Alberta Health Services

Communicable Disease Assessment (CDA)

Collection Notice

The collection of your personal information on this form, including the submission of your immunization records to your organization, is authorized under section 33(c) of the Freedom of Information and Protection of Privacy Act (Alberta).

Your information will only be used and disclosed as necessary to manage and administer your relationship with your organization, including your organization's workplace health and safety programs, allocation of staff resources and reasonably related purposes.

If you have questions or concerns about the collection of your personal information as provided for on this form, please contact an advisor at HR Shared Services by calling 1-877-511-4455, email hrcontactcentre@ahs.ca, or send your questions in writing by prepaid mail addressed to the attention of HR Shared Services at 10301 Southport Lane SW, Calgary AB T2W 1S7.

Instructions

READ all three (3) pages of this form.

COMPLETE, print, and sign form where required before submitting. **AHS cannot accept CDA forms signed using an electronic signature.**

SUBMIT the completed form *(all three pages)* even if you are awaiting records or cannot obtain them.

The form may be submitted to AHS for its own program, or to AHS as the service provider for APL, by:

- Emailing the form to Communicable Disease Assessment at whs.cda@ahs.ca

  or
- Faxing the form to: **780.670.3622**

Select the organization you will be working with *(if you will be working with both organizations, you need to submit 2 separate forms):*

☐ **Alberta Health Services (AHS)**
HR Shared Services
10301 Southport Lane SW
Calgary, AB T2W 1S7
Email: hrcontactcentre@ahs.ca

☐ **Alberta Precision Laboratories (APL)**
HR Shared Services
10301 Southport Lane SW
Calgary, AB T2W 1S7
Email: hrcontactcentre@ahs.ca

Attach all immunization records, and/or immunity testing records for the following:

Measles/Mumps/Rubella (MMR) Immunization
- Measles blood test results *(if applicable)*
- Rubella blood test results *(if applicable)*

Varicella (Chickenpox) Immunization
- Varicella blood test results

Pertussis *(Whooping Cough, dTap or Tdap)* Immunizations

Hepatitis B Immunization
- Hepatitis B antibody blood test results

Tetanus Diphtheria *(Td)* Immunization

Polio Immunization

Skin test for Tuberculosis
- Record of TB immunization *(BCG)*
- Record of TB blood test *(if applicable, e.g. IGRA)*

In addition to above, Laboratory Workers should attach evidence of
- Meningococcal Immunization
- Typhoid Immunization

Alberta Health Services

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Date Completed *(dd-Mon-yyyy)*	Last Name	First Name	
Other Names *(if applicable)*	Date of Birth *(dd-Mon-yyyy)*	Personal Health Number	
Country of Birth	If Canadian born, Province of Birth	Home Phone	Work Phone
Address		City	
Province	Postal Code	Preferred Email	
Employee Number/CPSA or MINC Number *(for physicians)*		Start Date *(dd-Mon-yyyy)*	
Title/Position	Department	Location	
Zone - See Map	Manager/Department Head Name		

Have you been previously employed by or held an appointment with AHS/APL or any of its former entities?

☐ Yes ☐ No **If you answered yes**, provide the following information:

Dates of Service *(from and to)*	Location/Facility

Communicable Disease History

Have you ever had Chicken Pox *(Varicella)* in Canada?

You should answer "yes" if:

- You have been diagnosed by a healthcare provider; or
- You have a strong personal history of past infection as evidenced by: visible scars, strong recollection of disease, or your child became ill with Varicella but you did not get sick.

☐ Yes

If you answered yes, provide the following: age _____, year of infection _____, in what Province _____

☐ No

☐ Unsure

Have you ever been diagnosed with Shingles (Herpes Zoster) by a healthcare provider?

☐ Yes

☐ No

Have you ever been treated in the past for a latent or active TB infection?

☐ Yes **If you answered yes**, provide the date of treatment _____

☐ No

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Immunization Records

In relation to the communicable diseases identified on this form, please submit the records you have been able to obtain. If your records are not complete, are only partially complete or you have not consented to WHS accessing Netcare as below, then WHS will contact you to book an appointment with an OHN.

Do not wait to submit this form. If you are waiting for records out of province/country please submit your immunization records to whs.cda@ahs.ca as soon as they are available. WHS will provide all work related immunizations and testing free of charge. You do not need to acquire these vaccines prior to submitting for CDA form.

You are required to submit this CDA Form within 90 days of employment regardless of your immunization records status or submission.

To find past immunization records, visit: https://www.albertahealthservices.ca/findhealth/service.aspx?id=5676

It could take an extended period of time to receive your records so please request them as soon as possible.

Consent for Netcare/AHS Paper or Electronic System Access and Validation

If your immunizations or immunity testing results were obtained in Alberta, you may authorize AHS to obtain your immunization records directly from AHS paper or electronic records or the Netcare system on your behalf.

With your written consent, AHS may obtain your:

- previous immunization history;
- lab results related to immunity in relation to any of the required immunizations identified on this form, and
- test results related to screening for Tuberculosis.

AHS will collect and retain these records for the purposes of your relationship with AHS or APL, as applicable. If you have questions about collection and use of the information obtained with your consent, please contact whs.cda@ahs.ca.

Consent

I consent to AHS collecting my health information identified on this form for the work related workplace health and safety purposes set out in this form.

Print Name *(first, last)*	Signature	Date *(dd-Mon-yyyy)*

Acknowledgement

I confirm that the information I have provided in this form accurately states, to the best of my reasonable knowledge and the records available to me, my immunization history in relation to the requested immunizations and will form part of my official file.

I understand that if I have provided false information on this form, I may be subject to investigation and discipline.
I understand that my organization will rely upon the information I have provided to protect the health and safety of patients, visitors, staff, students, contractors, volunteers and others who are present at the locations where I am working or providing services to my organization.

If I become aware of any material change in the information provided on this form or related immunization records, I will promptly inform my organization of the change.

Print Name *(first, last)*	Signature	Date *(dd-Mon-yyyy)*