

CRITI CARE, INC.
Emergency Medical Services
EMS Education Services
Paramedic Academy

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Student Name (please print) _____

Mailing Address _____

City _____ Province _____ Postal Code _____

Date of Birth (dd/mm/yy) _____ / _____ / _____

Verification of either inoculation for the following diseases OR laboratory testing confirming the presence of antibodies specific to the following diseases that would render appropriate immunity:

MMR (Measles, Mumps, Rubella)

Td (Tetanus and Diphtheria)

VARICELLA (Chicken Pox)

HBV (Hepatitis B Vaccine) OR Hepatitis A & B Vaccine Combination

➤ **Initial Injection** Date: _____

➤ **1 Month Follow Up Dose** Date: _____

➤ **5 - 6 Month Final Booster** Date: _____

Confirmation of either:

Negative 2-Step PPD (Mantoux) skin test for Tuberculosis

Negative chest X-ray for Tuberculosis (developed < 1 year ago)

Physician's Name

Physician's Signature

Date of Affirmation

Name of Facility/Clinic