>
<td>OPUS DELUXE CARGO PANT</td>
<td>Navy</td>
<td></td>
<td></td>
<td>71.99</td>
</tr>
<tr>
<td>FJ706</td>
<td>FLEECE SAFETY RAIN JACKET</td>
<td>Dark Navy</td>
<td></td>
<td></td>
<td>95.66</td>
</tr>
<tr>
<td>MS508</td>
<td>S/S MILITARY SHIRT</td>
<td>Dark LAPD Navy</td>
<td></td>
<td></td>
<td>22.00</td>
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<tr>
<td>MS509R</td>
<td>L/S MILITARY SHIRT</td>
<td>Dark LAPD Navy</td>
<td></td>
<td></td>
<td>20.91</td>
</tr>
<tr>
<td>S42611</td>
<td>5-IN-1 HI VIS JACKET</td>
<td>Black</td>
<td></td>
<td></td>
<td>133.35</td>
</tr>
<tr>
<td>ANY</td>
<td>Dress Belts</td>
<td>Black</td>
<td></td>
<td></td>
<td>10% Off Reg. Retail</td>
</tr>
<tr>
<td>ANY</td>
<td>Toques</td>
<td>Black, Navy</td>
<td></td>
<td></td>
<td>10% Off Reg. Retail</td>
</tr>
<tr>
<td>ANY</td>
<td>CSA Approved Footwear, Polishable, 6&quot; minimum in height</td>
<td>Black</td>
<td></td>
<td></td>
<td>10% Off Reg. Retail</td>
</tr>
</tbody>
</table>

Extra charges for oversized items may apply

IMPORTANT INFORMATION:
Photo ID is required at point of sale

Acct: 90003221
000003917534

Document Issue Date: _____________
(The Document expiry date has priority over the program expiry date).
Program Expiry Date: Jan 31, 2022

If you require assistance please contact Mark’s Commercial 1.855.592.7444
Monday - Friday 7am-5pm MST
PERSONAL DECLARATIONS FOR NURSING & ALLIED HEALTH STUDIES STUDENTS

FITNESS TO PRACTICE

I, _______________________________, agree to immediately contact the Chairperson of the Nursing and Allied Health Studies Department, should I experience a significant change in my personal physical or mental health which affects my ability to participate in clinical practice.

_____________INITIALS

POLICE INFORMATION CHECK

I, _______________________________, acknowledge that if during my nursing program I am charged or convicted of a criminal offence it is my obligation to inform the Chairperson of the Nursing and Allied Health Studies Department.

_____________INITIALS

Name: (print) ______________________________
Signature: ______________________________
Keyano College Student ID Number: __________
Date: (year) _____ (month) _________ (day) ______

BScN Year 1 [ ] Year 2 [ ] Year 3 [ ] Year 4 [ ]
PN Year 1 [ ] Year 2 [ ]
HCA [ ]
PCP [ ]
ACP [ ]