

Page 1 Student ID OR Photo ID

STUDENT ID CARD

**NAME:**

JOHN BLANK

STUDENT ID:

GU-2055-1042

PROGRAM:

BACHELOR OF SCIENCE IN COMPUTER SCIENCE

DATE OF BIRTH:

APRIL 15, 2039



GREENWOOD
UNIVERSITY



VALID UNTIL:
DECEMBER 2056

Nationally Coordinated Criminal History Check Certificate

EXAMPLE ONLY

Page 1 of 1

Page 2b Only if International student

Overseas Police Check OR Overseas Statutory Declaration

From Appendix 3- link here: https://www.heti.nsw.gov.au/_data/assets/pdf_file/0007/473173/Overseas-Student-Statutory-Declaration.pdf

Page 3 - Undertaking/Declaration Form

Undertaking/Declaration Form



Tick the appropriate option for question 2. either a. or b.

I, PRINT YOUR NAME HERE (select all applicable options):

1	I agree to abide by the requirements of the NSW Health <u>Occupational Assessment, Screening and Vaccination against Specified Infectious Diseases (OASV) Policy Directive</u> including <u>Appendix 1 Evidence of Protection</u> .
2	I consent to assessment and I undertake to participate in the assessment, screening, and vaccination process; AND a. ☒ I am not aware of any personal circumstances that would prevent me from completing these requirements; OR b. ☐ I am aware of a medical contraindication(s) and/or I am persistent hepatitis B non-responders that may prevent me from fully completing these requirements and have provided documentation of the medical contraindication(s) as required by the NSW Health OASV Policy Directive (Section 5: <u>Medical Contraindications and Hepatitis B Vaccine Non-Responders</u>). I request consideration of my circumstances. If NSW Health accepts my medical contraindication and/or I am a hepatitis B non-responder: i. ☐ I understand that I will be informed of the risks of infection, the consequences of infection and management in the event of exposure and agree to comply with the protective measures required by the health service and as defined by <u>PD2023_025 Infection Prevention and Control in Healthcare Settings</u> ; AND ii. ☐ If the medical contraindication is temporary, I understand I must be reviewed and agree to be vaccinated once the medical exemptions end.
3	If I have received the minimum number of doses to commence employment/attend placement and I am granted temporary compliance, a. ☐ I undertake to complete the outstanding vaccination and/or tuberculosis requirements within the timeframes required by the NSW Health OASV Policy Directive and agree to comply with the protective measures required by the health service; AND b. ☐ I understand that failure to complete the outstanding vaccination and/or tuberculosis requirements within the appropriate timeframe(s) may result in suspension from further clinical placements/duties and may jeopardise my course of study/ work/employment.

Declaration

I, PRINT YOUR NAME HERE
declare that the information provided is correct and I will abide by the requirements of the undertaking.

Date of birth 01/01/1996 Worker/Student ID (if available)

Email University email

Contact number

NSW Health Agency/Education provider

Signature sign Date

Parent/guardian name

(where required for workers/students under 18 years)

Parent/guardian signature [Signature]

Date

NSW Health Code of Conduct Agreement for Students

Step 1: Read the NSW Health Code of Conduct

The NSW Health Code of Conduct is available here:

https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2015_049.pdf

Step 2: Enter your details

Name: J.D BLANK

Date of Birth: 01/01/1996 Gender: M Student ID: 111222333

University/TAFE/Training Organisation: Uni of Nowhere

Email address: j.d.blank@uni.edu.au

Step 3: Declaration and signature

1. I have read and understood the NSW Health Code of Conduct, and agree to comply with its provisions at all times whilst attending student placements in NSW Health.
2. I undertake that if I am charged or convicted of any criminal offence after the date of my National Police Certificate that I will notify NSW Health before continuing with my clinical placement.
3. I declare that the information I have provided to NSW Health for the purpose of undertaking student placements is correct to the best of my knowledge. I understand that if I am found to have deliberately withheld or provided false information, my placements may be withdrawn.

Signature:  Date: 29/11/2021

Ensure all sections completed- please use Uni email. Date and sign bottom

NSW Health



Tuberculosis (TB) Assessment Tool

Occupational Assessment, Screening
and Vaccination Against Specified Infectious Diseases

FILL IN ALL DETAILS

Your Personal Information

Family Name		Given Name(s)	
Date of Birth		Phone Number	
Medicare Number [if eligible]	Position on card [number next to your name]	Expiry Date	
Address (street number and name, suburb and postcode)			
Email			
Employer/Education Provider		Stafflink/Student/Other ID	
Course/Module of Study OR Place of Work			
Signature		Date completed	

Please complete all questions in Parts A, B and C.

Part A: Symptoms requiring investigation to exclude active TB disease

Do you currently have any of the following symptoms that are not related to an existing diagnosis or condition that is being managed with a doctor?	Yes	No
1. Cough for more than 2 weeks?	☐	☐
2. Episodes of haemoptysis (coughing blood) in the past month?	☐	☐
3. Unexplained fevers, chills or night sweats in the past month?	☐	☐
4. Significant* unexpected weight loss over the past 3 months? *loss of more than 5% of body weight	☐	☐

Tuberculosis (TB) Assessment Tool

Occupational Assessment, Screening and Vaccination Against Specified Infectious Diseases

Family Name

Given Name(s)

Stafflink/Student/Other ID

Part B: Previous TB treatment or TB screening or increased susceptibility		Yes	No
1. Have you ever been treated for active TB disease or latent TB infection (LTBI)? <i>If Yes, please state the year and country where you were treated and provide documentation (if available)</i> Year Country		☐	☐
2. Have you ever had a positive TB skin test (TST) or blood test (IGRA or QuantiFERON TB Gold+)? <i>If Yes, please provide copies of TB test results.</i>		☐	☐
3. Do you have any medical conditions that affect your immune system? <i>e.g. cancer, HIV, auto-immune conditions such as rheumatoid arthritis, renal disease</i>		☐	☐
4. Are you on any regular medications that suppress your immune system? <i>e.g. TNF alpha inhibitors, high dose prednisone</i> <i>Please provide details here:</i> 		☐	☐

Part C: Possible TB exposure risk history	
The following questions explore possible previous exposure to TB	
1. In what country were you born? <i>If born overseas, when did you migrate to Australia?</i> 	
First Assessment Only	
1a. Is your country of birth on the list of high-TB-incidence countries? <i>For the up-to-date list of high TB incidence countries, please go to https://www.health.nsw.gov.au/Infectious/tuberculosis/Pages/high-incidence-countries.aspx</i>	Yes ☐ No ☐
1b. If Yes, as part of your visa medical assessment, did you have a negative TB skin test (TST) or blood test (IGRA or QuantiFERON TB Gold+)? <i>*If yes, please provide a copy of the result</i>	Yes ☐ No ☐
2. Have you had direct contact with a person with infectious pulmonary TB without adequate personal protective equipment and did not complete contact screening?	Yes ☐ No ☐
3. Have you ever visited or lived in any country/ies with a high TB incidence in your life (first assessment) or since your last TB Assessment? <i>If Yes, please list below the countries you have visited, the year of travel and duration of stay</i>	Yes ☐ No ☐

Country visited	Year of travel	Duration of stay (please specify d/w/m)	Country visited	Year of travel	Duration of stay (please specify d/w/m)

Please read this carefully. You may have visited multiple high incidence TB countries and cumulatively this travel could be 3 months.

Tuberculosis (TB) Assessment Tool

Occupational Assessment, Screening and Vaccination Against Specified Infectious Diseases

Family Name

Given Name(s)

Stafflink/Student/Other ID

Other relevant information to assist with determining TB risk

E.g. pre-migration TB screening -CXR reported as normal and negative IGRA on

Date

All workers and students need to submit this form to their NSW health agency or education provider.

Education providers must forward this form to the NSW Health agency for assessment.

The **NSW Health agency** will assess this form and determine whether TB screening or TB clinical review is required.

NSW TB Services contact details:

<https://www.health.nsw.gov.au/Infectious/tuberculosis/Pages/accessing-your-local-TB-service.aspx>

Privacy Notice: Personal information about students and employees collected by NSW Health is handled in accordance with the Health Records and Information Privacy Act 2002. NSW Health is collecting your personal information to meet its obligations to protect the public and to provide a safe workplace as per the current Occupational Assessment Screening and Vaccination Against Specified Infectious Diseases Policy Directive. All personal information will be securely stored, and reasonable steps will be taken to keep it accurate, complete and up to date. Personal information recorded on this form will not be disclosed to NSW Health officers or third parties unless the disclosure is authorised or required by or under law. If you choose not to provide your personal information, you will not meet the condition of placement. For further information about how NSW Health protects your personal information, or to learn about your right to access your own personal information, please see our website at www.health.nsw.gov.au

For Official Use of NSW Health Agency or NSW TB Service

Please refer to **Appendix 3 - TB Assessment Decision Support Tool** for guidance on documenting outcomes from this TB Assessment:

- ☐ TB Compliant
- ☐ Advice sought from local TB service/chest clinic
- ☐ TB Screening required – referred to GP or local TB service/chest clinic
- ☐ TB Clinical Review required – referred to local TB service/chest clinic
- ☐ Other

Name of assessor and role

Contact Number

Health Agency/District/Network

Date of assessment

Page 8 Blood Borne Virus Declaration

Management of health care workers infected with HIV, hepatitis B or hepatitis C and health care workers who perform exposure prone procedures



Attachment 1: Blood Borne Virus Student Declaration Form



All student health care workers of a discipline* that undertakes exposure prone procedures (EPPs) must complete this document prior to their first clinical placement, and again after repeat testing has been undertaken every three years. Students will only be permitted to attend clinical placements if they have submitted this form.

The educational provider must ensure that all student health care workers of a discipline* that undertakes EPPs have completed this form and submitted it for assessment by NSW Health.

Declaration	Initials
I have read and understand the requirements of the Australian National Guidelines for the Management of Healthcare Workers Living with Blood Borne Viruses and Healthcare Workers who Perform Exposure Prone Procedures at Risk of Exposure to Blood Borne Viruses and the NSW Health policy Management of health care workers infected with HIV, Hepatitis B or Hepatitis C and health care workers who perform exposure prone procedures .	
Select either A or B ☒ A: I have undergone testing for blood borne viruses** (BBVs) at commencement of study in Australia or within the 12 months prior to commencement. ☐ B: I have undergone a repeat test for BBVs within a three year period from the date of my last test.	
The date of my test was: <u>24/11/2024</u>	J.D Blank
I agree to the following: - be tested for Hepatitis B, Hepatitis C and HIV at least once every three years. - have appropriate and timely testing and follow up care after a potential occupational exposure associated with a risk of BBV acquisition. - have appropriate testing and follow up care after potential non-occupational exposure, with testing frequency related to risk factors for virus transmission. - notify the person identified in the health facility local procedures if I am newly diagnosed with a BBV and will refrain from performing EPPs until a risk management plan has been developed by the NSW Health agency during the placement. - cease performing all EPPs if diagnosed with a BBV until the criteria in the National Guidelines are met.	
Declaration: I <u>John David Blank</u> declare that I comply with the requirements of the National Guidelines and that the information provided is correct.	
Full name: <u>John David Blank</u>	Date of Birth: <u>01/01/1996</u> Student ID: <u>111 222 333</u>
Email: <u>j.d.blank@uni.edu.au</u>	Education Provider: <u>Uni of Nowhere</u>
Date: <u>2/12/2024</u>	Signature: <u>J.D Blank</u>

*Disciplines that undertake exposure prone procedures include: medicine; midwifery; paramedicine; dentistry and oral health.

**Relevant blood borne viruses are Human Immunodeficiency Virus (HIV), Hepatitis B and Hepatitis C.

Page 9 10, 11 etc

Vaccination and Immunisation evidence including any childhood vaccination card ,TB testing &/or TB clinical review documentation

Only a GP or Immunisation Nurse can fill in this 'Vaccination Record Card' using evidence sighted from your IHS or other immunisation records. The GP or RN must stamp each entry with practice stamp

Vaccination Record Card for Category A Workers (including Students)



Personal Details (please print)

Please refer to instructions on page 3

Surname	Blank	Given Names	John David
Address	100 Tree St		
	State: NSW	P/code: 1234	Date of Birth
Staff/student ID	11222333		
Email	j.d.blank@uni.edu.au		
Contact Numbers	Mobile: 0404 111 222	Work:	N/A
Medicare Number	967654321	Position on card:	1
		Expiry date:	03/2028

Vaccine	Date	Batch name and Batch No. (where possible)	Official Certification by Vaccination Provider (clinic/practice stamp, full name and signature next to each entry)
Adult formulation diphtheria, tetanus, acellular pertussis (whooping cough) vaccine (adult dose of dTpa vaccine)			
Dose 1	1/1/2000	\$#1123	A.P (Alison Print RN) <i>[Stamp: A Print RN NMW000000234]</i>
Booster 10 years after previous dose	2/4/2019	A12345	A.P (Alison Print RN) <i>[Stamp: A Print RN NMW000000234]</i>
Booster 10 years after previous dose			
Hepatitis B vaccine (age appropriate course of vaccinations AND hepatitis B surface antibody ≥ 10 mIU/mL OR core antibody positive)			
Dose 1	2/5/1997	Not Available	A.P (Alison Print RN) <i>[Stamp: A Print RN NMW000000234]</i>
Dose 2	2/12/1997	Not Available	A.P (Alison Print RN) <i>[Stamp: A Print RN NMW000000234]</i>
Dose 3	5/6/1998	Not Available	A.P (Alison Print RN) <i>[Stamp: A Print RN NMW000000234]</i>
AND			
Serology: anti-HBs (Numerical value)	7/10/25	Result 102 mIU/mL	AP (Alison Print RN)
		Result mIU/mL	
OR Serology: anti-HBc		Positive Negative	
Measles, Mumps and Rubella (MMR) vaccine (2 doses MMR vaccine at least 1 month apart OR positive serology for measles, mumps and rubella OR birth date before 1966) Serology is NOT REQUIRED following completion of a documented MMR vaccination course.			
Dose 1	2/2/97		A.P (Alison Print RN) <i>[Stamp: A Print RN NMW000000234]</i>
Dose 2	3/3/97		
OR			
Serology Measles		IgG Result	
Serology Mumps		IgG Result	
Serology Rubella (include numerical value and immunity status as per lab report)			
		IgG Result	<i>[Stamp: A Print RN NMW000000234]</i>
Varicella vaccine (age appropriate course of vaccination OR positive serology OR AIR history statement that records natural immunity to chickenpox) Serology is NOT REQUIRED following completion of a documented varicella vaccination course.			
Dose 1			
Dose 2			
OR			
Serology Varicella	1/4/2025	IgG Result 756 (immune)	A.P (Alison Print RN)

Personal Details (please print)

Surname	Blank	Given name:	John David
Date of Birth	01/01/1996	Staff/student ID	111222333
Contact	Mobile:	Work:	

Varicella vaccine (age appropriate course of vaccination OR positive serology OR AIR history statement that records natural immunity to chickenpox)			
OR			
Australian Immunisation Register (AIR) History Statement that records natural immunity to chickenpox		AIR Statement Sighted ☐ YES ☐ NO	
Vaccine	Date	Batch name and Batch No. (where possible)	Official Certification by Vaccination Provider (clinic/practice stamp, full name and signature)
Influenza vaccine (strongly recommended for all workers & mandatory for Category A workers and students)			
Fluguardri	5/5/25	4587	A-P (Alison Print RN)
COVID-19 vaccine (Strongly recommended for all Category A workers)			A Print RN NMW000000234

TB Screening	Date	Batch No. (where possible) or Result	Assessed by/Given by/Read by (clinic/practice stamp, full name and signature)
Requires TB screening?		☒ YES ☒ NO	
Past vaccination BCG		☐ YES ☐ NO	
Interferon Gamma Release Assay (IGRA) (circle test result)			
IGRA	1/4/25	Positive Indeterminate <u>Negative</u>	A P (Alison Print RN)
IGRA		Positive Indeterminate Negative	A Print RN NMW000000234
Tuberculin Skin Test (TST) – TB Service/Chest Clinic only			
TST Administration			
TST Reading		Induration mm	
TST Administration			
TST Reading		Induration mm	
Referral to TB Service/ Chest Clinic for TB Clinical Review required?		☐ YES ☐ NO	
TB Clinical Review			
Chest X-ray			
Other			
TB Compliance – TB Service/Chest Clinic or OASV Assessor (circle correct response)			
TB Compliance Assessment		Compliant Temporary Compliance Non-compliant	
TB Compliance Assessment		Compliant Temporary Compliance Non-compliant	

Please note- there may be a few pieces of vaccination evidence including serology reports. Ensure IHI has been removed from Australian immunisation Records

Immunisation History Statement (IHS)



Australian Government
Services Australia

medicare

Immunisation history statement

As at: 20-Jun-2023
For: [REDACTED]
Date of birth: 23 Feb 2017
Individual Healthcare Identifier (IHI): 8003608833468150
NIP immunisation status: Up to date

Schedule	Date given	Immunisation	Brand name given
Birth	23 Feb 2017	Hepatitis B	H-B-VAX II (paediatric)
2 months	24 Apr 2017	Rotavirus	Rotarix
		Pneumococcal	Prevenar 13
		Diphtheria, Tetanus, Pertussis, Hepatitis B, Polio, Hib	Infanrix Hexa
4 months	24 Jun 2017	Rotavirus	Rotarix
		Pneumococcal	Prevenar 13
		Diphtheria, Tetanus, Pertussis, Hepatitis B, Polio, Hib	Infanrix Hexa
6 months	24 Aug 2017	Pneumococcal	Prevenar 13
		Diphtheria, Tetanus, Pertussis, Hepatitis B, Polio, Hib	Infanrix Hexa
12 months	23 Feb 2018	Pneumococcal	Prevenar 13
		Measles, Mumps, Rubella	MMR II
		Meningococcal C, Hib	Menitorix
18 months	24 Aug 2018	Measles, Mumps, Rubella, Varicella	Priorix-Tetra
		Diphtheria, tetanus, pertussis	Infanrix
		Haemophilus influenzae type B	ActHIB
4 years	23 Feb 2021	Pneumococcal	Prevenar 13
5 years	23 Feb 2022	Influenza	FluQuadri

Next NIP Immunisations due

diphtheria, tetanus and pertussis due on 23 Feb 2029

HPV due on 23 Feb 2029

Notice/s

Disclaimer

This document is not for clinical use, and is a sample only created on 20-Jun-2023

This link will help you find your Immunisation History Statement

[Medicare online account help - Get an immunisation history statement - Services Australia](#)

Additional Supporting Immunisation or TB testing documents if applicable

LAB REPORT	
Patient Name:	I.AM.BLANK
ID Reference:	00011212325458
Test:	Rubella
Requesting Dr:	Dr A.B
Collection Date:	1/1/2019

EXAMPLE ONLY

Rubella IgG 83 IU/ml

Titre : =or> 15 = Immunised to Rubella.
 10 - 14 = Low immunity to Rubella. Suggestive of re-vaccination, and a follow-up sample should be taken to evaluate immunity.
 < 10 = Consider absence of immunity to Rubella.

Requested Tests: GLUf, LFT, LIPS, EUC, GFR, ESR, FBC, RubG, HBsAg, HBsAb, HCV, MEA, MUM

Clinical History: No clinical notes provided.

LAB REPORT	
Patient Name:	I.AM.BLANK
ID Reference:	00011212325459
Test:	Interferon gamma release assay test (IGRA test)
Requesting Dr:	Dr A.B
Collection Date:	2/12/2021

EXAMPLE ONLY

GAMMA-INTERFERON ASSAY FOR CMI RESPONSE TO M.TUBERCULOSIS ANTIGEN

Assay: QuantiFERON-TB Gold

Collection Date: 2/12/2021
 Collection Time: 13:20

Antigen	Corrected qIFN IU/mL	Result
TB1 (CD4+ response)	0.04	Negative (cutoff 0.35)
TB2 (CD4+ & CD8+ response)	0.00	Negative (cutoff 0.35)
Mitogen control	6.21	Acceptable (>0.50)

Interpretation:
 Latent M.tuberculosis infection unlikely.

A negative result may not exclude active tuberculosis. If active TB is suspected, chest X-ray and mycobacterial culture should be performed.

All testing performed on serum or plasma unless otherwise specified.

Requested Tests : VZ, RUL, QTB, MMZ, HEP

ONLY COMPLETE THIS FORM IF YOU HAVE NO EVIDENCE OF HEPATITIS B VACCINATION BUT HAVE DEFINITELY COMPLETED A COURSE OF AGE APPROPRIATE HEPATITIS B VACCINATION.

NSW Health



Hepatitis B Vaccination Declaration

Occupational Assessment, Screening and Vaccination Against Specified Infectious Diseases

This form is to be used where a hepatitis B vaccination record is not available.

Please download the form before filling it in.

Stafflink/candidate ID

Section A: All sections to be completed by the Declarant in conjunction with an appropriately trained assessor

I, _____ declare that
[print name of declarant in CAPITAL LETTERS]

I have received an age-appropriate course of hepatitis B vaccine consisting of _____ *(insert number)* vaccine doses.

The approximate year I was vaccinated against hepatitis B was _____

I do not have the record of vaccination because: _____

I make this declaration believing it to be true

Declared on: _____ *[date]*

[signature of declarant]

Section B: To be completed by an Assessor (Section B must be completed before submitting this form).

An Assessor includes: a doctor, accredited nurse immuniser, paramedic, registered nurse or enrolled nurse, who has training on the policy directive, interpretation of immunological test results and vaccination schedules.

Applying my clinical judgement, I am satisfied that the declarant's hepatitis B vaccination history and serology demonstrate compliance and long term protection.

Assessor name

Assessor qualification

Assessor signature _____

Date

SHPN (HP NSW) 230509

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