DOCUMENT CHECKLIST

WESTERN COMMUNITY COLLEGE

HCA pre-requisites for the practicum

S No	Documents
1.	Physical Fitness
2.	TB (Report)
3 (a)	Tetanus + TDAP
3 (b)	Poliomyelitis
3 (c)	Measles /Mumps/Rubella
3 (d)	Hepatitis B
3 (e)	Varicella (Chicken Pox)
3 (f)	Influenza Vaccination (Flu)
4.	First Aid + CPR 'C'
5.	Food Safe
6.	WHMIS
7.	Medication Management
8.	Criminal Record Review
9.	Violence Prevention – 8 certificates (Learning Hub)
10.	Covid 2 Certificates- PPE &Hand Hygiene (on Learning Hub)
11.	Covid Vaccine (both doses)

Note: The student needs to submit these documents within one month from the start date of the program.

WESTERN COMMUNITY COLLEGE

PHYSICAL FITNESS CERTIFICATE

…….

Signature of candidate

I, Dr. ……. after careful personal examination of the case do hereby certify that …… (Name of the Student), whose signature is given above is found physically fit to undergo health care assistant program.

Also, candidate's flu shot is up to date.

Signature_____

Name _____

Date _____

Seal

WESTERN COMMUNITY COLLEGE

TB TEST CLEARANCE FORM

(FOR ADMISSION TO HCA PRACTICUM)

Instructions:

Please complete the sections below and return this form to the Western Community College. Please not that registration will not be allowed until all health clearances are met.

First Name _____ Last Name _____

Mailing Address _____

City _____ Province _____

Postal Code _____ Phone Number _____

Date of Birth _____

TUBERCULOSIS CLEARANCE REQUIREMENTS

TB clearance must be dated within 6 months prior to the start date of the practice education and clearly state that the skin test or chest x-ray was negative.

For Physician's/Clinic Use Only:

TB (PPD-MANTOUX)

Date given: _____ Date read: _____Results: _____

OR

Chest X-Ray (required if skin test is positive, 10mm or >) This must be dated within 1 year prior to the start of the practice education

Date x-ray taken: _____ X-Ray Results: _____

Printed Name of Physician/Clinic _____ Telephone No._____

Official Signature _____ Date _____

OFFICE USE ONLY: Verified _____ (Sign) Date: _____

WESTERN COMMUNITY COLLEGE

WCC IMMUNIZATION TRACKING TOOL

Student Name: _____ Date: _____

Date of Birth: _____

IMMUNIZATION	DATE GIVEN	GIVEN BY	NEXT DOSE DUE
Tetanus/Diphtheria/Pertussis			
Poliomyelitis			
Measles/Mumps/Rubella			
Hepatitis B			
Varicella Vaccination (Chicken Pox)			
Tuberculin Status			
Influenza Vaccination			

All information/statements on this form are true and complete. I understand that evidence of falsified documents or misrepresentation will result in cancellation of my admission or registration.

Student Name:

Signature:

Dr. Signature:

Dr. Name:

Stamp: