Approved at Faculty Meeting January 22, 2008
Modified November 22, 2008
Approved January 20, 2009
Updated April 9, 2019
Approved April 30, 2019

POLICY ON STUDENTS & STUDENT APPLICANTS WITH INFECTIOUS DISEASES

FACULTY OF DENTISTRY
DALHOUSIE UNIVERSITY

Principles:
The Faculty of Dentistry at Dalhousie University is committed to protecting and maintaining the rights of patients and health care workers (HCWs), as well as the integrity of the educational process of dental professionals.

The Accreditation Requirements for each of the clinical programs associated with or within the Faculty of Dentistry at Dalhousie University stipulate the direct provision of patient care by our students to attain sufficient clinical experiences to meet the defined competencies for a beginning practitioner. These clinical experiences include exposure-prone procedures (1-4). These exposure-prone procedures have been determined to pose an increased risk of bloodborne disease transmission due to their nature and the type of instruments and devices typically used for exposure-prone procedures (5-7). Therefore, students cannot avoid providing care that involves exposure-prone procedures. For this reason, the Faculty of Dentistry has determined that the performance of exposure-prone procedures places patients at increased risk.

Entry into the health care professions is a privilege offered to those who are prepared for a lifetime of service to the public. Students, faculty and all HCWs have a fundamental responsibility to provide care to all patients assigned to them without prejudice and to ensure that care is delivered competently and safely. A failure to accept this responsibility violates a basic tenet of the dental profession – to place the patient's interest and welfare first. For this reason, all HCWs have an ethical obligation to their patients to know their own infectious disease status (especially with respect to HBV, HCV and HIV). If negative to HBV, HCV and HIV, testing should be performed on a schedule based on the individual's level of risk and whenever an exposure occurs (7).

Students in health care professions are at risk of contracting infectious diseases during the course of patient care activities (8). A policy of mandatory immunizations and Routine Practices (Standard Precautions) can protect students from some of these infectious diseases.

Percutaneous injuries can place a HCW at risk to occupational exposure to HBV, HCV and HIV. Therefore, training and education on the prevention of injuries is an absolute necessity in all HCWs educational programs.

In order to minimize the risk of transmission of bloodborne viruses (BBV) from HCW to patient, the HCW must adhere to Routine Practices, including proper handwashing, use of PPE as required and adherence to the proper management of sharps. When the HCW follows these guidelines, the risk of transmission of a BBV from HCW to patient is negligible. If exposure-prone procedures (EPPs) are performed, the risk of transmission is slightly higher but is still minimal. Although impossible to attain zero risk of BBV transmission from a HCW to a patient, the risk can be made negligible due to the efficacy of the HB vaccine and effective drug regimens to suppress HCV and HIV (7).

Any student applicant or student in any clinical program within the Faculty of Dentistry infected with a BBV will receive counselling regarding their BBV status (7).

Terms
"Clinical Programs" includes but is not limited to Dentistry, Qualifying Program, Dental Hygiene, Bachelor of Dental Hygiene, Graduate Periodontics Residents, General Practice Residents, Paediatric Dentistry Residents and OMFS Residents. This also includes any courses, short programs, re-licensure or re-entry programs within these jurisdictions.

"Exposure-prone procedures" (EPP) "Exposure-prone procedures (EPPs) are invasive procedures where there is a risk that injury to the HCW may result in the exposure of the patient's open tissues to the blood of the HCW. For transmission of a BBV from an infected HCW to patient to occur during an EPP, three conditions are necessary (9):*

1. HCW must sustain an injury or have a condition that allows for exposure
2. HCW's blood must come in contact with a patient's wound, traumatized tissue, mucous membranes, or similar portal of entry
3. HCW must be sufficiently viremic EPPs with risk of transmission include (10):
   a. Digital palpation of a needle tip in a body cavity (a hollow space within the body or one of its organs); or the simultaneous presence of the HCW's fingers and a needle or other sharp instrument or object (such as bone splinters, sternal wires etc.) in a blind or highly confined anatomic site, e.g., as may occur during major abdominal, cardiothoracic, vaginal, pelvic and/or orthopedic operations
   b. Repair of major traumatic injuries
   c. Cutting or removal of any oral or perioral tissue, during which the patient's open tissues may be exposed to the blood of an injured infected HCW."

** The definition of EPP is taken directly from the 2018 Public Health Agency of Canada's"* ***Guideline on the Prevention of Transmission of Bloodborne Viruses from Infected Healthcare Workers in Healthcare Settings".*** *The guideline does not provide a list of risk categories for EPPs due to the lack of sufficient evidence to accurately categorize the transmission risk of dental and medical procedures. The PHAC guideline recommends that experts in the discipline or specialty determine which procedures fit into the category of an EPP* (7)**.**

"HBV" means hepatitis B virus.

"HCV" means hepatitis C virus.

"HIV" means human immunodeficiency virus.

"HCW" means health care worker and includes students, student applicant and resident trainees.

"Non-responders" or "individuals with inadequate antibody titres" refer to individuals susceptible to Hepatitis B due to inadequate antibody titres. Such individuals have a titre $\leq$ *10 mIU/mL (or IU/L) for anti-HbsAg* (11).

"Students" include all students and residents in undergraduate and graduate dental and dental hygiene programs.

1.0 Immunization and Immunity status of applicants to Faculty of Dentistry Clinical Programs

Acceptance into any of the clinical programs at the Faculty of Dentistry is conditional upon receipt of a completed copy of the Dalhousie University, Faculty of Dentistry Immunization Record (all students other than OMFS) (**Appendix 1**) or the Capital Health "Infectious Diseases and Immunization Checklist for Healthcare Worker Students" form (OMFS students) (**Appendix 2**) that provides evidence of required immunizations, post-serological testing and evidence of immunity.

This document must be submitted to the **Dean's office** by the applicants when confirming acceptance into their clinical program.

2.0 Hepatitis B immunization requirements for applicants and registered students in Faculty of Dentistry Clinical Programs

All student applicants to any Faculty of Dentistry undergraduate or graduate clinical programs must be immunized against Hepatitis B unless a medical contraindication is present.

All student applicants to any Faculty of Dentistry undergraduate or graduate clinical programs must demonstrate immunity to HB (anti-HBs >10 IU/L) prior to the beginning of any clinical rotation.

If immunity is not acquired after the first 3-dose series, a second 3-dose series should be initiated. Post-serological testing must occur 1-6 months following completion of the 3-dose series and the results submitted to the Clinical Nurse.

Should the second 3-dose series fail to result in immunity, consultation with occupational health or infectious diseases specialists should be initiated. The student will need to be tested at an interval determined by their level of risk (in consultation with their physician) and whenever an exposure occurs.

Any student applicants who were born in or previously resided in high or intermediate HBV endemic countries (**Table 1**) must be tested for anti-HBc and HBsAg in addition to anti-HBs to fully determine their HBV status (7).

3.0 Students or student applicants infected with HBV

Any student or student applicant infected with HBV is restricted from performing EPPs until the student or student applicant

a. is under the care of a physician with expertise in the management of HBV
b. is medically managed according to current recommendations
c. has regular scheduled monitoring of their HBV DNA level
AND
d. has a HBV DNA level below 10^3 IU/ml (5 x 10^3 GE/ml) and the HBV DNA level is assessed regularly (every 3 to 6 months)

Students or student applicants who have HBV DNA level below 10^3 IU/ml (5 x 10^3 GE/ml) would not have any practice restrictions based on their HBV status on its own.

If a HCW-to-patient transmission of HBV occurs, the HCW must cease all patient care activities immediately until a determination for fitness to return to practice is made by an expert panel (**Ad-hoc Committee on Bloodborne Pathogens -** College of Physicians and Surgeons of Nova Scotia - 421-2209). If the recommendation from the Committee is to refrain from patient care activities, then the student shall inform others as necessary depending on circumstances, but in all circumstances shall inform the Assistant Dean, Clinics and the Clinical Nurse.

Hepatitis B is a highly infectious disease. The HBV can remain infectious on environmental surfaces for up to 7 days and can be transmitted even in the absence of visible blood (12-15). Hepatitis B is 100 times more infectious than HIV and 10 times more infectious than Hepatitis C (16-18).

The key marker for determining infectivity of HB used to be the presence of HBe antigen (19, 20). However, it is now recognized that a small subset of people can be HBe negative and have a high viral load (10, 21). Therefore, the standard for measuring HB infectivity currently is a measure of viral load (22-27).

Studies have shown that there can be significant fluctuations in viral load in patients that are HBe negative and even higher fluctuations in viral load in patients not on treatment (7, 22, 28).

Any HCWs infected with HIV, HCV and/or HBV that are not performing EPPs do not need to have any restrictions on their practice based on their BBV status alone (7).

4.0 Declination of Hepatitis B vaccine or Non-Responders to the Hepatitis B vaccine

Applicants declining to be immunized against Hepatitis B or are non-responders are to be counseled by the Assistant Dean of Student Affairs, the Assistant Dean, Clinics and Building Services and the Clinical Nurse and the prior to admission and their request for accommodation in the nature of a waiver of this admission requirement will be assessed on case-by-case basis (7, 29, 30).

Any final acceptance of such applicants shall be conditional upon such applicant signing **The Agreement Form for Hepatitis B Antibody, Antigen and Viral DNA Testing** (**Appendix 3**) and the **Hepatitis B Vaccine Declination Statement** (if applicable) (**Appendix 4**).

Students becoming HBsAg positive and whose viral load exceeds 10^3 IU/ml (5 x 10^3 GE/ml) during the course of their studies will be removed from patient care activities involving EPPs, which modification of the Clinical Program could prevent a student from meeting graduation requirements (31). Such students shall report their status in accordance with the process set out in section 2.2. If and when the student is under the care of a physician with expertise in the management of Hepatitis B and the viral load has been reduced to below this threshold, the student will then have no clinical restrictions.

5.0 Management of HCWs infected with HCV

Any student or student applicant infected with HCV should be seen by a physician that has expertise in HCV management and managed and monitored according to the current recommendations.

Students and student applicants are restricted from performing EPPs until the student or student applicant:

a) is under the care of a physician with expertise in the management of HCV
b) has completed a course of effective antiviral therapy
AND
c) has an undetectable viral load at least 12 weeks post-treatment

If there is a transmission from HCW to patient, the HCW must cease practice immediately until it has been determined by an expert panel that he/she is fit to return to practice (7).

6.0 Management of HCWs infected with HIV

Students and student applicants should be tested for HIV at an interval determined by their level of risk and whenever an exposure has occurred.

Students and student applicants infected with HIV should be seen by a physician that has expertise in HIV management and managed and monitored according to the current recommendations.

Students and student applicants are restricted from performing EPPs until the student or student applicant:

a) is under the care of a physician with expertise in the management of HIV
b) is on effective antiretroviral therapy or has been diagnosed as an elite controller
AND
c) has an undetectable viral load

If there is a transmission from HCW to patient, the HCW must cease practice immediately until it has been determined by an expert panel that he/she is fit to return to practice (7).

7.0. Communicable Disease Status

Any applicant with any active infectious disease is required, on acceptance to inform the Assistant Dean for Student Affairs and the Assistant Dean, Clinics and Building Services to discuss whether this condition could impact on his or her ability to successfully complete their clinical program.

Students who develop an infectious disease during the course of their clinical program must follow the same protocol.

Each situation will be assessed on a case-by-case basis.

With respect to medical conditions, work related illness and work restrictions, students in the Faculty of Dentistry are responsible for monitoring their own health status. Students who have acute or chronic medical conditions that render them susceptible to opportunistic infection should discuss with their personal physicians and the Director of Clinics whether the condition might affect their ability to safely perform their duties. It is the ethical obligation of the student to report such conditions to the Dean's office. The Assistant Dean, Clinics has the authority and responsibility to exclude students from work or patient contact to prevent further transmission of infection. Decisions concerning work restrictions will be based on the mode of transmission and the period of infectivity of the disease (see Table 2) (29, 31-34).

This policy is consistent with the Canadian Dental Association's Code of Ethics which states, under Article 2, Competency (35): *"A practitioner should inform the dental licencing authority when a serious injury, dependency, infection or other condition has either immediately affected, or may affect over time, his or her ability to practice safely and competently."*

The reporting obligations will be consistent with the requirements of the Nova Scotia Government.

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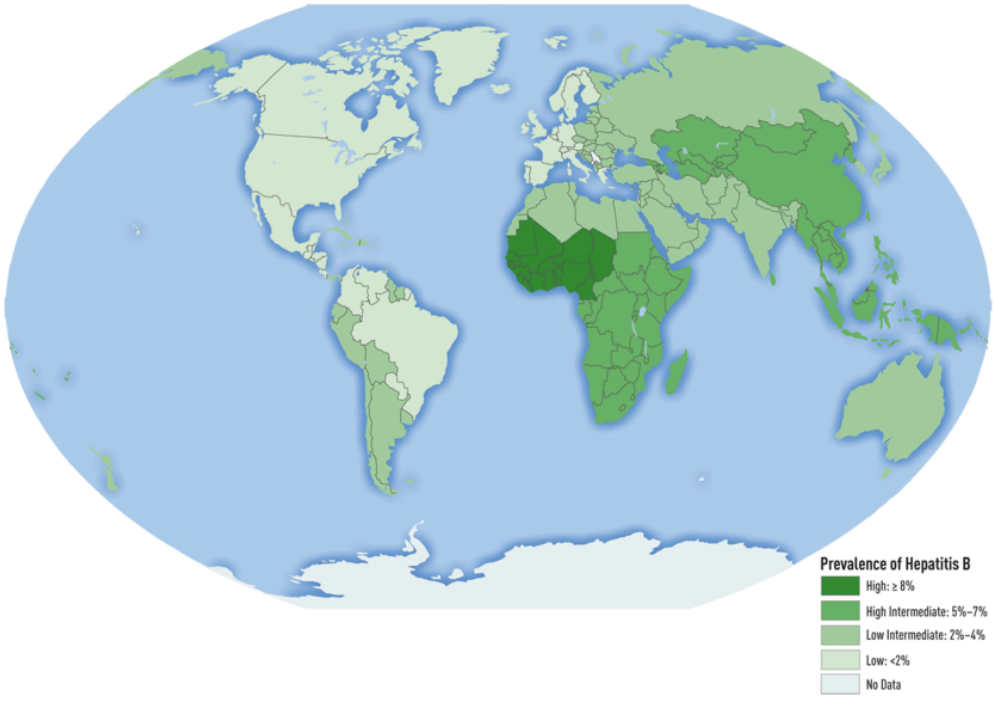
Table 1. HBV Endemic Countries



MAP 3-4. PREVALENCE OF CHRONIC HEPATITIS B VIRUS INFECTION AMONG ADULTS[1]

[1] Disease data source: Ott JJ, Stevens GA, Groeger J, Wiersma ST. Global epidemiology of hepatitis B virus infection: new estimates of age-specific HBsAg seroprevalence and endemicity. Vaccine. 2012; 30(12): 2212-2219.

List of countries by prevalence of chronic hepatitis B virus infection among adults:

High (≥8%): Benin, Burkina Faso, Cameroon, Cape Verde, Chad, Côte d'Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, São Tomé and Príncipe, Senegal, Sierra Leone, Togo

High Intermediate (5%-7%): Angola, Armenia, Azerbaijan, Botswana, Burundi, Cambodia, Central African Republic, China, Comoros, Congo, Democratic Republic of the Congo, Djibouti, Equatorial Guinea, Eritrea, Ethiopia, Federal States of Micronesia, Fiji, Gabon, Georgia, Indonesia, Kazakhstan, Kenya, Kiribati, Kyrgyzstan, Lao People's Democratic Republic, Lesotho, Madagascar, Malawi, Malaysia, Maldives, Marshall Islands, Mauritius, Mongolia, Mozambique, Myanmar, Namibia, Papua New Guinea, People's Republic of Korea, Philippines, Rwanda, Samoa, Seychelles, Solomon Islands, Somalia, South Africa, Sri Lanka, Sudan, Swaziland, Taiwan, Tajikistan, Thailand, Tonga, Turkmenistan, Uganda, United Republic of Tanzania, Uzbekistan, Vanuatu, Zambia, Zimbabwe

Low Intermediate (2%-4%): Afghanistan, Albania, Algeria, Argentina, Aruba, Australia, Bahamas, Bahrain, Bangladesh, Barbados, Belarus, Belize, Bhutan, Bolivia, Bosnia and Herzegovina, Brunei Darussalam, Bulgaria, Chile, Croatia, Cuba, Czech Republic, Dominica, Dominican Republic, Ecuador, Egypt, Estonia, Grenada, Guyana, Haiti, Hungary, India, Iraq, Islamic Republic of Iran, Jamaica, Japan, Jordan, Latvia, Lebanon, Libyan Arab Jamahiriya, Lithuania, Macedonia, Martinique, Moldova, Montenegro, Morocco, Nepal, Netherlands Antilles, New Zealand, Pakistan, Palestine, Peru, Poland, Puerto Rico, Republic of Korea, Romania, Russian Federation, Saint Lucia, Saint Vincent and the Grenadines, Singapore, Suriname, Trinidad and Tobago, Ukraine, Uruguay

Low (<1%): Andorra, Austria, Belgium, Brazil, Canada, Colombia, Costa Rica, Cyprus, Denmark, El Salvador, Finland, France, Germany, Greece, Guatemala, Honduras, Iceland, Ireland, Israel, Italy, Mexico, Nicaragua, Panama, Paraguay, United States of America, Venezuela
No data: Serbia

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Source: https://www.cdc.gov/travel-static/yellowbook/2016/map_3-04.pdf

Table 2. Work Restriction Guidelines for HCWs with Infectious Diseases

Table 2	**Work restrictions for HCWs in clinical programs infected with or exposed to major infectious diseases in health care settings.**	
Disease/Problem	**Clinical Restriction**	**Duration**
Conjunctivitis	Restrict from patient contact and contact with patient's environment.	Until discharge ceases.
Cytomegalovirus Infection	No restriction	
Diarrheal Disease Acute stage (diarrhea with other symptoms) Convalescent stage Salmonella species	 Restrict from patient contact, contact with patient's environment, and food handling Restrict care of patients at high risk	 Until symptoms resolve. Until symptoms resolve; consult with local and provincial health authorities regarding need for negative stool cultures.
Enteroviral Infection	Restrict from care of infants, neonates, and immunocompromised patients and their environments	Until symptoms resolve.
Hepatitis A	Restrict from patient contact, contact with patient's environment, and food handling.	Until 7 days after onset of jaundice.

Table 2 (continued)	**Work restrictions for HCWs in clinical programs infected with or exposed to major infectious diseases in health care settings.**	
Disease/Problem	**Clinical Restriction**	**Duration**
Herpes simplex Genital	No restrictions	
Hands (herpetic whitlow)	Restrict from patient contact and contact with patient's environment.	Until lesions heal.
Orofacial	Evaluate need to restrict from care of patients at high risk.	See Faculty Guidelines on Management of Patients with Herpetic Lesions.
Human immunodeficiency virus	Do not perform exposure-prone procedures until counsel from the **Ad-hoc Committee on Bloodborne Pathogens** has been sought; Committee should review and recommend procedures that personnel can perform, taking into account specific procedures as well as skill and technique. Routine practices are always to be followed.	
Measles Active	Exclude from clinical activity	Until 7 days after the rash appears.
Post exposure (susceptible personnel)	Exclude from clinical activity	From fifth day after first exposure through twenty-first day after last exposure or 4 days after rash appears.
Meningococcal infection	Exclude from clinical activity	Until 24 hours after start of effective therapy.
Mumps Active	Exclude from clinical activity	Until 9 days after onset of parotitis.
Post exposure (susceptible personnel)	Exclude from clinical activity	From twelfth day after first exposure through twenty-sixth day after last exposure, or until 9 days after onset of parotitis.

Table 2 (continued)	**Work restrictions for HCWs in clinical programs infected with or exposed to major infectious diseases in health care settings.**	
Disease/Problem	**Clinical Restriction**	**Duration**
Pediculosis	Exclude from clinical activity	Until treated and observed to be free of adult and immature lice.
Pertussis Active	Exclude from clinical activity	From beginning of catarrhal stage through third week after onset of paroxysms or until 5 days after start of effective antibiotic therapy.
Post exposure (asymptomatic personnel)	No restriction, prophylaxis recommended	
Post exposure (symptomatic personnel)	Exclude from clinical activity	Until 5 days after start of effective antibiotic therapy.
Rubella Active	Exclude from clinical activity	Until 5 days after rash appears.
Post exposure (susceptible personnel)	Exclude from clinical activity	From 7th day after first exposure through twenty-first day after last exposure.
Staphylococcus aureus infection Active, draining skin lesion	Exclude from clinical activity	Until lesions have resolved
Carrier state	No restriction unless personnel are epidemiologically linked to transmission of the organism.	
Streptococcal Infection, group A	Exclude from clinical activity	Until 24 hours after adequate treatment is started.
Tuberculosis Active disease	Exclude from clinical activity	Until proven non-infectious
Positive TST (latent TB)	No restriction	

Table 2 (continued)	**Work restrictions for HCWs in clinical programs infected with or exposed to major infectious diseases in health care settings.**	
Disease/Problem	**Clinical Restriction**	**Duration**
Varicella (Chicken pox) Active disease	Exclude from clinical activity	Until all lesions dry and crust.
Post exposure (susceptible personnel)	Exclude from clinical activity	From tenth day after first exposure through twenty-first day (twenty-eighth day if varicella- zoster immune globulin [VZIG] administered) after last exposure.
Zoster (shingles) Localized, in healthy person	Cover lesions, restrict from care of patients at high risk	Until all lesions dry and crust.
Generalized or localized in immunosuppressed person	Exclude from clinical activity	Until all lesions dry and crust.
Post exposure (susceptible personnel)	Exclude from clinical activity	From tenth day after first exposure through twenty-first day (twenty-eighth day if varicella-zoster immune globulin [VZIG] administered) after last exposure or if varicella occurs when lesions crust and dry.
Viral respiratory infection, acute febrile	Consider excluding from care patients at high risk, or contact with such patients' environment during community outbreak of respiratory syncytial virus and influenza	Until acute symptoms resolve.

Table 2 is modified from *Morbidity and Mortality Weekly Report (MMWR) RR-17 Guidelines for Infection Control in Dental Health Care Settings- 2003* (29)

Approved at Faculty Meeting January 22, 2008
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Approved at Faculty Meeting January 22, 2008
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Appendix 1

DALHOUSIE UNIVERSITY
Inspiring Minds

FACULTY OF DENTISTRY IMMUNIZATION/CPR RECORD

Last Name	First Name	Middle Initial

Banner ID #	Birth Date (DD/MM/YY)	Phone

Mailing Address	Email

Degree Program or Position (Check One)

- ☐ Bachelor of Dental Hygiene (BDH)
- ☐ Undergraduate Program Dental Hygiene (DH)
- ☐ Doctor in Dental Surgery (DDS)
- ☐ Qualifying Program Dentistry (QP)
- ☐ Graduate Program Dentistry
- ☐ Other _____

This section to be completed and signed by your physician:

Required Immunization	Dates Immunization Received (DD/MM/YY)			Antibody Titre Results* or Laboratory Diagnosed History of Disease	
				Date	Results
Tetanus, diphtheria, pertussis (Td/Tdap) 1 dose within past 10 years	Dose 1				
Polio (IPV) Primary Course	Dose 1				
German Measles (Rubella) 2 doses after age 12 months	Dose 1	Dose 2			
Measles (Rubeola) 2 doses after age 12 months	Dose 1	Dose 2			
Mumps 2 doses after age 12 months	Dose 1	Dose 2			
Varicella (Chicken Pox) 2 doses	Dose 1	Dose 2			
Hepatitis B or A/B Series of 3 doses*	Dose 1	Dose 2	Dose 3		
Post-vaccination Serology Test (all applicants)* **1. Hepatitis B Surface Antibodies (anti-HBs)**					
Additional Post-vaccination Serology Tests (for applicants from countries endemic with HB – High & Intermediate)*					
1. Hepatitis B Surface Antigen (HBsAg)					
2. Hepatitis B Core Antibodies (anti-HBc)					

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Baseline PPD (Tuberculosis Screening) 2-Step Mantoux	Step 1	Induration
	Step 2	Induration
Annual 1-Step Mantoux	Step 1	Induration
If there is a documented prior positive TST, previous treatment for active TB, or previous treatment for latent TB, a TST is not required. Medical evaluation and a chest X-ray within 1 year are required. Date of Chest X-ray: ___ / ___ / ___. Please attach copies of chest X-ray report. DD MM YY		

** Copies of antibody titre results must accompany this form.*

Physician Signature: _____ Date: _____

Influenza			
Year 1	Year 2	Year 3	Year 4
CPR / AED Certification (Annual renewal is recommended). *Copy of certification must accompany this form.*			
Year 1	Year 2	Year 3	Year 4

Authorization for Disclosure of Information

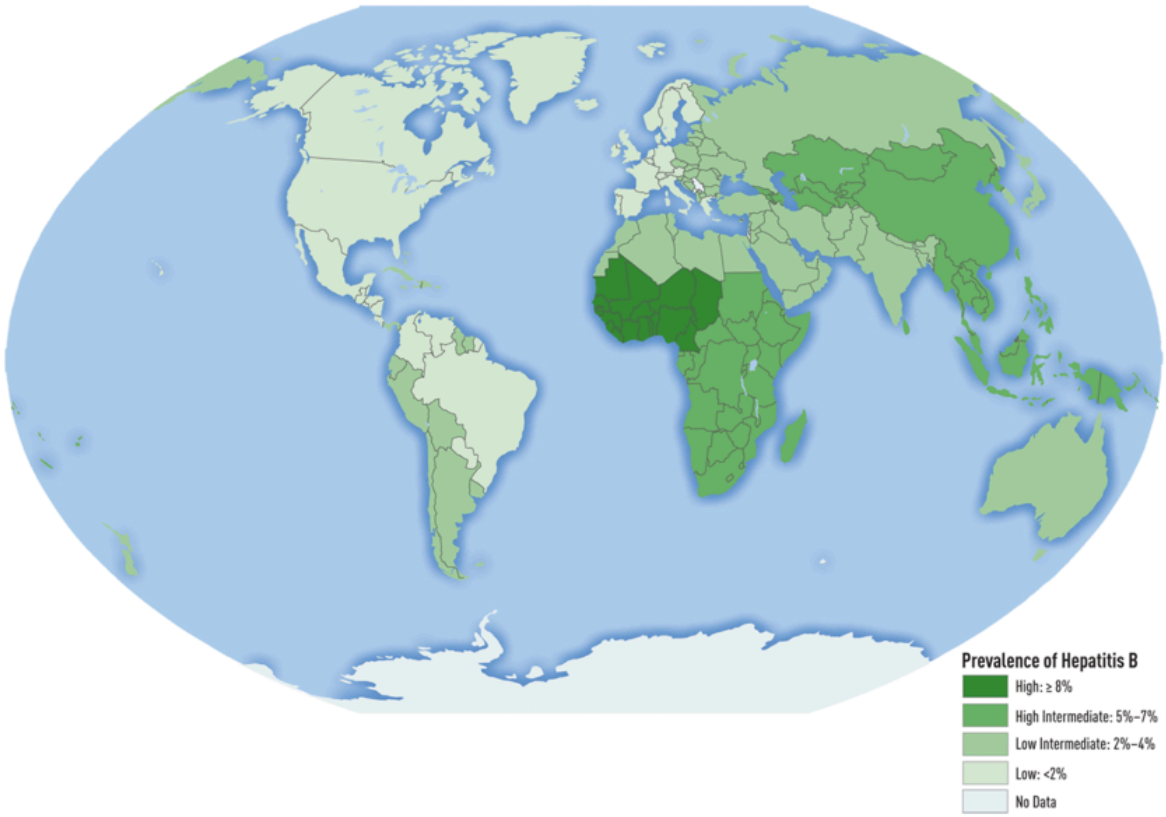
I understand that it is my responsibility to inform the appropriate personnel of any communicable disease, special need or medical condition which may place me at a risk or pose a risk to others during clinical placements. The information on the immunization form will be kept confidential within my clinical site. However, under the following circumstances and for the duration of the program, I authorize the release of this immunization record to: 1. The clinical site personnel where an occupational exposure occurs; 2. The treating medical site/institution (if required); 3. Another clinical placement site (if requested).

_____ _____
Signature of Student Date

Return Completed form to: Clinical Nurse, Faculty of Dentistry
Dalhousie University • 1459 Oxford Street • Halifax NS B3H 4R2 Canada. Forms may also be faxed to 902-494-1757.
For questions regarding this form, please call Ms. Sue Murphy @ 902-494-1673.

*Post-serology testing for applicants born or previously residing in high HBV endemic countries must include both HBcAb and HBsAg as well as HBsAg to fully define HBV status prior to acceptance into the program. This includes applicants from all countries except for those listed as having a Low (<1%) incidence of hepatitis B.

Approved at Faculty Meeting January 22, 2008
Modified November 22, 2008
Approved January 20, 2009
Updated April 9, 2019
Approved April 30, 2019



MAP 3-4. PREVALENCE OF CHRONIC HEPATITIS B VIRUS INFECTION AMONG ADULTS[1]

[1] Disease data source: Ott JJ, Stevens GA, Groeger J, Wiersma ST. Global epidemiology of hepatitis B virus infection: new estimates of age-specific HBsAg seroprevalence and endemicity. Vaccine. 2012; 30(12): 2212-2219.

List of countries by prevalence of chronic hepatitis B virus infection among adults:

High and Intermediate HBV Endemic Countries

High (≥8%): Benin, Burkina Faso, Cameroon, Cape Verde, Chad, Côte d'Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, São Tomé and Príncipe, Senegal, Sierra Leone, Togo

Intermediate (5%-7%): Angola, Armenia, Azerbaijan, Botswana, Burundi, Cambodia, Central African Republic, China, Comoros, Congo, Democratic Republic of the Congo, Djibouti, Equatorial Guinea, Eritrea, Ethiopia, Federal States of Micronesia, Fiji, Gabon, Georgia, Indonesia, Kazakhstan, Kenya, Kiribati, Kyrgyzstan, Lao People's Democratic Republic, Lesotho, Madagascar, Malawi, Malaysia, Maldives, Marshall Islands, Mauritius, Mongolia, Mozambique, Myanmar, Namibia, Papua New Guinea, People's Republic of Korea, Philippines, Rwanda, Samoa, Seychelles, Solomon Islands, Somalia, South Africa, Sri Lanka, Sudan, Swaziland, Taiwan, Tajikistan, Thailand, Tonga, Turkmenistan, Uganda, United Republic of Tanzania, Uzbekistan, Vanuatu, Zambia, Zimbabwe

Low Intermediate (2%-4%): Afghanistan, Albania, Algeria, Argentina, Aruba, Australia, Bahamas, Bahrain, Bangladesh, Barbados, Belarus, Belize, Bhutan, Bolivia, Bosnia and Herzegovina, Brunei Darussalam, Bulgaria, Chile, Croatia, Cuba, Czech Republic, Dominica, Dominican Republic, Ecuador, Egypt, Estonia, Grenada, Guyana, Haiti, Hungary, India, Iraq, Islamic Republic of Iran, Jamaica, Japan, Jordan, Latvia, Lebanon, Libyan Arab Jamahiriya, Lithuania, Macedonia, Martinique, Moldova, Montenegro, Morocco, Nepal, Netherlands Antilles, New Zealand, Pakistan, Palestine, Peru, Poland, Puerto Rico, Republic of Korea, Romania, Russian Federation, Saint Lucia, Saint Vincent and the Grenadines, Singapore, Suriname, Trinidad and Tobago, Ukraine, Uruguay

Low HBV Endemic Countries

Low (<1%): Andorra, Austria, Belgium, Brazil, Canada, Colombia, Costa Rica, Cyprus, Denmark, El Salvador, Finland, France, Germany, Greece, Guatemala, Honduras, Iceland, Ireland, Israel, Italy, Mexico, Nicaragua, Panama, Paraguay, United States of America, Venezuela
No data: Serbia

Source: https://www.cdc.gov/travel-static/yellowbook/2016/map_3-04.pdf

Approved at Faculty Meeting January 22, 2008
Modified November 22, 2008
Approved January 20, 2009
Updated April 9, 2019
Approved April 30, 2019

Appendix 2

nova scotia health authority

OCCUPATIONAL HEALTH SAFETY & WELLNESS
Immunization & Infectious Diseases Screening

It is your responsibility to obtain proof that you have had the following vaccinations **prior** to your appointment with the Occupational Health Nurse and to bring this fully completed Form or documentation with you. As proof You **MUST** supply one of the following:

1. This form completed and signed by a Medical Doctor (MD) , Occupational Health Nurse (OHN), Nurse Practioner (NP), Registered Nurse (RN)
   OR
2. Documentation of all requirements listed below

Name: _____ _____ Date of Birth (YYYY/MM/DD): _____/_____/_____
Last Name First Name

Varicella, Tetanus/Diphtheria/Pertussis, Measles/Mumps/Rubella: All employees **must** provide written confirmation of either the vaccine series **or** proof of immunity via serology.

	Date Vaccine Given (YYYY/MM/DD)	**Serology Date** (YYYY/MM/DD)	**Serology Date & Result**
Varicella	1) 2)		
Td (Td – once every 10 years)			
TdaP (Tdap – once as an adult)			
MMR Measles Mumps Rubella	1) 2)		Measles: Mumps: Rubella:

Hepatitis B: All employees who have the potential to be exposed to blood/bodily fluids must provide written confirmation of the vaccine series and proof of immunity via serology.

Hepatitis B Series # 1	1) 2) 3)		HBsAb:
Hepatitis B Series # 2 (only required if not immune after initial series)	1) 2) 3)		HBsAb:

Tuberculosis**: For all employees who have patient contact:
- If history of TB disease or treatment with INH, please indicate and provide copy of most recent CXR. If previous BCG vaccine given, provide documentation and any TST results post-BCG. If employee has had a 1 or 2 step TST in the past, provide dates and results.
- **If no previous TB testing, OHSW can provide testing.**

Tuberculosis**	Date 1st step given:	Date of Read:	Result:	mm
	Date 2nd step given:	Date of Read:	Result:	mm
	BCG Date (if applicable):	CXR Result (if applicable):		

Signature of - MD, OHN, NP, RN: _____ **Date:** _____

SEE CONTACT LIST ON BACK FOR OCCUPATIONAL HEALTH & PUBLIC HEALTH INFORMATION

May 2017

Approved at Faculty Meeting January 22, 2008
Modified November 22, 2008
Approved January 20, 2009
Updated April 9, 2019
Approved April 30, 2019

Appendix 3

Agreement Form for Hepatitis B antibody, antigen, and Viral DNA Testing

As a health care provider, Hepatitis B is an occupational risk. I understand that due to my serology results, I remain susceptible to Hepatitis B.

I agree to undergo serological testing on an annual basis or on a schedule determined by the Faculty of Dentistry until graduation from the clinical program.

Student Name_____Signature_____

Asst. Dean, Clinics_____Signature_____

Clinic Nurse_____Signature_____

Date_____
Month / Day / Year

Approved at Faculty Meeting January 22, 2008
Modified November 22, 2008
Approved January 20, 2009
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Approved April 30, 2019

Appendix 4

Hepatitis B Vaccine Declination Statement

I understand that as a student in an oral health care program, I am at risk of acquiring hepatitis B (HBV) infection due to occupational exposure to blood and or other body fluids. I have been advised that vaccination is a requirement of the clinical programs. I have been provided with counseling and information regarding hepatitis B. The efficacy, safety issues and benefits regarding the hepatitis B vaccination have been explained to me. However, I decline the vaccine at this time. The **Agreement Form for Hepatitis B Antibody and Antigen Testing** must also be signed as a condition of acceptance into the clinical program.

Student Name_____ Signature_____

Asst. Dean, Clinics_____ Signature_____

Clinic Nurse_____ Signature_____

Date_____
Month / Day / Year