MD Program
UNIVERSITY OF TORONTO

Additional Immunization Requirements Form for Returning Students

Information for Students
In accordance with the Council of Ontario Faculties of Medicine (COFM) Blood Borne Viruses Policy, returning students will be required to know and report their serological status with respect to blood borne viruses. Please **ensure your physician understands** that this form must be completed as indicated, along with all other registration requirements. Medical students who do not comply with the COFM Blood Borne Viruses Policy may be excluded from clinical activities.

Deadline: Please submit the completed form online, using ShareFile, by **August 28, 2017**.

- Upload to this ShareFile folder: https://utmed.sharefile.com/r/06599406d3f04a9e
- Save your file as: "Class – LastName, FirstName – BBV – 2017" (e.g. 1T9 – Smith, Mary – BBV – 2017)

Notice of Collection
The University of Toronto respects your privacy. The personal information provided on this form will be used by the administrative and student service offices at the Faculty of Medicine to administer your enrollment and program-related activities in the University of Toronto Doctor of Medicine Program.

The personal information provided on this form will only be used and protected in accordance with the Freedom of Information and Protection of Privacy Act. If you have any questions about this policy and/or ShareFile, please contact Janet Hunter, Director of Enrolment Services & Faculty Registrar, at 1 King's College Circle, Toronto, Ontario, M5S 1A8 or registrar.medicine@utoronto.ca.

SECTION 1 - STUDENT INFORMATION

Student Number:	**Year of Study:** ☐ 2nd ☐ 3rd ☐ 4th
Last Name:	**First Name:**

SECTION 2 – SEROLOGICAL STATUS

1. **HEPATITIS C:** STUDENTS MUST RETAIN COPIES OF THEIR HEPATITIS C SEROLOGY RESULTS, AS WE MAY REQUEST THE ORIGINAL COPY.

   Date of test: _____ (mm/dd/yyyy)

   Titre: ☐ Reactive ☐ Non-Reactive

2. **HUMAN IMMUNODEFICIENCY VIRUS (HIV):** STUDENTS MUST RETAIN COPIES OF THEIR HIV SEROLOGY RESULTS, AS WE MAY REQUEST THE ORIGINAL COPY.

   Date of test: _____ (mm/dd/yyyy)

   Titre: ☐ Reactive ☐ Non-Reactive

SECTION 4 – STUDENT AUTHORIZATION

I give my consent that the information on this form may be shared with university/hospital teaching and administrative staff in appropriate cases.

Signature of student: _____ **Date (mm/dd/yyyy):** _____

SECTION 5 – CLINIC/HEALTH CENTRE AUTHORIZATION

I certify that the above information is complete and accurate:

_____
(name, address, and phone number of clinic/health care centre/hospital where the form was completed)

Signature of health care professional: _____ **Date (mm/dd/yyyy):** _____