

COMMITMENT FORM – December 2nd 2020 version

I, the undersigned _____, agree, for the entire duration of my internship, to take all the necessary precautions to avoid any risk of spread of COVID-19, namely:

- Attend the IPC training course organized by the institution;
- Closely monitor COVID-19 symptoms;
- Rapidly take a COVID-19 diagnostic test in the presence of COVID-19 symptoms;
- Respect the physical distancing instructions of 2 meters as much as possible when around co-workers, supervisors, personnel, etc.;
- Use the minimally required personal protective equipment (PPE) (procedure mask and eye protection) not only in clinical situations, but also in teaching/learning situations;
- Wear eye protection for trainees who have contacts with patients occurring at a distance of less than 2 metres;
- Wear eye protection for trainees involved in contacts within a distance of less than 2 meters with patients;
- Immediately warn my internship supervisor if I came in contact, in the last 14 days, with a person that has tested COVID-19 positive, either in my professional or personal life;
- In the event of a confirmed diagnosis of COVID-19, immediately inform my internship supervisor, my internship environment, and my attending physician.

I confirm that I do not have any of the following symptoms:

- | | |
|---|--------------------------|
| ▪ Fever | ▪ Headaches |
| ▪ Onset or worsening of a cough | ▪ Aching muscles |
| ▪ Difficulty breathing | ▪ Intense fatigue |
| ▪ Sudden loss of sense of smell without nasal congestion, with or without loss of taste | ▪ Major loss of appetite |
| ▪ Sore throat | ▪ Nausea and vomiting |
| | ▪ Diarrhea |

1. Do you intend to work at another health and social services facility 14 days before or during your internship at the CISSS de Laval?

Yes: Name of the facility: _____ No

2. Do you intend to complete an internship at another health and social services facility 14 days before your internship at the CISSS de Laval? Yes No Name of the facility: _____

3. If you have answered Yes to one of the questions above, to the best of your knowledge, are any of those facilities experiencing a COVID-19 outbreak? Yes No

This commitment takes effect from the date of signature thereof.

Last and first name of the trainee: _____

Signature of the trainee: _____

Date (DD-MM-YYYY): _____