2020 AFMC Form Status: _______________________

(See highlighted areas for any outstanding requirements)

Medicine Program Addendum - Additional Requirements

This form is to be completed and ATTACHED to the AFMC Student Portal Immunization Testing Form in order to meet all the immunization requirements for the University of Alberta MD Program.

The attached algorithms have been attached to this document to assist health care providers on the assessment and immunization recommendations for Hepatitis B for health care students in Alberta.

☐ ALL RECORDS & LAB REPORTS ARE ATTACHED to the AFMC student portal immunization form

Hepatitis B:

SELECT A CATEGORY:

☐ Student is NOT AT RISK of past infection – no further action required

OR

☐ Student is AT HIGH-RISK of past infection – students who have immigrated to Canada from a Hep B endemic country, those who have received repeated blood transfusions, those with a history of dialysis AND/OR those with lifestyle risks of infection.

If the student is at high-risk of past infection, the following serology is also required:

Anti-HBc: Date: _____________________  ☐ POSITIVE  ☐ NEGATIVE

IF RESULT IS POSITIVE - follow-up with a physician is required as well as a letter explaining any implications on the students’ clinical practice.

☐ Lab report is attached

☐ Physician’s letter is attached

HBsAg:

As identified on the AFMC Student portal form, the HBsAg was:

☐ NEGATIVE – no further action required

☐ POSITIVE - follow-up with a physician is required as well as a letter explaining any implications on the students’ clinical practice.

☐ Physician’s letter is attached

HEPATITIS B NON-RESponder:

If a student is a non-responder to Hepatitis B immunization, follow-up with a physician is required as well as a letter explaining any implications on the students’ clinical practice.

☐ Physician’s letter is attached

For information on what is considered a non-responder to Hepatitis B Immunization, along with information on appropriate immunization scheduling, please review the attached algorithms.

____________________     ______________________        _______________
Clinic Stamp:
Name of HCP  Signature  Date