

(S100) Dental Technology (Fall Term 2026)

3rd Year students: Semester 5 & 6

Due date: August 21, 2026

3RD YEAR RETURNING STUDENT CHECKLIST & ACTION REQUIRED

- **Important Notice:** If you are planning to continue your studies in this program, it is your **responsibility** to start and meet all the Health Form requirements outlined below. If you **fail** to complete, submit, and upload these requirements to Placement Pass by ParaMed by the given deadline, you will be **excluded** from dental clinical practice which can jeopardize your academic standing & lead to program **withdrawal**. All costs, service fees and fine associated with the overall medical and additional requirements are responsibility of the student.
- Even if you have graduated from another Dental or Health Sciences program either at George Brown College or from another college/university/institution **and/or** has experience working in any dental or health related profession, you are mandatory required to complete all the non-medical certificates below. If you **fail** to do so, you will be **excluded** from clinical/dental/field practice which can jeopardize your academic standing & may lead to program **withdrawal**.

MEDICAL REQUIREMENTS (mandatory except Flu Shot)

Book an appointment with your doctor/Walk-In Clinic. Bring this health form to your appointment and advise your doctor to sign and stamp your health form documents upon completion of all medical requirements. Please read all detailed instructions on pgs. 2 & 3

- Tetanus, Diphtheria & Pertussis (*Tdap/ADACEL and must be valid every 10 years*)
- Seasonal Flu Shot (*recommended every year in November or December*) **pg. 2**
- Measles, Mumps & Rubella (*documentation of two doses of MMR vaccine OR laboratory evidence of immunity*) **pg. 2**
- Varicella (*documentation of two doses of Varivax vaccine OR laboratory evidence of immunity*), **pg. 2**
- Hepatitis B (*ask your doctor to do blood test, ATTACH copies of blood test reports and all immunization records*) **pg. 3**
- Two Consecutive Step Tuberculosis Skin Test, **pg. 3**
- Yellow immunization card or any type of immunization records
- Final signature of your doctor/physician and medical office stamp, **pages 2 & 3**

NON-MEDICAL REQUIREMENTS (mandatory)

Please read all detailed instructions on pages 4-5

- CPR level C Certificate (*must be valid each year for the dental practice from Sept 2026-April 2027*)
- Mask Fit Test Certificate (*must be valid every two years for the dental practice from Sept 2026-April 2027*)
- ParaMed Service Fees
- Fill-out & complete all the top sections with your name, ID#, program, issued/expiry dates and Agreement Form, **pgs. 2-5**

PARAMED PLACEMENT PASS SERVICE FEES (rates are subject to change without further notice)

Once you have everything completed, your final step is to create an account, submit and upload your Health Form documents to **ParaMed Placement Pass** at <https://georgebrowncollege.placementpass.ca/> by the given deadline. All fees are responsibility of the student.

(Service fees effective on September 1, 2025)

- Initial Clearance Fee-\$73.45 dollars tax included (unlimited document uploads until you received your first clearance, student will pay, and it is non-refundable)
- Subsequent Clearance Fee-\$36.73 dollars tax included (due to medical deficiency or incomplete requirements)

CONTACT US

- **Suzette Martinuzzi**, Pre-placement Coordinator
Telephone: (416) 415-5000 ext. 3415
Email: CPOHealthForm@georgebrown.ca
Business Hours and Locations (Appointment only):
Monday to Friday (9:00 am-4:00 pm) by appointment only

**3RD YEAR (S100) DENTAL TECHNOLOGY PROGRAM
 FULL PREREQUISITES HEALTH FORM (FALL TERM 2026)**

Name x _____

GBC ID# x _____

Tel x _____

Email x _____

Due date: **August 21, 2026**

**MEDICAL REQUIREMENTS (mandatory)
 (DOCTOR/PHYSICIAN/HEALTH CARE PROFESSIONAL TO COMPLETE, SIGN & STAMP)**

Ontario legislation specifies certain surveillance requirements for those individuals entering into healthcare practice settings. The Program policy was developed in accordance with the Communicable Disease Surveillance protocols, as specified under the Ontario Public Health, OHA, OMA, LTCAO and Ontario School Boards to demonstrate students' meet these requirements prior to entering placement settings. This process is necessary to ensure that our students protect their health and safety, and the health and safety of patients, children, seniors, employees and other vulnerable people. The completion of this information is not optional, and all sections must be completed as outlined. Our placement agency partners have the right to refuse students who have not met their immunization standards. If, for medical reasons, your patient is unable to receive a required immunization or Chest X-ray, a medical note of this exclusion must be provided on the form. Even if you have graduated to another Dental or Health Sciences program either in George Brown College or from another college/university/institution **and/or** has experience working in any dental or health related profession, you are mandatory required to complete all the non-medical certificates below. If you **fail** to do so, you will be **excluded** from clinical/dental/field practice which can jeopardize your academic standing & may lead to program **withdrawal**.

1. **TETANUS, DIPHTHERIA & PERTUSSIS (TdAP/Adacel/Boostrix vaccine must be valid every 10 years) attach a yellow card or any immunization record.**

Date of last Tetanus, Diphtheria & Pertussis (Tdap/Adacel/Boostrix) booster ____/____/____(mm/dd/yyyy)

2. **SEASONAL FLU SHOT (recommended every year in November/December)**

Seasonal Flu Shot Given Date ____/____/____(mm / dd / yyyy)

3. **MEASLES, MUMPS & RUBELLA (MMR) (Two doses vaccine OR laboratory evidence of immunity)**

Documentation of receipt of two doses of MMR vaccine on or after the 1st birthday four weeks apart and attach a yellow card or any proof of immunization record. This vaccine is not recommended for pregnant women and pregnancy should be avoided for 3 months post immunization.

1st Dose date ____/____/____
 mm/ dd / yyyy

2nd Dose date ____/____/____
 mm/ dd / yyyy

OR

Laboratory evidence of immunity and attach a copy of "Antibody IgG" blood test report. If the result is Immunity or Reactive, **no** booster shot required. But, if the result is **Non-immunity or Non-Reactive**, you must provide **two doses** as per instruction above. Serologic testing for immunity is **not** recommended after vaccination.

4. **VARICELLA (CHICKEN POX) (Two doses vaccine OR laboratory evidence of immunity)**

Documentation of receipt of two doses of Varivax vaccine on or after the 1st birthday four weeks apart and attach a yellow card or any proof of immunization record. This vaccine is not recommended for pregnant women and pregnancy should be avoided for 3 months post immunization.

1st Dose date ____/____/____
 mm/ dd / yyyy

2nd Dose date ____/____/____
 mm/ dd / yyyy

OR

Laboratory evidence of immunity and attach a copy of "Antibody IgG" blood test report. If the result is Immunity or Reactive, **no** booster shot required. But, if the result is **Non-immunity or Non-Reactive**, you must provide **two doses** as per instruction above. Serologic testing for immunity is **not** recommended after vaccination.

Final Signature of doctor/physician/health care professional _____ **(pg. 2)**

Date (mm/dd/yyyy): _____ **Medical Office Stamp:** _____ **(pg. 2)**

3RD YEAR (S100) DENTAL TECH-MEDICAL REQUIREMENTS (Due date: August 21, 2026)

NAME x _____ GBC ID# x _____

5. **HEPATITIS B INSTRUCTION:** All students must complete an initial “antibody immunity” laboratory blood test if previous Hep B vaccine was received. Ask your doctor to check the appropriate box, document the dates of any junior or adulthood vaccination record. Ask your doctor for a copy of laboratory blood test report and attach it on the form as outlined below.
- Initial Immune/Reactive/Positive (> 10 U/L) “Anti-HBs or HBsAb” lab test result:** NO injections or doses required, attach a copy of lab blood test report and this is done.
 - Initial Non-Immune/Non-Reactive/Negative/Low (>0 or <10 U/L) “Anti-HBs or HBsAb” lab test result:** Student must proceed to Section A & B as outlined below: After the student has completed a new 2nd dose, they will be given a temporary clearance to proceed to dental/field/clinical practice. Student is expected to complete the series and provide update on vaccination record per academic year.
Section A-Primary Series (doctor must document any proof of junior or adulthood vaccination record)
 - 1st dose _____ / _____ / _____ (mm/ dd / yyyy)
 - 2nd dose _____ / _____ / _____ (mm/ dd / yyyy)
 - 3rd dose _____ / _____ / _____ (five months after 1st dose, repeat HBsAb lab test after four weeks)
 - If the repeat HBsAb lab test result was “**immune/reactive**”, it is done and attach a copy of lab test report.

→ If the repeat lab test result was “**non-immune**”, proceed to Section B series below.

Section B-Second Series (doctor must document any proof of junior or adulthood vaccination record)
 - 4th dose _____ / _____ / _____ (mm/ dd / yyyy)
 - 5th dose _____ / _____ / _____ (mm/ dd / yyyy)
 - 6th dose _____ / _____ / _____ (five months after 4th dose, repeat HBsAb lab test after four weeks)
 - If the lab test result is still “**non-immune/non-reactive**”, student status will be considered a “**non-responder/exemption**”.
 - Carrier lab test result:** NO injections or doses required and attach copy of most recent “**HBsAg-Antigen Positive**” blood test report.
 - Is this student safe to attend their placement? Yes or No**

6. **TWO CONSECUTIVE STEP-TUBERCULOSIS SKIN TEST (must be valid each year for the duration of dental practice from Sept 2026 to April 2027, please read and follow all instructions below)**
- All students must complete and provide proof of Two Consecutive Step-TB Skin Test and we will NOT accept a Chest X-ray report only.
 - Failure to do Step 2 TB within 7-21 days after Step 1, you will need to redo both TB Skin Test again and extra fees will apply.
 - If you have proof of previous Two Consecutive Step-TB Skin Test done in the past and the result was both “**Negative**”, do annual Step 1-TB Skin Test.
 - If you have proof of previous Two Consecutive Step-TB Skin Test and the result was “**Positive**”, NO more annual TB Skin Test and your doctor needs to do annual physical exam and answer letters (A-F) below.
 - If you had BCG vaccination it is NOT a contraindication for skin test, you are still required to provide proof and complete a Two Step-TB skin test.
 - It is mandatory that your doctor/health care professional properly complete, sign & stamp all the information outlined below. NO exceptions!

PREVIOUS YEAR: STEP 1 TB SKIN TEST

_____/_____/_____/_____/_____/_____ (Date Given: mm / dd / yyyy) (Date Read: 48-72 hours after date given) (Induration size) (mm)

PREVIOUS YEAR: STEP 2 TB SKIN TEST (7-21 days after Step-1)

_____/_____/_____/_____/_____/_____ (Date Given on opposite arm: mm / dd / yyyy) (Date Read: 48-72 hours after date given) (Induration size) (mm)

CURRENT YEAR: STEP 1 TB SKIN TEST

_____/_____/_____/_____/_____/_____ (Date Given: mm / dd / yyyy) (Date Read: 48-72 hours after date given) (Induration size) (mm)

CURRENT YEAR: STEP 2 TB SKIN TEST (7-21 days after Step 1)

_____/_____/_____/_____/_____/_____ (Date Given on opposite arm: mm / dd / yyyy) (Date Read: 48-72 hours after date given) (Induration size) (mm)

- TB SKIN TEST POSITIVE (+) WITH MORE THAN >10 MM INDURATION SIZE**
DOCTOR/PHYSICIAN MUST DO ANNUAL PHYSICAL EXAM & ANSWER LETTERS (A-G) BELOW:
- a) **Chest X-ray (if TB Positive only, ATTACH a copy of the X-ray report valid within two years)** Result _____ Date _____ (mm/dd/yyyy)
 - b) History of disease? Yes or No Date (mm/dd/yyyy) _____
 - c) Prior history of BCG vaccination (need documentation? Yes or No Date (mm/dd/yyyy) _____
 - d) Does this student have signs/symptoms of active TB on physical examination? Yes or No
 - e) INH Prophylaxis (Treatment)? Yes or No Date (mm/dd/yyyy) _____ Dosage _____
 - f) Specialist (Public Health) Referred? Yes or No Date (mm/dd/yyyy) _____
 - g) Is this student safe to attend their placement? Yes or No

Final Signature of doctor/physician/health care professional: _____ (pg. 3)

Date (mm/dd/yyyy): _____ **Medical Office Stamp:** _____ (pg. 3)

George Brown College & ParaMed Agreement Form

Name _____

Program: (S100) Dental Technology-3rd year in Fall Term 2026

I _____ (Print Name) understand that any false statement is grounds for cancellation of admission.

I understand that the college has the right to cancel my admission privilege on the basis of medical information submitted or withheld. I understand that it is my responsibility to inform the appropriate George Brown College personnel of any communicable disease, special need, exception or medical condition which may place me at risk or pose a risk to others at George Brown College or on placement.

I will pay all the services fees and authorize ParaMed to review the above information.

 (Signature) (Date)

Element of Risk

All experiential learning programs, such as field trips, clinical and field placements or job shadowing involve certain elements of risk. Injuries may occur while participating in this activity without any fault of the student, the placement or the college. By taking part in this activity, you are accepting the risk that you may be injured. Following the Health and Safety rules of your placement is required. By signing below you agree that you have reviewed the element of risk and are willing to comply with the Health and Safety Rules of your placement.

If an injury should occur, it must be reported immediately to your supervisor and to your faculty. Completing Workers Safety Insurance Board forms and reporting any injury while participating in placement must take place within **72 hours** of occurrence.

 (Signature) (Date)

Contact Us

Suzette Martinuzzi, Coordinator at (416) 415-5000 ext. 3415 or via email CPOHealthForm@georgebrown.ca
 Virtual Business Hours: 9:00 am to 3:30 pm, by appointment only

FREEDOM OF INFORMATION AND PROTECTION OF INDIVIDUAL PRIVACY ACT The personal information on this form is collected under the legal authority of the Colleges and Universities Act, R.S.O. 1980, Chapter 272, Section 5, R.R.O. 1990, Regulation 77 and the Public Hospital Act R.S.O. 1980 Chapter 410, R.S.O. 1986, Regulations 65 to 71 and in accordance with the requirements of the legal Agreement between the College and the agencies which provide clinical experience for students. The information is used to ensure the safety and wellbeing of students and clients in their care.