



MEDICAL CERTIFICATE OF FITNESS

INSTRUCTIONS FOR COMPLETING THE MEDICAL CERTIFICATE OF FITNESS PROVIDED ON THE REVERSE SIDE OF THIS FORM

Dear Physician:

The individual identified below has registered to attend the health related course indicated at the KLC College: Healthcare, Business, Education. Because of physical demands of this training and profession, it is necessary to determine the appropriateness of the individual to the course.

_____ **Personal Support Worker**

- heavy lifting and bending
- shift work
- extended periods of time on feet

_____ **Pharmacy Technician**

- prolonged periods of standing
- high reaching
- some degree of lifting

_____ **PT/OT Assistant**

- heavy lifting and bending
- extended periods standing

_____ **Dental Assistant**

- extended periods of sitting with no back support
- some degree of lifting
- extended periods of arms extended

Does this individual have any limitations which could interfere with any of the above indicated physical demands required?

YES **NO**

Please explain (if Yes) _____

The following verification must be completed, with results recorded, if checked off: (placement location policy dictates these requirements)

_____ **1.) TWO-STEP Mantoux Test**

Date of T.B. Step One _____ Result _____

Date of T.B. Step Two _____ Result _____

_____ **2.) VERIFICATION FOR IMMUNITY TO CHICKEN POX, MEASLES, RUBELLA, AND MUMPS**

Date _____ Positive Negative

_____ **3.) THREE-STEP HEPATITIS B VACCINATION**

Date of Step One: _____ Date of Step Two _____

(Date of Step Three not required by KLC)

Please note: If testing is done through the Health Unit, results must be forwarded to your family physician for completion of this form..

PHYSICIAN'S SIGNATURE: _____

PHYSICIAN'S NAME (PRINTED): _____

TELEPHONE: _____

DATE FORM COMPLETED: _____

STUDENT'S NAME: _____

ADDRESS: _____

POSTAL CODE: _____ TELEPHONE: _____

DATE OF BIRTH: _____

Day Month Year

KLC COLLEGE: HEALTHCARE, BUSINESS, EDUCATION DOES NOT ASSUME RESPONSIBILITY FOR ANY CHARGES OR FEES INCURRED FOR COMPLETION OF THIS FORM OR ANY RELATED TESTING.

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