**MD Student Outbreak/Exposure Notification Form**

Please use the following template to report the details of your recent COVID-19 exposure at a medical education site to the MD Outbreak/Exposure Coordinator at [md.outbreak@utoronto.ca](mailto:md.outbreak@utoronto.ca).

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**Subject Line: MD Student Outbreak Notification**

**Message:**

Dear MD Outbreak Coordinator,

Please find the details of my recent COVID-19 exposure at a medical education site.

**Section A: Personal Information**

|  |  |
| --- | --- |
| University of Toronto Student Number: |  |
| Last Name: |  |
| First Name: |  |
| Year of Study: |  |
| Academy: |  |
| University of Toronto Email Address: |  |
| Cell Number: |  |

**Section B: Details of Exposure**

|  |  |
| --- | --- |
| Date Exposure Notification Received: |  |
| Date of Exposure (if known): |  |
| Additional Details of Exposure (if known): |  |
| Site Contact (individual who has provided the notification): |  |
| Current Rotation or Elective Placement: |  |
| Site (e.g. name of the hospital): |  |
| Preceptor Name: |  |

**Section C: Future Rotation or Elective Site**

|  |  |
| --- | --- |
| Scheduled Start Date of Next Rotation or Elective Placement: |  |
| Next Scheduled Rotation or Elective Placement: |  |
| Site (e.g. name of the hospital): |  |
| Preceptor Name: |  |

**Section D: Additional Resources**

To ensure that we can provide rapid and comprehensive support, please kindly type your full name to give us your consent to allow the MD Outbreak/Exposure Coordinator to share the details provided on this form with our teaching team.

|  |  |
| --- | --- |
| Please type your full name: |  |

The [Office of Health Professions Student Affairs (OHPSA)](https://md.utoronto.ca/OHPSA) offers a variety of support services to students, which includes the option for confidential personal counselling. To ensure you receive full access to these available supports we kindly request consent to share details provided on this form with OHPSA and to permit a representative to contact you. To provide your consent, please type your name into the box below:

|  |  |
| --- | --- |
| Please type your full name: |  |

**Section E: Other Comments**

Please let us know if you have any additional questions or requests:

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